2023 Quality Assessment and Performance Improvement Program

Overview

Health Alliance Plan (HAP) is a subsidiary of Henry Ford Health, one of the nation's leading health care systems. HAP provides coverage to individuals, companies, and organizations of all sizes, partnering with doctors, employers, and community groups to improve the overall health of every community we serve. HAP's mission is to enhance the health and well-being of the lives we touch.

Company highlights:

- Founded in 1960
- Based in Detroit, Michigan
- 430,000 members
- 1,100 employees
- 50,000 health care provider partners

Chief executive: Michael Genord, MD, MBA
President and CEO, Health Alliance Plan
President and CEO, HAP Empowered Health Plan
Executive Vice President, Henry Ford Health

Governance

HAP is governed by a diverse volunteer board of directors representing a variety of industries that include health care, automotive/manufacturing, financial services, education, professional services, consumer services and community planning.

Subsidiaries and business partnerships

Alliance Health and Life Insurance Company®– Alliance offers fully insured and experience-rated PPO and EPO products, as well as administrative services only (ASO) and self-funded products.

ASR Health Benefits–ASR Health Benefits is a full-service, third-party administrator based in Grand Rapids, Mich., offering competitive options for employers seeking to self-fund their health benefit costs and a statewide provider network.

HAP Empowered Health Plan–HAP Empowered is a licensed HMO that offers two types of plans – Medicaid and MI Health Link (for members who are eligible for both Medicaid and Medicare). Medicaid programs include MIChild, Children's Special Health Care Services and the Healthy Michigan Plan.

Network

HAP's vast network includes more than 50,000 health care providers representing the leading doctors, hospitals and health systems in Michigan. Statewide and national provider networks are available through strategic partnerships with Physicians Care Network in Michigan and Aetna Signature Administrators™ program, offering access to Aetna's national PPO network outside of Michigan and northwest Ohio. Nationally recognized for quality and customer satisfaction.

Effective Oct. 1, 2022, McLaren Greater Lansing Hospital and its 125 providers joined the HAP network. This means that all McLaren facilities and providers in Michigan are now in-network for members of HAP's Medicare Advantage HMO and PPO, commercial (employer group and individual) HMO and PPO, and

Medicaid plans.

Scheurer Health facilities and providers, which were already in-network for HAP's commercial and Medicare plans, are now in-network for HAP Empowered Medicaid plans. Scheurer Health has two health clinics, five rural clinics and 29 providers in the thumb region, which are now in-network for members of HAP's Medicare Advantage HMO and PPO, commercial (employer group and individual) HMO and PPO, and Medicaid plans.

Products
HAP is a full-service health insurance company with distinct product lines:

- **Employer group plans** –HMO, PPO, EPO, Choice Network and consumer-driven health plans. Employer groups have access to fast, accurate and friendly service from knowledgeable local experts. Timesaving online tools make it easy to enroll and disenroll employees, access invoices and check rosters.

- **Individual plans**–HAP has HMO, PPO and health savings account plans available for individuals and families not covered through an employer health plan.

- **Medicare**–HAP offers HMO and PPO Medicare Advantage plans, prescription drug plans and Medicare Supplement (Medigap) plans for individuals and employer-sponsored employees and retirees.

- **Medicaid** – HAP Empowered Health Plan is an HMO offering coverage for those eligible for both Medicare and Medicaid, as well as traditional Medicaid. Programs include MIChild, Children's Special Health Care Services, and the Healthy Michigan Plan. MI Health Link is for members who are eligible for both Medicaid and Medicare.

- **Self-funded**–Through ASR Health Benefits and Alliance Health and Life (AHL), HAP offers options for employers and health and welfare funds that are seeking to self-fund their health benefit costs.

Mission
The HAP Quality Assessment and Performance Improvement (QAPI) program aims to ensure that safe, effective, patient centered, timely, efficient, and equitable clinical care and services are provided to members. HAP also seeks to demonstrate value and improve quality through the elimination of over, under, and misuse of services. 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 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 Quality Improvement (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, 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 (CQMC) 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 https://www.hap.org/medicare

The HAP QAPI program includes:

- Performance improvement projects designed to achieve significant and sustained improvement in health outcome and enrollee satisfaction
- Collection and submission of performance measurement data
- Mechanisms to detect under and overutilization
- Mechanisms to assess quality and appropriateness of care for beneficiaries with special health needs

The QAPI focuses on coordinating activities for continuous quality improvement of clinical care and safety, and for services across the delivery system by improving the health status of the members in the following ways:

- Identifying and reducing healthcare disparities
- Identifying organizational opportunities for performance improvement
- Identifying over and underutilization of services
    - Monitoring includes provider performance reports such as provider and member specific details on underutilization and overutilization of services, as well as provider profiles consisting of HEDIS® gaps in care reports, utilization, and financial data.
- Implementing interventions to improve the safety, quality, availability, accessibility of, and member satisfaction with, care and services
- Promoting members' health through health promotion, disease prevention, and condition management through targeted interventions
- Partnering with physician practices to host health fairs
- Encouraging the development of informed members engaged in healthy behaviors and active self-management
- Measuring, assessing, and coordinating the following:
    - evidence-based clinical quality
    - patient safety
    - practitioner availability and accessibility, including dental care
    - member and practitioner satisfaction

The Quality Management (QM) Department 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 members.

The program description defines the following:

- QI Program Structure
    - Reporting relationships of QI Department staff, QI Committee and any subcommittee
    - Resources and analytical support
    - Delegated QI activities, if the organization delegates QI activities
    - Collaborative QI activities

    - How the QI and population health management (PHM) programs are related in terms of operations and oversight
- Behavioral healthcare aspects of the program
- Involvement of a designated physician in the QI program
- Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program
- Oversight of QI functions of the organization by the QI Committee

NCQA

HAP's commitment to public accountability for the quality program has been demonstrated through 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 HAP Empowered for Medicaid and MI Health Link. In addition, HAP Empowered earned Deeming Status for the Medicaid Module and Long-Term Services and Supports (LTSS) Distinction status (MI Health Link).

Scope

The QAPI applies to members enrolled through Medicare & Commercial products in HAP. HAP has a long-standing commitment to quality improvement initiatives that encompass the full spectrum of care and services provided by HAP. The QAPI 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 physicians to encourage improvement. The 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. Priorities may be subject to change during the year based on new information, changing regulatory or accreditation requirements, or member needs:

- *Behavioral Health Care:* CBHM engages a population health perspective which focuses on whole person care to improve the member clinical heath outcomes and engagement by addressing the members strengths and challenges that are present in 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 member education such as, member outreach initiatives, health events, and educational mailings. Initiatives for 2023 include provider incentives and access to care outreach. The Population Health & Performance Improvement teams support the QAPI by providing educational programs and materials for tobacco cessation, high-risk and routine pregnancy, and to promote preventive care including well child visits and immunizations. Reminders are also sent to members for mammograms, pap smears, lead screening, immunizations, annual physicals, and well child/adolescent visits. The Population Health Management Department, in conjunction with Quality, is responsible for submitting an annual report to MDHHS on health promotion and disease prevention programs, and outreach, referral, and follow-up activities related to member participation rates.

- *Evidence-Based Medicine*: Practice guideline implementation programs include clinical practice and preventive service guidelines, regular monitoring for practitioner performance, and member education such as 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 member, 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. The Hospital Quality and Safety Committee collaborates with applicable internal customers to provide data, research findings, and support in meeting strategic objectives. The committee facilitates the monitoring, analysis and reporting of certain preventable medical errors that occur during hospitalizations as regulated by Centers for Medicaid and Medicare Services (CMS). The preventable medical errors include, but are not limited to, catheter associated urinary tract infections, vascular catheter-associated infections, falls and trauma, and manifestations of poor glycemic control that are not present upon admission. Through contributing HAP departments, these conditions are identified from claims and payment data that may identify these issues that contribute to poor patient safety.

- *Collection and submission of performance measurement data*: 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 for 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:
    - Outreach initiatives to improve member engagement and self-management of chronic conditions
    - Provider group collaboration and outreach initiatives to improve practice-site delivery of health care to members
    - 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 on. 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 with 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 completes a network analysis and a provider satisfaction survey annually. HAP also utilizes the provider newsroom communications, provider education, and office staff education to engage providers. 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 website. These activities are reported to the CQMC annually.

Objectives

The objectives of the HAP 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 health and well-being using 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. Worksheet requirement
D. To develop data-driven disease and condition management strategies to improve provider compliance with clinical guidelines and standards, thus enhancing members' health. To engage in health promotion and education for providers and members in areas of clinical priority to enhance members' health and encourage active self-management.
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 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 that identify disparities in health and that address social determinants of health as well as cultural and linguistic needs of the members.

2023 Initiatives

- Quality Program Performance
    - Achieve 4.5 stars for MA HMO and MA PPO
    - Maintain zero CAPs for the Commercial FEHB program
- Address Purchaser, Accreditation and Regulatory requirements as evidenced by maintaining NCQA Health Plan accreditation
- Through the Member Connections Committee, coordinate CAHPS member satisfaction improvement initiatives to achieve corporate member satisfaction goals
- Maintain a Population Health approach in providing integrated, interdisciplinary care coordination at HAP across all clinical settings and members' circumstances optimizing the use of community resources.
- Address social determinants of health, and initiate efforts to reduce racial and ethnic disparities with a focus on existing disparities in access to healthcare and health outcomes through ongoing interventions in support of Quality Improvement Projects (QIP) and Chronic Care Improvement Program (CCIP)
- Promote Coordination of Medical and Behavioral Health care
- HAP Provider Network Performance is optimized to support members based on value driven care, clinically appropriate utilization, and high quality population outcomes
- Review, investigate, and monitor concerns regarding affiliated providers which have the potential to negatively affect the quality, safety or integrity of services rendered to HAP members and to determine appropriate follow-up as necessary
- Evaluation of the Quality Program Activities as evidenced by completion of the annual evaluation of the Quality Program, Work Plan, and Quantitative Assessment.

Reporting Relationships

Structure

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 QI Program includes measurable goals related to health outcomes. Goals are specific for improving access and affordability for the health care needs of the members. Goals are monitored to evaluate the improvement of care coordination and delivery of services for members.

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 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.

Physician Leadership & Involvement

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. The 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 following committees:

- CQMC
- Credentialing Committee
- Pharmacy and Therapeutics Committee
- Coordinated Behavioral Health Management (CBHM)
- Quality and Utilization Improvement Committee
- Clinical Quality Management Committee

The Medical Director also serves as clinical expert for the behavioral health Population Health Management project team. The Medical Director for Behavioral Medicine provides ongoing consultative support for all behavioral health quality activities, population health management, preventive health programs, and utilization management.

HAP Clinical Quality Management Committee (CQMC) and Other Committees

The Vice President, Clinical Operations and Strategy chairs the CQMC. The CQMC is comprised of Henry Ford Health physicians, HAP network physicians, HAP Board members, HAP Medical Directors, and representatives from Quality, Case Management, Utilization Management, Population Health Management, Network Management, Credentialing, Pharmacy, Appeals & Grievance, Coordinated Behavioral Health Management (CBHM), and the Medicare division. The CQMC analyzes, evaluates, and approves the Quality Program and Work Plan, annual evaluation, and monitors progress toward meeting program goals and objectives, identifies needed actions and ensures follow up as needed. 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 committee meets a minimum of five times per year.

Resources

Significant staff resources are dedicated to quality management activities. Approximately 11 full-time equivalents reside in the quality management department (Appendix A). Several organizational committees or subcommittees are charged with activities to support the QAPI. These committees and subcommittees provide reports to the CQMC as applicable, at least once a year and upon request.

CQMC Subcommittees:

Peer Review Committee (PRC)

Objective: To evaluate and maintain oversight of the clinical and/or technical performance concerns of HAP affiliated providers. In accordance with HAP policies and accreditation standards, provider concerns may be identified through 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 Oversight Committee

Objective: The Credentialing Committee reviews and evaluates 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 Connections Committee (MCC)

Objective: Member engagement and input is critical to fulfilling the mission and vision of HAP. The purpose of the Member Connections Committee is to augment the skills and input of the Executive team and provide a forum for engaged discourse and projects to help guide and drive the operational excellence of the enterprise through validated review. The MCC provides oversight of Member retention and benefit activities within HAP, its third-party vendors, including providers and physicians.

Membership

- Marketing
- Transformation Office
- Consumer Operations
- Digital Engagement
- Population Health Management
- Appeals & Grievance
- Quality Management

- Performance Improvement
- Market Strategy & Consumer Analytics
- Compliance
- Pharmacy
- Community Outreach
- Other departments as applicable

Chairperson: Vice President, Consumer Experience & Marketing
Meeting Frequency: Meets at least 10 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 ensure that clinical criteria is annually reviewed.
- To review Health Care Management audits for timeliness and appropriateness of approvals and denials.
- To ensure 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)

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 Subcommittee formulary decisions
- Approve P&T related policies and procedures
- Works cooperatively with other system committees to identify opportunities to enhance ambulatory drug therapy and integrate formulary and drug use evaluation with condition management and wellness programs
    - Oversees the administration of the Michigan Medicaid Common Formulary, including products on the Single Preferred Drug List
    - Adopts updates to the formulary and utilization management criteria, as established by the State's Medicaid P&T Committee and the Common Formulary Workgroup
    - Provides feedback on drug utilization review (DUR) activities conducted internally and in conjunction with the pharmacy benefit manager (PBM)

Membership

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

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

Executive Quality and Compliance Committee (EQCC)

Objective: 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 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. The EQCC serves to ensure appropriate oversight of internal and delegated operations in line with applicable laws, regulations, federal/state contract obligations, as well as supports and protects the rights of HAP members, providers, and other stakeholders through appropriate and timely resolution of escalated articles.

Additional Responsibilities:

- Reviews and approves reports from other Compliance and Quality sub-committees
- Proactively provides executive oversight and support to the compliance and Quality programs as well as oversight of annual audit and quality improvement plans.
- Creates a culture of compliance and ethics by, among other activities, ensuring appropriate resources for the Compliance and Quality programs at HAP
- Serves to prevent violations of applicable laws, regulations, federal/state contract obligations, and professional organization requirements as well as supports and protects the rights of HAP members and other stakeholders.
- Proactively audits and monitors to identify violations of laws, regulations, and applicable professional organization requirements and provides appropriate response, mitigation, and remediation to any such misconduct as soon as it is suspected or discovered.
- Encourages individuals to promptly report any conduct, ethics, or compliance concerns that they reasonably believe violates HAP's Code of Conduct, applicable laws and regulations, professional organization requirements, or HAP policy or procedure.
- Appropriately disciplines individuals 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, or report such failures 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 that non-compliance or unethical practices will not be repeated.

Membership

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

Confidentiality of Committee Information
HAP is responsible for implementing mechanisms to protect the confidentiality of all information obtained or generated during committee meetings. This includes results of record reviews and other information HAP obtains from facilities and providers on the services received by covered members. The confidentiality of members, providers and practitioners, 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.

Additional forums utilized to exchange ideas and obtain input for the HAP QAPI include the Henry Ford Health Corporate Quality Committee, CLF and the Network Assessment Committee.

- Henry Ford Health, HAP's parent company, provides ongoing support for HAP's QAPI. The Henry Ford Health System Quality Committee 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, Henry Ford Wyandotte Hospital, Henry Ford Behavioral Health Services, and Community Care Services. Additional representatives include the Henry Ford Health Chief Quality Officer and other quality professionals supporting the system improvement teams. The Quality committee 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 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 leaders. 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 purpose of the Network Assessment Committee is to drive provider engagement and ensure an adequate network, through growth and expansion activities in order to support the HAP mission and fulfill obligations of EQCC.

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 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.

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 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 complaints, performance monitors, and quality indicator data. Complaints and performance monitors are investigated when specific thresholds are met.

- Customer Operations/Customer Service Workforce management and customer service work together to monitor metrics (number calls received, average speed to answer and abandonment rate). The workforce management uses historical data to predict future staffing needs. The workforce management team creates schedules that best fit the forecasted model to make sure that we have enough staff for the predicted calls. Forecasting is anticipating call volume based on historical trends, current trends, and business insights. Reports are also created to view historical trends across a variety of key indicators. The team monitors and tracks queue level performance which includes tracking agents' activities in real time. Real time management is the process of monitoring call center Key Performance Indicators (KPI's) and agents in real time statuses so that adjustments can be made to meet the departments service level goals in addition to monitoring and forecast trends both teams meet regularly to discuss the forecast and real-time data to make updates as needed. The workforce management and customer service are in constant contact with each other to make sure that we are aligned with how to handle operations day-to-day.

External Collaboration

HAP 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 assisting with the determination and supporting of identified members' ongoing care needs. HAP 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:

- **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 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 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. The QAPI and annual evaluation are made available to members and providers upon request and are also found on the website.

Work Plan
The QI Work Plan includes all HAP lanned 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.

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.

Internal Quality Improvement Activities
The HAP Quality Improvement Program supports the application of the principles of Continuous Quality Improvement (CQI) to all aspects of HAP'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 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 Medicaid population. The survey evaluates key satisfaction drivers including health plan performance and the members' experience with providers and access to care. The results are collected and analyzed annually and used to improve satisfaction among members.

Functional Areas:

Complex Case Management
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 member is at the center of the care planning process, which identifies their own choices, preferences, and priorities. Through person-centered care planning, the member takes ownership of their care and becomes the active driver of their care. Once determined that a member has complex care needs and would benefit from case management services, the member receives a comprehensive evaluation of their physical and psychosocial function and well-being. Furthermore, all barriers that prevent participation and adherence are identified and addressed.

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

- The degree and complexity of their illness or condition is typically severe.
- Multiple chronic illnesses
- Chronic illnesses that result in high utilization
- The level of case management and care coordination necessary is typically intensive and/or the number of resources required for member to regain optimal health or improved functionality is

typically extensive

Population Health Management
HAP recognizes that population health management is built on a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors which impact health outcomes among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age), and the distribution of health conditions, health-related behaviors and outcomes including but not limited to physical, dental, behavioral, and social needs among different geographic locations and groups (such as socioeconomic, racial/ethnic, or age).

HAP utilizes various data sources to identify target populations for interventions. These sources include but are not limited to HEDIS®, HRAs, claims, lab, pharmacy, risk stratification software, and enrollment files. Member data can then be stratified by subpopulations often including gender, age, geographic regions, race and ethnicity however can differ based on Line of Business and available detail. The use of claims data, pharmacy and laboratory results also provide the plan with further data to identify health disparities. HAP also uses UM data and health risk assessment results to monitor and track health disparities.

HAP stratifies membership data monthly via the following databases:

- HRA forms for HMP population
- Claims/lab/pharmacy
- Post-ED Follow up calls screening for SDoH
- Referrals to Complex Case Management
- Medicaid Enrollment files
- HEDIS®
- Care Connect 360 for HAP Members

HAP stratifies new members monthly and re-stratifies the entire population on a quarterly basis using the enrollment files to identify subpopulations. Stratifying at these intervals will ensure members with increased risk and social needs are identified and interventions can be implemented.

HAP utilizes information such as medical and dental claims data, pharmacy data and laboratory results, supplemented by UM data, HRA results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address health disparities, improve community collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations, including:

- Demographics: Race, ethnicity, gender, age, language, deaf/hard of hearing, geographic location and income level (percent of federal poverty level [FPL])
- Members who are eligible for Medicaid based on an eligibility designation of disability, children eligible for CSHCS, people with Special Health Care Needs (PSHCN), and foster children
- Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such a race, ethnicity, gender, age, primary language, deaf and hard of hearing, geographic location, or income level
- Subpopulations experiencing a disparate level of social needs: transportation, housing, food access, unemployment or education level
- Women with high-risk pregnancies
- Members with high prevalence of chronic conditions, such as diabetes, obesity, cardiovascular disease and oral health disease.
- Members in need of Complex Case Management, including high risk members with behavioral, medical, and/or oral health diagnoses who are high utilizers of services

- Other populations with unique needs as identified by MDHHS, such as foster children or homeless members

Transitional Case Management

The Transitions of Care (TOC) Case Management Program is telephonic. The focus of this program is to assist members who need short-term help, generally 30 days or less, with identifying and accessing health care services that are appropriate for their care needs. HAP's TOC team supports discharge planning and prevents readmissions by ensuring members have resources needed upon discharge from inpatient facilities, including hospitals, skilled nursing facilities, and inpatient rehabilitation facilities. Program characteristics include:

- The goal is a safe discharge
- The resources required vary with the inpatient event
- Telephonic TOC programs utilize the Boost 8P Assessment to identify the member's needs post discharge.

P*rogram Support*

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

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

Utilization Management

HAP performs utilization management services for all products, the services vary based on covered services, benefit designs, and product authorization requirements. HAP's goal is to promote and monitor the delivery of appropriate, quality health care to its members, maximizing favorable practice patterns and health outcomes, and minimizing potential harm to members and unfavorable, inappropriate use of resources.

HAP performs medical management services, including hospital and ambulatory care review; care management of complex medical cases and chronic diseases; hospitalizations and transfers; outpatient referral and durable medical equipment management; and pharmacy review and management.

The HAP Utilization Management Program promotes fair and consistent utilization management decision making and ensures that members have access to care. In conjunction with its Quality Management department, HAP develops and implements quality improvement initiatives with the goal of improving services; improving the satisfaction among members and providers; and promoting integration of utilization management with care management and pharmacy management.

UM Program's Role in the QI Program

The Population Health and Clinical Operations and Strategy departments at HAP support the HAP Quality Improvement Programs by:

- Annually reviewing clinical criteria to ensure accuracy
- Ensuring appropriate health care professionals are responsible for the UM decision-making process
- Seeking advice from board-certified consultants
- Ensuring medical decisions are made timely and accurately
- Evaluating new technology
- Assessing member and provider experience with the UM process
- Providing access to urgent and emergent care
- Ensuring the use of evidence-based medical and pharmacy policies
- Monitoring the activity of all delegates and ensuring adequate delegate staffing as member counts change (formalized in the Pre-Delegation Assessment and Delegation Agreement).
- UM activities generate data that provide necessary information for QM activities such as:
    - Improving timeliness of healthcare services
    - Improving health outcomes
    - Encouraging the appropriate use of resources
    - Ensuring access to care

Quality issues that are identified during UM activities are referred to HAP's Quality Management department and forwarded, when indicated, to the Peer Review Committee and/or Credentialing Committee for investigation and possible implementation of a corrective action plan.

The scope of the Utilization Management Program includes:

- The evaluation of data available through the utilization process to improve the quality of services provided to members
- Providing authorization and oversight of care rendered across the entire health care continuum
- Medical necessity determinations for Children's Special Health Care Services (CSHCS) members.
- Medical directors may consult with the Office of Medical Affairs when making consultations to determine appropriate subspecialists, hospitals, and ancillary providers available to render services. Medical directors may also follow this process when determining appropriate durable medical equipment for CSHCS members.
- Information sources used to make determinations of medical appropriateness.
- The evaluation of multiple resources to determine members who would benefit from case management services.
- Ensure that care given is consistent with accepted practice guidelines.

HAP 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.

Patient Safety

HAP 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 Building Operations to promote awareness of corporate safety responses to emergencies including pandemics, fire and weather disasters, and workplace violence.
- Review, investigation, and monitoring concerns regarding affiliated providers or practitioners who have the potential to negatively affect the quality, safety, or integrity of services rendered to HAP members and to determine appropriate follow-up as necessary.
- Maintaining ongoing oversight of provider and practitioner performance via the Power BI tracking reports and, through the same Power BI system, track all performance and corrective action plans implemented.
- Maintaining a liaison relationship with HFH for alignment of patient and member safety goals
- 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

Community Stewardship and Outreach

HAP is known for community giving and volunteerism. HAP employees volunteer for many community events each year. HAP's charitable giving and community outreach focuses on wellness, youth, education, diversity, community development and arts and culture. The HAP community outreach and strategic partnership team leverages relationships to build brand awareness and membership for all lines of business, while helping to improve the lives we touch.

Key Initiatives:

- Establish and manage relationships with human service agencies and non-profit organizations that support community health and well-being.
- Develop and present member engagement activities to aid in retention for all lines of business.
- Partner with HFH, other contracted providers and enrolled employer groups to present community events and member engagement activities.
- Coordinate Medicaid and MMP Consumer Advisory Councils to gather member feedback and meet contractual obligations.
- Collaborate with HAP HCM and Quality teams to produce and execute "Clinic Days" to close gaps in care for HAP members.
- Identify, promote, and coordinate HAP employee volunteer opportunities.
- Manage high-profile corporate initiatives such as the AHA Heart Walk, the HAP Crim Festival of Races and "Game on Cancer".

Wellness & Prevention

Self-Management Tools are available to all members through the member portal and support the "Keeping Members Heathy" area of focus. The self-management tools provide support in, at a minimum, the following areas:

- Healthy weight (BMI) Maintenance
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthy eating
- Managing stress

- Avoiding at-risk drinking
- Identifying depressive symptoms

Clinical Practice Guidelines
HAP 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 partners with the Michigan Quality Improvement Consortium (MQIC) to research, develop and approve the guidelines. HAP 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. These guidelines are available on the HAP web site: https://www.hap.org/providers/provider-resources/guidelines

Communication of Clinical Practice Guidelines
- Clinical Practice Guidelines are available statewide to MI physicians
- HAP 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.)

Pharmacy programs
HAP pharmacists ensure members have access to the highest quality medications at affordable rates while maintaining an evidence-based drug formulary and managing specialty drugs. As part of its medication therapy management program, HAP pharmacists counsel those with chronic conditions and their doctors to make taking multiple medications less confusing, safer, and more affordable.

Care Management
The Care Management programs provide care coordination across all settings, including acute outpatient and inpatient. Members identified as at risk for safety and symptom management related to medication are referred to HAP's Pharmacy department for a medication management evaluation.
The focus and objectives of the HAP Case Management programs are as follows:
- Provide case management services to all eligible members who opt into the Case Management Program
- Increase access to PCP's and follow-up care with PCP's
- Increase use of community resources based on identified needs
- Achieve and maintain a high level of satisfaction with CCM and TCM services as measured by the percentage of members in the CCM and TCM programs who rated their overall experience with their case manager as Very Satisfied or Satisfied, achieving 90% or higher
- Decrease preventable emergency department use
- Decrease readmissions to hospitals
- Improve access to medical care, mental health, and social services
- Improve coordination of care

- Improve transitions of care across healthcare settings and providers
- Promote preventative health care services
- Assure appropriate utilization of services
- Member health outcomes improvement

Network Analysis

Contracted HAP PCPs have a 24-hour per day, seven days per week responsibility and accountability to their assigned HAP members. Members will be assigned to contracted PCP providers of their choice within 30 miles or 30 minutes of their home residence for routine medical care and specialty referrals. HAP will provide reasonable availability and accessibility for primary care, specialty services, hospitalization, home care, DME, mental health, pharmacy services and other ancillary services by ensuring that it's Provider Network has providers available who are within 30 minutes or 30 miles of the member's residence. If there is not a provider in the member's county of residence, or within 30 minutes or 30 miles of the member's home residence, HAP will authorize the member to see an out of network provider.

The HAP provider network will have at least one PCP for every 500 members per servicing county. The HAP provider network will have at least one of each type of high-volume SCP for every 4,000 members per servicing county. In the event there are no available contracted practitioners that meet the standards, HAP will allow open access for that specialty until the requirement can be fulfilled.

HAP will evaluate their network at least every year to ensure adequate availability and accessibility for its members. The evaluation may occur more frequently if deemed necessary (i.e., large increase in membership or large decrease in providers or practitioners).

Provider Satisfaction

An annual provider satisfaction survey is conducted to determine the level of satisfaction providers have with HAP, including behavioral health providers. This survey is done to assess the strength of the relationship with providers in the plan and to identify areas of improvement. The 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, quality improvement, utilization management, pharmacy services, behavioral health, billing/ease of payment, referral and prior authorization processes, 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 Connections committee annually
- HAP examines the Key Driver Analysis to determine the high priority areas for improvement and primary recommendations
- HAP Member Connections 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 the Member Connections committee

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
On an annual basis, HAP contracts with an NCQA certified CAHPS® vendor to administer the member satisfaction survey. An annual CAHPS survey and supplemental questions as determined by MDHHS are submitted using the approved NCQA certified CAHPS vendor. HAP provides the NCQA summary and member level data to MDHHS annually in electronic or hard copy format. The results are utilized in designing QI initiatives. HAP utilizes the mail and telephone protocol for the survey. 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 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
- 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
- HAP reviews results and sends signed attestation to NCQA
- Vendor produces and sends NCQA Accredited Plan reports, including data tabulations, to HAP
- The results of the survey are analyzed, evaluated and reported to Member Connections Committee
- HAP examines the Key Driver Analysis to determine the high priority areas for improvement and primary recommendations
- HAP Member Connections Committee works with departments to create action plans for improvement
- Barriers and opportunities are identified, and action plans are developed and presented to Member Connections Committee

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.

HIPAA and Privacy
HAP staff work with data related to the development, review, and implementation of all aspects of the QAPI. HAP incorporates a systematic data collection and performance monitoring approach into all activities and complies with accrediting and regulatory requirements. The data collection follows the parameters set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Regulations, state mental health and substance abuse regulations, and NCQA regulations to

ensure that the data collected meets the minimum standards for disclosure of Protected Health Information (PHI), Individually Identifiable Health Information (IIHI), and Individually Identifiable Financial Information (IIFI). PHI may be accessed by HAP staff according to minimum necessary standards for the purposes of treatment, payment, and health care operations without obtaining the member or member representative's consent or authorization.

The privacy of member information is maintained by providing secure work sites, ensuring that computers and data submissions are password protected, and locking desks or cabinets that are used to store member PHI. PHI is monitored by the HAP Compliance Department to ensure that only employees with a need to know have access to the information and that the staff has access to the minimum of information needed to complete the task. Any violations of the HIPAA requirements for improper release of member PHI are managed by HAP's Human Resources Department in accordance with the HAP Compliance Program. The actions taken can include a verbal warning, education, suspension, management oversight for a period, or termination. This protection applies to all members, both living and deceased.

Protection of member PHI includes all activities performed by HAP. Unless a signed HIPAA consent form is on file with HAP, all member data will be de-identified prior to release to any entity where there is not a business need to have access to it. Exceptions to the HIPAA regulations are detailed in the HAP Corporate Compliance Policy which states that uses and disclosures of PHI for which member consent, authorization, or opportunity to agree or object is not required include the following:

- Purposes of public health activities, including preventing or controlling disease, public health investigations or interrogations, reports to the Food and Drug Administration (FDA) for adverse events or post-marketing surveillance.
- Concerning victims of abuse, neglect, or domestic violence, as required by law.
- Health oversight activities authorized by law, regulatory programs, or requirements, within the scope and authority of the regulations.
- For judicial and administrative purposes (including response to subpoena, discovery request, warrant, or other lawful process) to the legal body issuing the subpoena, or court order.
- Purposes of law enforcement or specialized government functions, including national security and intelligence activities.

Employees are required to complete annual HIPAA training and take post training tests to determine their level of knowledge of HIPAA and fraud and abuse. Documentation of the training is monitored through the Henry Ford Health University online training system. Reports can be generated as needed for oversight of the training requirement. Oversight entities such as CMS and MDHHS may review documents related to the compliance program and policies and procedures at any time.

Improving Services to HAP Members

Each year HAP sets goals to improve services to members. HAP submits 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 and Commercial populations. 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. Additional programs designed to improve the health and well-being of the members include HAP Case and Population Health Management programs and provider quality improvement education.

Population Health and Health Equity

The Population Health Management (PHM) Strategy outlines HAP's comprehensive and integrated programs that address population health management. HAP's approach to managing population health ensures that members' needs are being met across the continuum of care to ensure that they have access to high-quality, cost-effective health care. The strategy is a framework that defines how health services are offered and delivered to meet the needs of HAP's members across the four focus areas of population health, including:

- Keeping Members Healthy
- Managing Members with Emerging Risk
- Patient Safety or Outcomes across Settings
- Managing Multiple Chronic Illness

Annually, HAP reviews member population data through a combination of reports on characteristics, including demographics of HAP membership. This analysis of data includes a review of:

- Characteristics and needs, including social determinants of health
- Relevant subpopulations and subpopulation needs, examples:
    - Multiple chronic conditions
    - At-risk ethnic, language and/or ethnic groups
- The needs of children and adolescents
- The needs of individuals with disabilities
- The needs of individuals with serious and persistent mental illness

Annually, a comprehensive analysis inclusive of clinical, cost/utilization and experience measures is completed to evaluate the effectiveness of the PHM programs and the overall impact of the PHM strategy. The *Population Health Management Impact Measure* report is reviewed and approved by the CQMC annually.

Transitions of Care

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

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

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

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

Quality Improvement Projects/Performance Improvement Projects

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

HAP 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

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.

HEDIS® measures are collected, reported, and analyzed to determine the quality of care delivered by HAP. The HEDIS® results are reported annually to NCQA, MDHHS 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. The results are compared to NCQA benchmarks as well as internal goals. The CQMC reviews the results and recommends methods and projects to improve the outcomes. These results are also shared with the network PCPs. Potential barriers to receiving recommended services are also analyzed.

Pay for Performance Reporting

The HAP Incentive Program rewards participating providers and provider organization (PO) groups for performance based on selected HEDIS®, PCMH, SDoH and Care Management measures.

HAP's Pay for Performance and value-based payment arrangements support contracted provider practices by instructing them how to be successful in achieving patient goals in the following areas:

- Monitoring quality
- Tracking patient care outcomes
- Active involvement in all aspects of coordinating care for their patients

These goals can be achieved by:

- Monitoring HEDIS® gaps in care
- Tracking patient discharges and ER visits
- Coordinating all patient care by:
    - Utilizing patient care reports and tools in monitoring performance in shared savings or
    - Risk-based contracts

If providers participate in these activities and utilize the tools provided to them, they are able to transform their practices into highly efficient, quality, patient centric homes for their patient's health care needs.

HEDIS® Gaps in Care Reporting

Detailed HEDIS® gaps in care reporting is distributed to contracted providers monthly for the HAP products. These reports contain a roster of patients specific to the provider that may benefit from population health activities along with their gap closure rates in comparison to their peers. These reports identify HAP members who are HEDIS® eligible and have not received indicated services and/or have not had a visit with their primary care provider within the calendar year. This allows providers to proactively outreach their patients regarding needed services. Providers also have access to this information on the provider portal.

Work Plan

The QI Work Plan is documented and executed annually and reflects ongoing activities throughout the year and addresses:

- Yearly planned QI activities and objectives
- Time frame for each activity's completion
- Staff members responsible for each activity
- Monitoring of previously identified issues
- Evaluation of the QI program

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 is reviewed and evaluated annually by the CQMC and the Board of Directors and revised or updated as necessary. The annual written evaluation of the QI program includes:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of measures of performance in the quality and safety of clinical care and quality of service.
- Evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices.

Communication on Quality Improvement Program with Stakeholders

HAP's QAPI is administered by the 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 QAPI 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, Medication Therapy Management Program (MTMP), documents and evaluations, and network analysis. The CQMC then makes recommendations for any necessary changes. The activities of the CQMC are reported to the Board of Directors.

Appendix A

Quality Resources	
Position	Percentage FTE allocated to MCO QI
Chief Medical Officer	.50
Vice President Clinical Operations & Strategy	1
Medical Director - HCM	.5
Medical Director of Behavioral Medicine	.5
Director, Quality Management	1
Manager, Quality Management	1
Senior Project Coordinator	2
Clinical Quality Coordinator	1
RN Quality Management	1
Quality Coordinator	1
Quality Analysis Associate	1
Senior Management Engineer	1