

Midwest Health Plan

Annual Evaluation of the Continuous Quality Improvement Program for 2008

During the calendar year 2008, MHP continued to make improvements in the quality and safety of the care our members receive. We serve members in Wayne, Washtenaw, Livingston, Macomb, Oakland, and St. Clair counties. Our membership was relatively stable for the year, our January membership was 64,631 and our year end membership is 64,248. We continually evaluate our internal structures and processes and make changes based on results of surveys, audits, and feedback from our providers, office staff and members.

Highlights of the 2008 Quality Improvement Program include:

- Recognized by the Michigan Association of Health Plan (MAHP) with a Pinnacle Award “honorable mention” for MHP’s health fair, “At the Heart of the Community’s Health”.
- Selected to work with MDCH and 5 SE Michigan health plans on a 3-year, multi-state grant on “Reducing Disparities at the Practice Site” project with the Centers for Health Care Strategies.
- Increased network by adding 37 PCP locations, 7 urgent care centers, and 370 specialty providers.
- Implemented a new McKesson case management and disease management information system.
- Modified the authorization process by eliminating the need for referrals for many services. The changes were made in an effort to reduce barriers for members to obtain services. The new authorization process became effective 11/1/08.
- Modified provider contracts (effective 1/1/09) to include a Pay for Performance component with financial incentives for various HEDIS measures. Concurrent with the contract changes was a \$1 million increase in overall payments to PCPs . Providers are able to select fee for service or capitation methods with additional bonus dollars being paid above the FFS or CAP rates for specific services (e.g., well visits, immunizations, pap and mammograms, diabetic screenings, etc.).
- Continued to improve HEDIS rates, particularly in female health, diabetes care, and access to care measures.

Opportunities for 2009:

- NCQA Reaccreditation
- Medicaid bid process
- Need to continue improvements in HEDIS and CAHPS scores. In spite of the increases in 2008, NCQA benchmarks have also increased placing MHP below the 75th percentile in many areas. MHP’s accreditation status changed from “Excellent” to “Commendable” in 2008. With reaccreditation in 2009, an even greater percentage of the score will be from HEDIS and CAHPS measures, which will make it more difficult to achieve “Excellent” status without significant increases in HEDIS and CAHPS scores.

The 2008 Activities Work Plan

The 2008 Activities Work Plan is attached. The goals and objectives are listed. The items shaded have been completed or are ongoing activities. The 2009 Work Plan will incorporate changes based on the results of the CQIP evaluation, updated performance goals, continuous monitoring activities, member complaints, state requirements, and results of audits and surveys.

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Continuous Monitors

The continuous monitoring activities for the year are also attached. The continuous monitors are reviewed at all the QIC meetings. This monitoring of data will continue in 2009. Trends and patterns are discussed at the QIC. Examples include: membership declined in 2008 in part because of the entrance of Health Plan of Michigan in Wayne County and the negative impact it had on MHP's standing in the State's auto-assign algorithm; pharmacy costs and number of scripts PMPM decreased, telephone abandonment rates remained above goal for most of the year with improvements in the fall when new customer services staff was hired, but the rate rose again towards the end of the year. MHP will continue to utilize the monitors to track and trend data relevant to previously identified issues and problems and potential areas of concern.

Patient Safety

MHP addressed patient safety during 2008 in a variety of areas, including:

- Development, review, updating, and distribution of clinical practice guidelines through participation in the Michigan Quality Improvement Consortium (MQIC);
- Monitoring provider compliance with clinical practice guidelines;
- Publishing safety information for members in the MHP member newsletter, member handbook, and Directory;
- Publishing safety information for providers in the MHP PCP newsletter, provider manual and website;
- Conducting office site visits to assess compliance with OSHA, accessibility, medication and vaccine storage, reporting vaccines to the Michigan Childhood Immunization Registry (MCIR) and medical record keeping practices;
- Identifying members who are receiving medications from multiple prescribing physicians and notifying their PCP for follow-up to ensure member safety;
- Promoting patient safety at Health Fairs.

Results from the 2008 audit of 300 medical records showed that the following areas met or exceeded our goal of 90%: diagnosis was consistent with findings (100%), treatment plans were consistent with diagnosis (100%), no risk due to quality of care issues (100%), past medical history documented (99%), and allergies listed (95%). Areas of deficiencies included: problem list in the record (73%) and consultation note in record (77%). When compared with 2007 medical record audit results, there was an improvement in allergies listed in patient records from 88% in 2007 to 95% in 2008.

MHP has continued to work with our largest health care systems (Oakwood and DMC) to provide inpatient and emergency room discharge information back to PCP's, provided documentation forms to PCPs to improve their record keeping, discussed the audit results at a PCP Administrative meeting, sent individual results to the providers, published the results in the newsletter and will re-monitor medical records in 2009. MHP also continued work with its largest primary care provider, Midwest Health Center (MHC) to implement an "Adult Medicine Problem List" into their records. Midwest also purchased Wellcentive (registry) for MHC and is working with the center to implement a patient-centered medical home.

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MHP is making progress towards influencing network-wide safe clinical practices through the efforts described above, and has expanded the focus to other providers (hospitals). MHP has worked with our largest (volume of admissions) hospital system (Oakwood) to promote continuity of care. MHP's web site has a link to information on hospital safety from the Michigan Health and Safety Coalition. This site lists the area hospitals and the volume of procedures and surgeries performed, staffing in the intensive care unit and computer order entry. Our providers and members are informed this information is available on our web site via special mailings, newsletters and manuals/handbooks.

CQIP Committee Structure

The CQIP structure for MHP stayed the same in 2008. Peer Review consultants are used to review criteria and cases and the QIC reviews and approves the UM program and associated reports. The UM Committee re-established regular meetings to review and approve criteria and other utilization management activities. The subcommittees of Confidentiality and Corporate Compliance (Fraud and Abuse), that were implemented in 2004 continue to meet every other month. The flow of information to the QIC is appropriate and meets the regulatory and accrediting body standards. The Peer Review subcommittee met once this year to review a UM case. The management team at MHP meets approximately weekly and any pertinent issues are reported to the QIC. The structure of the QI Program remains the same and has been functioning well. The Medical Director is chairman of the QIC, UM, Credentialing, Peer Review, and Pharmacy and Therapeutics Subcommittees. MHP leadership (Department Directors) are involved in the Subcommittees and the QIC.

Practitioner Participation on Committees

Throughout the year, an evaluation of the committee members and their participation in the QI Committee and Subcommittees has been monitored. We continued the practice of giving the practitioners compensation of \$125 to attend the meetings. We implemented the concept of "participating" provider in order to have specialists input on some committees. This involved the committee support person reviewing the committee information with the practitioner prior to the meeting to get their feedback and input on issues. Their feedback and input would be discussed at the committee and subcommittee meetings and they would be listed in the minutes as participating instead of present. This process has worked well and the "participating" provider input is discussed at the meetings.

Participation by the practitioners on the QIC has remained satisfactory. The Behavioral Health Care provider is an active member of the QIC. The participation on the Credentialing Subcommittee has remained consistent with good physician participation. The Pharmacy and Therapeutics Subcommittee participation has been consistent as the committee has been meeting monthly in 2008.

Network Evaluation

MHP expanded its provider network during 2008 with the addition of 37 primary care locations and 370 specialty care practitioners as well as 7 urgent care centers. A review of our provider and practitioner network is performed annually. MHP continues to meet its member to provider ratios in all areas except for specialists in Macomb and St. Clair counties. Because of the difficulties in finding specialty providers willing to contract at Medicaid rates, MHP has a policy of allowing members to seek specialty care in Macomb and St. Clair counties from non-contracted specialists. This policy has ensured member access to care in areas where our network is small. To address the need for additional OB/Gyn providers in Macomb County, MHP made agreements during 2008 with St. John Hospital and

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Henry Ford Hospital in Macomb to take MHP OB patients. Additionally, Bi-County Hospital can refer OB patients to Henry Ford Hospital Macomb. Goals for 2009 are to continue to expand the network in Macomb, Livingston, and St. Clair counties and continue to increase membership.

Adequacy of Resources

MHP experienced staff turnover during 2008 in Quality, Health Services, and Customer Services areas but the key positions were filled and additional staff continues to be added to meet operational needs. Customer Service also added staff during 2008, including another Arabic-speaking customer representative. It was important to have a second Arabic-speaking representative to provide coverage for breaks, lunches, and absences. Due to the cultural diversity of our population, Customer Service continues to have Arabic and Spanish speaking representatives, and Provider Services has two representatives who speak Arabic.

There continues to be a lack of physical space to house new staff that is needed. MHP continues to investigate additional work space. Cubicles and file cabinets have been moved and re-arranged to allow for the addition of desk space for new employees. Plans are underway for a move to a new office location in 2010. Until then, space constraints will continue to be an issue.

Our staffing in 2008 was adequate to continue with the services we were providing for our providers and office staff, however it was not adequate in Customer Services. Customer Services Department needs to move to a larger work space to accommodate new positions. They have used a number of “temporary” employees, working them into full time positions if they are satisfied with their skill level. The Quality Improvement Department had turnover during 2008. The Department lost its Disease Management Manager and Quality Director. A new Quality Director was hired in the summer of 2008 and is now well integrated with the MHP team. The Department is using contracted nurses to support Disease Management efforts and has consolidated its Health Outreach and Disease Management efforts under one manager. This arrangement is working well in part because of the implementation of the McKesson disease management software system which provides enhanced automated support for both health promotion and disease management efforts.

Behavioral Health

Behavioral health care coverage included in the Michigan Medicaid health plan contract is a limited benefit in terms of scope, duration of treatment, and the conditions for which the health plan is responsible for providing treatment. The State of Michigan carved out mental health services in 1998 from the managed Medicaid plans except for 20 outpatient visits. The health plan is only responsible to provide outpatient treatment for mild to moderate symptoms with minor or temporary functional impairments. MHP members may access the limited behavioral health services directly by seeing a network or non-network provider, or by obtaining a referral from their PCP who directs them to a particular provider. All inpatient psychiatric hospitalizations and partial hospitalization services require authorization from the local Community Mental Health Board in the county where the member resides. Case Management services, Intensive Out-Patient therapy (IOP), Active Community Treatment (ACT) and other services are all provided by the Community Mental Health Boards with no communication to the Medicaid health plans. Substance abuse services are also a benefit exclusion under the Medicaid contract. In addition to the carve out of services, the State of Michigan mandated that health plans must

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cover all psychotropic medications and related side effect drugs with no prior authorization requirements.

In summary, the Medicaid behavioral health benefit structure and delivery system severely limits MHP's access to behavioral health information. Members have open access to CMH providers; health plans do not receive notification of treatment type, length or recommendations; inpatient treatment is not a benefit under the health plan (making follow up for services unmanageable); and coverage in the health plan is limited to 20 outpatient visits per year. Midwest Health Plan allows direct access to behavioral health services for the 20 visits. Because of the direct access, MHP does not perform centralized triage for behavioral health. Upon member or practitioner request, MHP issues a referral for behavioral services to facilitate prompt payment.

In spite of the limited access to information and the fragmented nature of the current arrangements, MHP takes steps to coordinate and improve continuity of medical and behavioral health care. MHP implemented a Continuity of Care process flow with one of the County CMH Boards in 2007 in an effort to improve member care. Other areas that were monitored and acted upon during 2008 included:

- Monitoring feedback from behavioral health providers to PCPs through questions on the annual Provider Satisfaction Survey.
- Monitoring the Antidepressant Medication Management HEDIS measure for optimal practitioner contacts, effective acute phase treatment, and effective continuation phase of treatment for Depression.
- Monitoring depression screening for diabetic patients.
- Monitoring screening for postpartum depression through MHP's Rosebud program.

Barrier analysis and actions to address the barriers were identified and implemented during 2008.

Health Outreach/Disease Management

The Health Outreach and Disease Management programs continued in 2008. These include the following:

Health Outreach Programs

Rosebud Prenatal Management Program

The Rosebud prenatal and neonatal case management program was implemented in July 2002 for low risk and high risk pregnant members. When a member is referred to Rosebud, she is assessed by a Prenatal nurse case manager for her level of risk, and placed either into the low risk program called Special Delivery, or the high risk program in which she is placed into Case Management. Both programs follow the member throughout her pregnancy and after she delivers. In 2008, 279 members were referred for enrollment. Of those members, 37 were enrolled in the Special Delivery (low risk) program, 22 were determined to be at high risk and enrolled in Case Management, 56 members were unable to be contacted, and 158 declined to participate in the program. After the member delivers, a follow up evaluation is conducted to determine the effectiveness and impact the program had on the member's health.

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Childhood Immunization Incentive Program

MHP has an incentive program in place for members who participate in ensuring that children complete all recommended immunizations by age 2. Each time an office sends us a copy of a member's immunization record with proof that a 2-year old member's immunizations were completed by the recommended age, the parent of the child will be sent a \$5 gift certificate to a local retail store. Our immunization rates have steadily increased and there is positive feedback from members and providers regarding the incentive program.

Maternal Infant Health Program (MIHP)

During 2008 the Michigan Department of Community Health (MDCH) completed the redesign of the Maternal Support Services and Infant Support Services (MSS/ISS) program to become the Maternal Infant Health Program (MIHP). MHP continues to screen and refer members to MIHP and completed contracting activities in 2008 with all MIHP providers operating in the service area. In the past, MHP worked with five main vendors, including Priority Health Services, Mother's Friend, Care Plus, Dimensions, Detroit Health Department. In addition information is sent to the member encouraging them to enroll in the MHP Rosebud Prenatal/Neonatal Program. MHP has been part of a workgroup with other southeastern Michigan health plans working with a large health care system (Detroit Medical Center) in Detroit to increase MIHP participation.

Lead Testing Education for Members and Providers

MHP began conducting a quarterly mailing in 2003 to parents of children who have been identified by the State of Michigan's Blood Lead Registry as never having been tested for lead poisoning. Those mailings continued throughout 2008. The letter sent to the member is personalized with the child's name, as well as their primary care physician's name and phone number, in hopes of making it easier for the parent to call for an appointment. We also generate lists of these members and send them to the assigned primary care physicians informing them that the test is due as well. As indicated in the table below, lead screening rates steadily increased from 2004 to 2007 and then fell slightly in 2008.

Blood Lead Testing of Three Year Olds

Length of Enrollment	2004	2005	2006	2007	2008
Total Enrollment	55%	64%	71%	75%	74%
Continuous Enrollment	62%	75%	79%	84%	82%

The State has established goals of 80% for both Total Enrollment and Continuous Enrollment, so we have exceeded the current Continuous Enrollment goal and are making progress towards the more challenging total enrollment goal.

I Can Quit – Tobacco Cessation Program

MHP has used Leade Health since March 2004 to run a tobacco cessation program that has continued throughout 2008. In 2006, the Michigan Department of Community Health selected a new vendor, the American Cancer Society, to administer the State Quitline, but due to our positive working relationship, Midwest Health Plan opted to continue our agreement with Leade Health. Enrollees receive 5 proactive calls from a coach over a 12 month period to develop a personalized plan for

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quitting. Program participants also receive an educational workbook, toolkit, breath mints, stress relieving “quit” putty, and motivational refrigerator magnet. They are eligible to receive prescription coverage for smoking cessation medications, nicotine patches and nicotine gum. Between March 2004 and December 2008, 248 members have enrolled in the program. Enrollment has remained steady, with an average of 50 enrollments per year over the past four years. Based on the 2008 Leade Health outcomes report, 20 of our “I Can Quit” program participants used pharmacotherapy and 16 that used medications preferred to use nicotine replacement therapy.

Disease Management Programs

Midwest Health Plan (MHP) made significant changes to its Disease Management program in 2008 with the implementation of McKesson’s Disease Monitor software system. The new software system provides for an integrated and systematic way to identify members eligible for the program, stratify based on severity of disease, and track member interventions. McKesson integrates claims, encounter, pharmacy, lab and case management data into one system and generates tailored and personalized letters based on very specific rules and criteria. McKesson is now being used for MHP’s Asthma and Diabetes DM programs.

Diabetes Program

2008 was a year of transition for the Diabetes Program. During the first half of 2008, there were a total of 2088 diabetic members with 258 enrolled in the Healthy at Heart program. Following implementation of McKesson, participation changed from an “opt-in” to “opt-out” basis with targeted letters mailed to members based on pre-defined rules using claims, encounter, pharmacy, and lab data. Enrollment in the Diabetes Program at year-end was 2,542 with no members opting-out. A summary of diabetes program participation is provided below.

Diabetes Program Interventions

Intervention	Numerator	Denominator	Rate
General diabetes educational mailing	2,088	2,088	100%
Healthy at Heart (Jan –July)	258	2,088	12.4%
HRA follow-up	39	392	10%
Missing services letter (Aug-Dec)	2,524	2,542	99.2%
Lapse or atypical Rx letter (Aug-Dec)	2,378	2,542	93%
Abnormal lab follow-up letter (Aug-Dec)	190	1,287	14.8%
Follow-up after hospitalization letter (Aug-Dec)	35	1,287	3%
Lab results indicate uncontrolled diabetes letter (Aug-Dec)	1,082	1,287	84%
Diabetes self management classes	82	2,088	4%
Referral to Case Management due to 3+ hospital admissions	15	1,287	<1%
Diabetes and hyperlipidemia letters (Aug – Dec)	653	2,542	26%

MHP evaluates the effectiveness and outcomes of its Diabetes program through annual analysis of HEDIS indicators as well as a number of member and provider participation rates. HEDIS trends for Comprehensive Diabetes indicate improvements in many areas. HbA1c testing increased from 60% in 2004 to 75% in 2008; PoorHbA1c Control fell from 67% in 2004 to 46% in 2008 (lower rate is better); Eye Exams increased from 32% in 2004 to 58% in 2008; LDL-C Screening increased from

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64% in 2004 to 72% in 2008; and Monitoring for Nephropathy increased from 36% in 2004 to 80% in 2008. In spite of these increases, LDL-C control fell from 47% in 2004 to 27% in 2008.

Asthma

The focus for our asthma program is on patient education and resources for the physician including guidelines and management updates. During 2008 MHP also implemented McKesson disease monitor for its asthma program. Members are identified for inclusion via claims, pharmacy, utilization and case management data, and physicians are also encouraged to refer patients. MHP receives monthly notification of members admitted to the ER for asthma-related services, they are encouraged to follow up with their primary care physician with 7 days of discharge. In 2008 there were 185 asthma admissions with 48 seeing their PCP within 7 days, or 26%. All members receive educational mailings at least twice a year. Members identified as high risk or in need, receive additional interventions, including the following:

Asthma Program Interventions

Intervention	Numerator	Denominator	Rate
General educational mailing	3,435	3,435	100%
HRA follow-up	87	392	22%
Follow-up after hospitalization letter	185	914	20%
Beta agonist overuse letter (Aug-Dec)	454	914	50%
Lack of Rx Corticosteroid letter (Aug-Dec)	287	914	31%
Case management referral (Aug-Dec)	2	3435	<1%
Asthma with GERD letter (Aug-Dec)	73	3,435	2%
Status Asthmatic diagnosis letter (Aug-Dec)	35	3,435	1%

MHP has seen improvements in its HEDIS Use of Appropriate Medications for Asthma rates from 2004 through 2008. The combined age group rate increased from 61% in 2004 to 84% in 2007 but then declined in 2008 to 81%. In spite of the increases, however, MHP rates continue to fall below the NCQA 75th percentile.

Depression Program

The Depression Program includes a depression screening tool that is available to physicians to administer to members in identifying those possessing depression risk factors. The screening tools are continually promoted through physician newsletters and physician meetings. Several articles were written for members and providers on the mental health issues; topics like “Depression During Pregnancy” and practice guidelines for physicians. We have incorporated depression screening into our diabetes disease management program and post-partum efforts. Educational materials and a screening tool on depression (Edinburgh) are sent as part of the New Mom’s packet. Results of the HEDIS ® Antidepressant Medication Management measure indicated MHP was just below the NCQA 75th percentile for Effective Acute Treatment and Effective Continuation Treatment.

Health Risk Assessment

MHP developed a Health Risk Assessment in 2003 for all its enrolled members and revised it in 2005. The survey was designed to identify members eligible for enrollment into our various disease

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management and health outreach programs. The survey is mailed out every month to all new members. We mail out approximately 1000 a month and receive about 25 back a month. We have used the information obtained to enroll and send members information about the following programs: Disease Management Programs: diabetes, asthma, high blood pressure, high cholesterol, depression and Health Outreach Programs: tobacco cessation, pregnancy, immunizations and lead testing.

MDCH Performance Improvement Programs (PIP) Initiatives

Cervical Cancer Screening

MHP developed a Cervical Cancer Screening Disparity PIP in 2008 and submitted it to MDCH for review. The PIP topic was selected for a number of reasons, including it reflects a high risk condition potentially affecting a large majority of adult women within the MHP population; the plan has ranked in the lower third of health plans for the past four years in HEDIS Cervical Cancer Screening measure; and MHP has a large percentage of Arabic members who may have a cultural bias against preventive medicine. 2008 is the baseline year with two study indicators measured: 1) The percentage of women, age 24-64, during the measurement year, with at least one pap test within the past three years, who were part of the 2008 HEDIS hybrid sample for Cervical Cancer Screening. 2) The percentage of Arabic women age 24-64, during the measurement year, with at least one pap test within the past three years, who were part of the 2008 HEDIS hybrid sample for Cervical Cancer Screening. A number of interventions were identified and implemented during 2008 and re-measurement will occur during 2009. Interventions included sending overdue listings to provider offices for follow-up; sending member reminder letters to women overdue for pap tests; and promoting women's health screenings at health fairs held at Midwest Health Center in Dearborn.

Access to Care

During 2008 MHP continued to work with MDCH and the Wayne County Medicaid health plans on an improvement project targeting low Access to Care rates in Wayne County. The project began in 2005 and continued into 2007 and 2008 as the "Practice Size Exploratory Project" (PSEP). HEDIS data at the practice site level was shared across plans to identify possible characteristics among low performing practices. In 2008, results from PSEP were used to prepare a proposal to the Centers for Health Care Studies (CHCS) for a multi-state grant opportunity. MDCH and the 6 health plans were awarded the grant in 2008 and the "Reducing Disparities at the Practice Site" project kick-off was in October of 2008. Using the PSEP data, the Michigan team identified 6 high-volume (Medicaid), low-performing practice sites that the health plans would work with in the upcoming 3 years to implement practice changes that would support the practice becoming NCQA certified as a Patient Centered Medical Home. MHP is taking a lead role in the RDPS project.

In addition to the project above, MHP has taken steps at the Plan to improve its HEDIS Access to Care results. Examples include making it easier for members to change PCPs by simply calling Customer Services. The new Pay for Performance incentive system which was developed in 2008 and is effective 1/1/09 includes a \$15 bonus for all well visits. This amount is above any fee for service or capitation amount paid to providers for preventive medicine services. To encourage members to visit their PCPs, MHP implemented an incentive for our Aged, Blind and Disabled (ABAD) members. All (approximately 8, 800) members were sent letters asking them to visit their PCP. They would receive a \$10 gift card after their visit.

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Member Newsletter and Teen Newsletter

MHP continued publishing a member newsletter three times a year and sending it to all member households and an adolescent newsletter targeted to all members between the ages of 11 to 21 twice per year. These newsletters focus on information about our health outreach and disease management programs and various health topics. The member newsletter reaches over 32,000 households three times a year and the adolescent newsletter reaches approximately 15,500 adolescents twice a year.

Preventive Health Guidelines

Midwest Health Plan makes available preventive health guidelines to our members written in both the English and Arabic language. The English version is distributed annually in the member newsletter and the Arabic version is sent directly to Arabic speaking members upon request on an annual basis. Guidelines are also distributed at educational programs including our health fairs and community education functions. In addition these guidelines are sent to physicians on an annual basis in one their monthly physician newsletter packets.

On Hold Messages

MHP continued producing health related “on-hold” messages every month. These messages discuss important topics related to Midwest’s health outreach initiatives, and programs that are free for members to join.

Performance Results

The following summary HEDIS, CAHPS, and Provider Satisfaction Survey results are presented with all results attached to this report. The goals for the HEDIS results are NCQA’s 75th percentile, unless otherwise noted.

HEDIS 2008

Areas of Improvement that met the 75th percentile Goal

- Chlamydia Screening Combined from 56% to 61% (Goal of 61%)
- Timeliness of Prenatal Care from 76% to 86% (Goal 86%)
- Postpartum Care from 51% to 62% (Goal 62%)
- Adolescent Well Care visits increased from 50% to 59% (Goal of 51%)
- LDL Screening after Acute CV event increase from 77% to 83% (Goal of 82%)

Areas of Improvement that didn’t meet the 75th percentile Goal

- Cervical Cancer Screening increased from 64% to 70% (Goal of 74%)
- Childhood Immunization Combo#3 increased from 58% to 64% (Goal 71%)
- Diabetes Care HbA1C-testing increased from 70% to 75% (Goal 84%)
- Diabetes Care Eye Exam increased from 54% to 58% (Goal 63%)
- Diabetes Care LDL-C screening increased from 70% to 72% (Goal 78%)
- Diabetes Care Monitoring for Nephropathy increased from 78% to 80% (Goal 82%)
- Appropriate Treatment for Children w/URI increased from 75% to 83% (Goal of 89%)
- Adult Access to Primary Care measures increased slightly but remained below goals
- Child Access to Primary Care measures all increased slightly but remained below goals.

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Areas Where Little or No Improvement Was Observed

- Childhood Immunizations Combo #2 decreased from 81% to 76% (Goal of 79%)
- Controlling Blood Pressure decreased from 53% to 50% (Goal of 60%)
- Appropriate Use of Meds for Asthma (combined) decreased from 84% to 81% (Goal of 90%)
- Appropriate Treatment Children w/Pharyngitis stayed the same at 19% (Goal of 69%)
- Diabetes Care LDL-C levels under 100 decreased from 30% to 27% (Goal of 37%)
- Breast Cancer Screening decreased from 55% to 52% (Goal of 59%)

Midwest Health Plan had the highest rate of all the Medicaid health plans in Michigan in Adolescent Well Child Visits. We rated above average in the following measures: Well Child Visits 3-6 years, Appropriate Treatment for Children with URI, Cervical Cancer Screening, Chlamydia Screening, Timeliness of Prenatal Care, and Discussing Smoking Cessation Strategies. And even though our results increased in the majority of HEDIS measures in 2008, we remain in the lower third of all Medicaid health plans in Michigan in the following measures: Childhood Immunizations Combo 2 and 3, Well Child Visits First 15 Months, Appropriate Treatment for Children with Pharyngitis, Diabetes HbA1c testing, Diabetes Poor HbA1c Control, LDL-C -Screening, LDL-C levels below 100, Nephropathy screening, Asthma Measures, Controlling High Blood Pressure.

In order to further increase our HEDIS rates to meet Michigan averages and NCQA benchmarks, MHP made significant provider contract changes at the end of 2008 in order to align provider financial incentives with HEDIS measures. We will continue efforts across all HEDIS domains of care in 2009.

Adult CAHPS Survey We again contracted with The Myers Group (TMG) to conduct our Adult CAHPS survey. We had a 24.7% response rate to the questionnaire. The results from 2008 showed statistically significant improvement in the Getting Needed Care composite from 73.5% in 2007 to 81.5% in 2008, and a statistically significant decrease in Rating of Health Care from 71.3% in 2005 to 63.4% in 2008. When compared with NCQA benchmarks, MHP ratings were statistically lower in How Well Doctors Communicate, Rating of Specialist, and Rating of Health Plan. Ratings in Smoking Cessation Medication were statistically higher than Quality Compass benchmarks.

Since CAHPS results are not provider or member specific, targeted interventions and follow up is general in nature. MHP conducted a barrier analysis to identify opportunities and develop target action plans to improve CAHPS rates. Some of the actions planned or implemented include:

- Continue to work with Team Health to make member calls to educate members on available programs and ensure members received the help they needed when calling customer service. Calls are made to new members, follow-up calls to members who called customer services, and random calls to members.
- A new authorization process was implemented effective 11/1/08 that removed the referral requirement for many services and should make it easier for members to get timely access to referral services.
- Convert PCP contracts to fee for service and/or pay for performance reimbursement. The new reimbursement approach was developed in 2008 and will become effective 1/1/09.
- MHP is working on a project to improve the capture of more accurate telephone numbers and will work with its CAHPS vendor to improve CAHPS response rates, particularly telephone

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response rates.

MHP continues to promote appropriate communication with the office, doctors and members via our Art of Active Listening program, monthly newsletters, and quarterly provider meetings, plus our incentives programs for providers, office staff, and members.

Child CAHPS Survey

The Child CAHPS Survey was not conducted in 2008. The State of Michigan contracted with The Myers Group to conduct the Child CAHPS survey in 2007 and used the 2007 results in performance measures during 2008.

Since CAHPS results are not provider or member specific, targeted interventions and follow up is general in nature. MHP continues to promote appropriate communication with the offices, doctors and members via our monthly newsletter, quarterly provider meetings, and the Art of Active Listening program for office staff. The QI Director participates in MDCH's Access to Care work group that is working to improve access to care in southeastern Michigan. MHP continued efforts to improve Child member satisfaction during 2008 but re-measurement will not be until 2009.

Annual Provider Satisfaction Survey

MHP providers were surveyed between March and April, 2008 by The Myers Group. 144 responses were received out of 524 physicians for a 28% response rate. Two measures showed statistically significant increases from 2006 to 2008. Rating of feedback (reports) from behavioral health care providers increased from 27% in 2006 to 41% in 2008, and Rating of feedback (reports) from Nursing Homes increased from 28% in 2006 to 46% in 2008. There was a statistically significant decrease in Extent to which plan controls costs while maintaining a high quality of care from 67% in 2007 to 53% in 2008. When compared with The 2007 Myers Group Book of Business benchmarks, MHP rated above the 75th percentile in Provider Relations composite, Utilization & Quality Management composite, and Pharmacy and Drug Benefits.

Physicians identified ten drivers of overall satisfaction and strength with the plan: 1) Timeliness of UM appeals process, 2) Timeliness to answer questions and/or resolve problems, 3) Quality of provider orientation process, 4) Extent to which UM staff share review criteria and reasons for adverse determinations, 5) Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the services they need, 6) Health plan takes physician input and recommendations seriously, 7) Ease of using formulary, 8) Consistency of review decisions, 9) Responsiveness and courtesy of the health plan's provider relations representative, and 10) Timeliness of UM's pre-certification process. No opportunities were identified to investigate and improve. A number of areas were identified to monitor.

Provider loyalty develops when the health plan consistently meets or exceeds the expectations of its providers. A loyal provider is very satisfied with the plan and willing to recommend the plan to other physicians and patients. There was no significant change in loyal providers from 2007 to 2008, but MHP was significantly higher than The Myers Group 2007 Medicaid Book of Business in this measure. Those 'indifferent' were significantly lower than the 2007 TMG Medicaid Book of Business. There have been very few Provider calls to MHP expressing their dissatisfaction. This is due in part to

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the fact that now we have 3 Provider Service representatives who are responsible for visiting each high volume provider (over 100 members) every month. The representatives are assigned to specific doctors so the doctors and their office staff know who to contact if they have a question or concern that needs to be addressed before their next visit. If a provider has a concern or question, typically the issue is resolved at the time of the call.

Nine questions are tied to the satisfaction with the Health Services (Utilization) Department and are compared to 'all other plans' TMG surveys. The composite increased from 52% in 2007 to 55% in 2008; however, none of the measures (or composite) showed statistically significant changes. All the Utilization measures showed ratings that were statistically higher than the 2007 TMG BoB benchmarks.

This survey will be re-conducted by The Myers Group in 2009.

Wait Time/Appointment Availability Survey

The annual Appointment Wait Time survey is conducted to determine if the high volume (>100 members) PCPs are meeting our standards of care for urgent (48 hours), routine (14 days), and preventive (14days) appointments. Our goal is 90% of our PCPs must meet these time frames. For reporting year 2008, 131 sites representing 78% of the membership were surveyed. The urgent care level was met by 98% of the PCP's, routine care was met by 100% of the PCP's, and preventive care was met by 87% of the PCP's. Every PCP who did not meet the time frame was contacted and a follow-up action was required. If no follow-up action is received a corrective action plan will be initiated.

After Hours Availability Survey

The annual After Hours survey is conducted to determine if members are able to contact their high volume (>100 members) PCP after routine office hours and be appropriately directed to services. We require that all of our providers are available to our members 24 hours a day and set a goal of 90% for specific questions. For reporting year 2008, 103 sites representing 250 PCP's and 78% of the membership were surveyed. 97% of offices contacted provided after-hours availability and directed the member appropriately. Each PCP that did not meet the standard was contacted and follow up action is required. If no follow-up action is received a corrective action plan is initiated.

Customer Services

Customer Services has brought in additional staff during the year and continues to monitor all calls into their department. The majority of calls into the department are inquiries about eligibility. The three highest reasons for complaints were: center location, unpaid claims, prior patient/physician relationship (transfers). Issues such as physician availability, unsanitary office conditions, care received unacceptable, center refusing to treat, waiting too long for an appointment, and waiting too long in the office were all lower down the list. All complaints are followed up in a timely manner. The complaints for Medicare beneficiaries are also logged on the Continuous Monitors. There were no Level II or Level III member grievances during 2008.

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Customer Services monitors speed of answering, call abandonment rate, and time to resolve a call. The call abandonment rate has continued to be above the goal (<5%) all year and has ranged from 5.2% to 22.9%, the average speed of answering has ranged from 36 seconds to 216 seconds (goal of 30 seconds), average hold time has ranged from 41 seconds to 214 seconds (goal of 30 seconds). Call volume remains high regarding eligibility, transportation, benefits, PCP transfers, and ID card inquiries. Customer Service is addressing these issues, looking at more training around phone etiquette and closing calls. The representatives are aware of the member's benefits and processes and procedures with other products and how they affect the members. The department continues to struggle with space within the department and has no work space for additional positions. Midwest is currently meeting with the phone vendor to determine if a phone prompt system for checking eligibility can be added to the phone. This would allow providers to easily access their eligibility thereby bypassing a Customer Service representative. The temporary staffing issue may also account for the department not being able to meet their goals every month. Despite all these issues, they received few member complaints about wait times on the phone. They will continue to monitor their indicators and review them at the QIC.

To assist with Customer Satisfaction, the Customer Services Department instituted "Welcome calls" to all new members starting in the fall of 2007. These calls welcome the member, make sure they received their welcome materials and answer any questions they may have.

Clinical Quality Issues Review

All calls that come into Customer Services are logged and reviewed. If the reason for the call is a potential provider issue related to quality of care, service, cleanliness of the office, attitude of provider, lack of availability, etc., the issue is referred to the QI Department. All issues are reviewed with the Medical Director and logged into the QI Issues spreadsheet. All potential or questionable issues are followed-up at the time of notification (ie. a site visit will be conducted if the complaint was that the office was not clean). Each month the entire log of cases is reviewed to determine if there are any patterns or trends with providers. If the provider has had 4 or more cases in a 6 month time frame, additional investigation and follow up is conducted. For 2008, there were no providers where additional monitoring or corrective action plans have been implemented based on the number of complaints.

Barrier Analysis

One on one meetings are conducted with our high volume providers and their office staff to discuss their HEDIS and CAHPS results. At these meetings, we explore with the providers who perform well what processes they have in-place that positively affects their rates. We explore the barriers that exist with offices that do not perform well and work to resolve them. We have concluded that the main reasons our HEDIS scores have not significantly improved is due to our large Arabic population (1/3 of our membership) and their culture of not seeking preventive care. We have a lot of new immigrants who are not accustomed to western preventive health care. We are working to improve the preventive care seeking behavior of the Arabic community, but realize that cultural change occurs over long periods of time. We are encouraged by the observed improvements in our HEDIS results, and will continue our interventions. We have added QI staff to focus strictly on women's health and are moving to do more ongoing case review to improve our administrative rates.

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The following lists the barriers to achieving our goals and what MHP is doing to reduce the barriers:

Member Barriers

- Many non-English speaking patients: Customer Service asks members if they have a preference for English, Arabic, Spanish etc. speaking providers; PCP Provider Manual and newsletters discuss the language interpretation services available through AT&T language line, the services for hearing impaired, and that we have Customer Services representatives that can speak Arabic and Spanish and help with translation, our phone system allows for information in either English, Arabic, or Spanish.
- Doctors don't speak their languages: MHP has many providers that speak Arabic, Spanish, and other languages. During the enrollment process, Michigan Enrolls is supposed to ask for language preferences, and Customer Service will transfer patients for language preferences.
- Don't know their benefits: Translated handbook into Arabic and Spanish languages spoken by greatest proportion of members, added frequently used benefit information to the Provider Directory for easy reference
- Access issues are some of the main reason members call MHP. While our network of providers meets our standards, members frequently transfer to another PCP. PCPs have stated that members threaten to transfer to another PCP if they are not given the medications they want.
- Patients don't understand the importance of preventive health services: MHP sends quarterly reminders for pap smears, mammograms, Chlamydia, child immunizations, and well child visits. Information is discussed in newsletters and at health fairs.
- Patients need to be better educated: MHP conducts annual health fairs, sends out three member newsletters per year and two adolescent newsletters, new moms sent congratulations packet with information and Bright Futures books, reminder cards are sent for pap smears, mammograms, immunizations, well child visits, and diabetes care. They are contacted as part of a follow-up to an asthma hospitalization.

Office /PCP Barriers to Giving Care

- Hard for offices to keep up with every health plan's benefits: All PCP's were given a member handbook for reference, all offices were given the handbook, our formulary is regularly updated on the web site, MHP offers orientation sessions to all offices to discuss our benefits. Handbook is now included in the PCP Administrative Manual
- Office unaware that MHP provides free transportation to members for medically necessary appointments: Information in member handbook, PCP newsletter, and PCP manual.
- Patients don't show up for appointments: A number of offices say they are too busy to call the member when they miss an appointment. MHP has contracted with Rosebud to assist the member making and keeping their postpartum visits, MHP sends out reminders to members to schedule necessary visits.
- Hard for offices to always remember to check for preventive services: PCPs receive lists of members who are due or overdue for services. These patient specific sheets can be placed on the patients' charts so when they do come in for services, it serves as a reminder to perform the service. Documentation forms have been revised and distributed to PCP's.
- Very busy in office and some patients report (via CAHPS) they wait >15 minutes in the PCP office. If the member calls and complains to MHP, the complaint is followed-up.

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- Feel their amount of capitation should be increased (despite budget deficits and cuts at the State). The new contract has incorporated additional payments to PCPs for a large number of services. There has also been a move from capitation to fee-for-service payment.
- Offices do not have reminder systems or call systems, set up in their office to track the patients: some larger practices have started put this in place, and the move to on-line billing may prompt more offices to explore these possibilities. MHP is working on a Reducing Disparities at the Practice Site project with MDCH and other Michigan Health Plans and will be working to encourage and promote practices to move towards a Patient-Centered Medical Home model during 2009.
- Many members with multiple chronic diseases that demand immediate attention: This takes time away from preventive services and requires a team-approach at the practice level. MHP will be promoting the Patient-Centered Medical Home in 2009 and is considering alternative payment approaches to practices who achieve PCMH certification.

Both Provider and Member Barriers

- Lack of shared decision making on both the part of the provider asking for input and for the member giving input
- Lack of mutual respect
- Lack of acceptance and understanding of Medicaid benefit limitations, and provider and member limitations.
- Personality conflicts—this accounts for the high number of member transfers to other PCPs

Health Plan Barriers

- Staffing limitations: Additional staff for UM and Customer Service have been difficult to hire. There remain open positions in Customer Services and Utilization, but there have been very few qualified candidates.
- Space at the Health Plan: There is a need to renovate the area or move to have space available for these new positions. Customer Services and Utilization still is in need of additional work space. A new building is under construction with an anticipated move in 2010.
- Financial limitations: with the State budget in a deficit, the reimbursement to health plans was cut. We have implemented a risk score project to educate providers about listing appropriate diagnoses and have developed incentives for members to come in for a physician visit and doctors to include all diagnoses. The MHP Board is very conservative in their administrative overhead costs and looks at controlling costs very closely.

Evaluation of Incentive Programs for Office Staff and PCPs:

- Newsletter Contest: Over 50 offices respond each month to the newsletter contest. They receive candy as the incentive for reading the newsletter and answering the test questions correctly. MHP lists the winners of the contest in the newsletter. MHP will continue the contest as this is one way we know some offices are reading the information. It also helps in promoting goodwill and developing the relationship between the health plan and the offices.

Credentialing Program

All timelines for the credentialing and re-credentialing of providers have been met. The number of PCPs has increased due to the addition of other product lines. Oversight of the delegates continues.

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Evaluation of Delegation

MHP delegates some credentialing functions. MHP delegates credentialing to the University of Michigan for PCPs and specialists, to Henry Ford Health Systems for their specialists, and to HVPA for their PCPs and specialists. Annual oversight audits are conducted and the U of M, HVPA, and HFHS have met or exceeded our requirements. We also delegate to an NCQA certified CVO-Professional Credential Verification Service.

MHP also delegates limited functions to Rx America for pharmacy management, including authorizations and patient safety. MHP monitors RxAmerica performance on a regular basis.

Additional Initiatives

We continue our quarterly PCP Administrative meetings. We average approximately 80 PCPs a meeting and they are typically our high volume providers. We use these meeting to update the PCPs on utilization issues, disease management/health outreach programs, QI issues, results of audits and surveys, financial status, contract issues, and specific topics of interest (HEDIS, diabetes, etc.).

MHP conducted one member health fair in conjunction with our largest provider and provided bone density screenings, blood pressure readings, foot exams for diabetics, and cervical cancer screenings. Attendance was over 1,000 and those that participated felt they learned from the information and gave us positive feedback. MHP will evaluate their health fair program (cost, attendance, staff time, etc.) to determine what type of programs to offer in 2009.

Summary

Overall, MHP has made progress in improving the quality of care, safety, and service to our members. We continue to work with our providers to access our web site for communications, eligibility lists, billing and member registries. We have continued to enhance our health outreach and disease management programs, and have added some elements to evaluate their effectiveness. We have implemented McKesson software for all our disease management, health outreach, and case management programs to assist us in tracking and stratifying the members. While our practitioner and provider network meets our standards for access, we will explore expanding our network in Macomb, Livingston, and St. Clair Counties to give more choices to our members. Our HEDIS and CAHPS scores continue to trend upward. We felt this is due to our numerous initiatives, incentives, personalized provider service representatives, and programs. We will be able to focus more on Women's Health with a dedicated staff addressing their needs. Due to State and regulatory requirements, as well as the need to improve the care our member's receive, the QIP bonus was replaced with a Pay for Performance bonus program in 2009 that provides additional fees for specific HEDIS-related services based on submitted claims and encounters. MHP has implemented initiatives to overcome some of the barriers in hopes of serving our members better. MHP is committed to improving the care our members receive.

Attachments

- 2008 Continuous Quality Improvement Program
- 2008 Quality Improvement Work Plan
- Action Plans for 2008
- 2008 Continuous Monitors

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- HEDIS Results Comparison Grid
- MHP's HEDIS Provider Satisfaction Report
- Network Analysis Meeting Minutes
- Program Descriptions for Asthma Program
- Program Description for Diabetes Program