MIDWEST HEALTH PLAN

Continuous Quality Improvement Program

Medicaid

2012

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INTRODUCTION AND PURPOSE

Midwest Health Plan, Inc. (MHP) has a continuous quality improvement program that links knowledge, structure, and processes together throughout MHP to assess and improve quality. Through it, MHP provides reliable, accessible, cost effective, and quality healthcare services. This program is consistent with the mission statement and goals of the Plan. The purpose of MHP's Continuous Quality Improvement Program (CQIP) is to enhance the quality and safety of health care services provided to the members served by MHP, and its practitioners, providers, and customers.

This comprehensive CQIP is a program that institutionalizes MHP's commitment to environments that improve clinical quality, maximize safe clinical practices, and enhance service to members throughout the organization. It is designed to objectively and systematically monitor and evaluate the appropriateness of clinical and non-clinical member care and services. Through the continuous process of monitoring and evaluation, MHP examines the components of its managed care service and delivery system, identifies opportunities for improvement, and recommends changes to effect those improvements. After recommendations are implemented, a re-examination of affected components enables the Plan to validate improvements by measuring service and delivery system enhancements. Approved by the MHP Board of Directors, the CQIP is updated as necessary and reviewed annually, at a minimum, to accommodate revisions that may be necessary to accommodate changing needs. The evaluation includes a description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services; the trending of measures to assess performance in the quality and safety of clinical care and the quality of services; an analysis of whether there have been demonstrated improvements in the quality of clinical care and the quality of service to members; and an evaluation of the overall effectiveness of the QI Program, including progress toward influencing safe clinical practices throughout the network.

MHP makes available to our members and practitioners upon request, information about our QI program, including a description of the QI program and a report on our progress in meeting our goals and our annual evaluation. This information is also found on our website of www.midwesthealthplan.com.

In order to understand our CQIP, we provide some background information. MHP is a Medicaid health plan serving Macomb, Oakland, Livingston, Wayne, St. Clair, and Washtenaw counties. We are heavily regulated by the State of Michigan. Member enrollment occurs through Michigan Enrolls, a contracted vendor for the State. MHP cannot market to prospective members nor can it enroll new members. Results from 2011 CAHPS indicate a diverse racial membership: 41% white, 29% Black/African-American, 6% Hispanic/Latino, 4% Asian, 2% American Indian/other Pacific Islander, 9% "other", presumably Arabic based on location demographics, and 9% unknown. The U.S. Census Bureau does not have a designated classification for the Arabic population as they are captured under "White" which is defined at persons originating in Europe, the Middle East and North Africa. MHP believes the CAHPS racial breakdown for "other", or Arabic, and Hispanics is lower than actual plan membership due to language barriers of members who do not speak English. Midwest also has a young membership population with nearly 69% in the 0-19 year age range.

MHP follows the State of Michigan's drug formulary and the State is responsible for performing new technology assessment.

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. On October 1, 1998, the state of Michigan carved out mental health services 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. Midwest Health Plan 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 limited coordination of care and communication to the Medicaid health plans. Substance abuse services also are benefit exclusion under the Medicaid contract. In addition to the carve out of services, the State of Michigan has elected to expand the pharmacy carve-out to include all antidepressants, anti-anxiety drugs, anti-psychotics, sedatives, hypnotics, SSRIs, anticonvulsants, MAOIs, ADHD drugs, disulfiram, and bipolar disorder medications.

In summary, the Medicaid behavioral health benefit structure and delivery system severely limits MHP's access and coordination of care 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.

GOALS AND OBJECTIVES

MHP's CQIP is ongoing, organized, peer-based and is designed to measure the outcomes of care and service, and apply interventions that continuously improve the level of care and service provided to its members. MHP is committed to delivering high quality health care. The following information is provided to give an overview of MHP's goals. The activities, start dates, persons responsible for activities, etc. are included in the QI Work Plan.

Quality Management and Improvement

The clinical conditions targeted for care improvement initiatives are:

- Hypertension
- Hyperlipedemia
- Diabetes
- Depression
- Asthma

These clinical areas were chosen because they are high volume diagnoses within MHP, the conditions are problem prone if not treated appropriately, high cost for ER usage, and past monitoring (HEDIS®) has shown a need to improve the care in these areas.

The preventive health care topics targeted for 2012 include:

- Childhood and adolescent immunizations
- Childhood blood lead screening
- Well visits for all ages
- Breast cancer screening (including disparities)
- Cervical cancer screening (including disparities)
- Chlamydia Screening
- ABCD Developmental Screening
- Pregnancy (Prenatal care and postpartum care)
- Body Mass Index (BMI)
- Tobacco Cessation

These preventive health areas were chosen because they affect a large part of our population, and past monitoring (HEDIS®) has shown a need to improve the care in these areas.

Service
The areas chosen to be targeted for monitoring and improvement activities during 2012 include:

- Phone service in Customer Services
- Follow-up visit after delivery
- Evaluation of the network in all counties
- Member access to care
- Maternal Infant Health Program (MIHP) referrals
- PCP availability after routine office hours
- Disparities initiatives, including Reducing Disparities at the Practice Site (RDPS) project
- Behavioral Health Care Coordination
- E-prescribing
- Health Information Technology (HIT)
- Other Performance Improvement Projects (PIP), as directed by MDCH

Satisfaction
To determine the level of satisfaction our adult members and providers have with MHP, annual surveys are performed, including a CAHPS adult member satisfaction survey and a Provider satisfaction survey with the Plan. Based on the results, activities are undertaken to improve the areas where results do not meet MHP's goals.

Continuity and Coordination of Care
MHP members are assigned to a PCP; however, they may receive health care services from other providers. These providers may include specialists, hospitals, local health departments, behavioral health care providers, and other providers inside and outside of MHP's network of providers. The following areas will be monitored to help ensure continuity and coordination of care:

- Continuity of care between hospitals and PCPs in regards to asthma follow-up after discharge.
- Communication of care coordination between specialists and PCPs as evidenced by consultant reports in patients' medical records.
- Communication of treatment information between hospitals and PCPs.
- Physician feedback through the annual PCP Satisfaction survey on satisfaction with receiving information/reports from consultants
- Coordination of care in regards to multiple prescribing physicians of medications.
- To the extent possible based on limited data, MHP monitors coordination of care between the behavioral health care providers and medical practitioners through the analysis of monitoring data, selection of opportunities for improvement, identification of barriers through focus groups, individual consultations, and at the QIC.

Patient Safety
MHP fosters a supportive environment to help practitioners and providers improve the safety of their practice. MHP informs members of what they can do help ensure they receive safe clinical care. These are accomplished through:

- Member education about getting the best care possible (handbook, directory, newsletters)
- Providing PCPs with current immunization schedules, clinical practice guidelines, and preventive health guidelines

- Providing PCPs with forms to document care and services
- Site visits that monitor for safe medication and vaccine practices, and medical record keeping practices
- Conducting annual audits of medical record keeping practices
- Updating web site to include links to safety related information
- Publish information about the Leap Frog group and other safety initiatives in the member and provider newsletters
- Development and implementation processes to have hospital discharge summaries sent to non-par providers
- Working with providers to report all pertinent diagnoses on the patients (CDPS scoring)
- Notifying members and providers about FDA drug recalls

Culturally and Linguistically Appropriate Services (CLAS)

MHP serves a culturally and linguistically diverse membership in Southeastern Michigan. The majority of its members reside in the cities of Dearborn and Detroit. The 2010 U.S. Census data indicates 82.7% of the residents of Detroit are African American, and within a few specific zip code areas in SW Detroit there is a large Hispanic population. According to the 2000 U.S. Census, Dearborn, MI is the city with the largest percentage of Arab-Americans at nearly 30%. Nearly 4% live in Sterling Heights, MI and 2.5% in Warren, MI, both cities in Macomb County, one of MHP's six servicing counties. There are no updated statistics since the completion of the 2010 U.S. Census.

The State of Michigan collects member race and ethnicity data from members at the time of enrollment and reports the information to MHP on the monthly enrollment files. Unfortunately, standard race and ethnicity categories do not include Arabic, one of MHP's largest ethnic groups. To supplement the race and ethnicity data obtained from the State of Michigan, MHP also analyzes census data from its service area. Data captured during 2011 HEDIS shows MHP's racial composition as follows: 41% White (MHP estimates at least 30% classified as white are actually Arabic), 29% Black of African American, 0.03% American Indian or Alaska Native, 6% classified as "Other", and nearly 24% of unknown ethnicity.

MHP has a number of activities and targeted initiatives to promote multicultural health care and reduce racial and ethnic health disparities, including:

- Annually assesses the cultural, ethnic, racial and linguistic needs of its membership and adjusts services (such as bi-lingual materials) and its practitioner network as needed;
- Captures race and ethnicity data from the State of Michigan's enrollment file;
- Publishes the MHP Member Handbook in English, Spanish and Arabic;
- Provides information in Midwest Provider Directory on languages spoken in physician offices;
- Incorporates culturally appropriate messages, including culturally appropriate photos, in member materials;
- Ensures the customer services department has an adequate number of Arabic and Spanish bi-lingual staff to meet member needs and provides telephone touch tone options to select a Spanish or Arabic speaking representative;
- Ensures the provider relations department has appropriate bi-lingual representatives to work with Arabic providers in the Dearborn area;
- Maintains Spanish and Arabic member health education materials and provides to members and providers as needed;
- Partners with community organizations such as Arab Community Center for Economic and Social Services (ACCESS) to promote health education in the community and take advantage of available Arabic language health education materials that have been developed by community organizations.;

- Analyzes the existence of health care disparities and takes action as needed, such as the Cervical Cancer Screening PIP and Childhood Obesity;
- Holds an annual health fair at Oakwood-Midwest Medical Center, MHP's largest health care center located in Dearborn, MI. The health fair is publicized in local Arab-American newspaper.

In 2011, Midwest Health Plan continued 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 to help 6 practices achieve NCQA certification as patient-centered medical home (PCMH).

<u>Utilization Management</u>
MHP works to provide appropriate care and services for its members. MHP monitors the utilization of:

- Inpatient admissions for appropriate level of care and length of stay
- Selected ambulatory procedures
- Pharmacy utilization
- Under and over-utilization of selected services
- Emergency Department usage

<u>Case Management</u>
The goal of Case Management is to help beneficiaries regain / maintain optimum health or functional capability in the right setting in a cost effective manner. Case managers are to assist the member with compliance to the health care program prescribed by their physician.

<u>Complex Case Management</u>
Beneficiaries identified for complex case management have needs which are determined to be serious and complex. The condition, for which case management is required, is persistent and disabling or may be life threatening. The condition can impact several systems –respiratory, cardiac, and gastrointestinal; (such as organ transplants, HIV/AIDS, progressive degenerative disorders and metastatic cancers.)etc. The needs of the member include a broad scope of services including: medical, social, and mental health. Several specialties may need to be coordinated to provide the best care and to achieve the desired outcome.

Complex Cases:

- Greater than 60 days of management
- Identification of multiple barriers to care and compliance
- Greater than once a week contact to move the case forward

<u>Intermittent Case Management</u>
Beneficiaries identified for Intermittent Case Management have complex chronic conditions and are at risk for repeat exacerbations. The member may be in need of education on their condition and may be in need of assistance with initial coordination of services. The goal of Intermittent Case Management is to educate the member on their condition and education on how to navigate the health care system.

Intermittent Cases:

- Less than 60 days of management
- Are medical condition specific

- Have identifiable barriers
- Once per week contact

<u>Coordination Case Management</u>
Beneficiaries identified for Coordination Case Management are in need of assistance with coordination of care. Beneficiaries will be given help with making appointments, arranging transportation, obtaining prescribed medications, and obtaining appropriate medical supplies.
Coordination Cases:

- Less than 30 days
- Have identifiable barriers
- Once or twice per month contact

Cases may be closed when the goals are met or when the member declines further case management. Beneficiaries who have exhausted all efforts to change behavior or when the MHPCM in conjunction with the PCP and MHP Medical Director determine the member is not making any changes in behavior the case may be closed. Final Evaluation of Case Management Services is determined through satisfaction surveys sent when a member is discharged from Case Management. The Case Management Program document is part of the UM Program.

<u>Credentialing and Re-credentialing</u>
MHP ensures that members have access to providers that have passed our credentialing and re-credentialing standards. MHP complies with NCQA standards and performs the following activities:

- Continue utilizing CACTUS credentialing database
- Oversight of delegated entities Henry Ford, U of M, St. Joseph Mercy, and others as required.

<u>Continuous Monitoring Activities</u>
MHP has developed and revised the many components included in the continuous monitoring activities. Each department records monitoring activities pertinent to their department on a monthly basis. These activities or monitoring items may be from previously identified issues, potential issues, State requirements, and other topics as deemed necessary. The continuous monitors are reviewed at the QIC. Each department reports on their monitors and discusses the reasons for variances, any trends, patterns, problems and potential solutions.

<u>Behavioral Health Care</u>
The Medicaid behavioral health benefit structure and delivery system has limited 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. A Behavioral Health Care Practitioner participates on the QIC and provides input and advises the QI Committee in the behavioral health care aspects discussed below. Even though MHP is not responsible for Behavioral Health Care, the following activities occur:

- Review of guidelines for the "Management of Adults with Major Depression", "Screening, Diagnosis and Referral for Substance Use Disorders", and "Management of Diabetes Mellitus – Screen for depression".
- Annual review of HEDIS ® Antidepressant Medication Management (effective acute treatment and effective continuation treatment)
- Expand contracting and credentialing of Behavioral Health Care providers to provide PCPs with a referral network and help ensure adequate access (even though there is open access)
- Continue to participate in MDCH Behavioral Health Care Advisory Committee of health plans to work on coordination of care issues

- Continue attending/participating in Coordination of Care Council CMH/QHP/Substance Abuse Coordinating Agency
- Assist in transferring information from Community Mental Health Boards (continuity of care form) to PCPs when received from CMHBs
- Review of data regarding behavioral health care—network analysis component, cultural diversity of providers, location
- Review of the behavioral health care programs—prevalence of depression screening among diabetic members, prevalence of depression screening at postpartum visit, antidepressant mailings to members and new moms, Prime MD, results of HEDIS measures that relate to behavioral health care, results of PCP satisfaction survey in area of continuity of care of receiving reports from behavioral health care specialists, review of pharmacy data related to multiple prescribing practitioners.

Michigan Department of Community Health Initiatives (MDCH)

Appropriate Lead Testing in Children
MHP has had Lead Testing in Children as Preventive Health Indicator for several years and continues to monitor it on a monthly basis. We have consistently exceeded the Michigan managed care plan average rate in terms of compliance in this area for 2 and 3 year olds, and exceeded the State of Michigan's goal of 80% by October 2008 with a rate of 81% for continuously enrolled 3 year olds. MHP ensures all new members receive health guidelines for lead testing, quarterly reminder mailings are sent to parents and providers, all new moms receive lead poisoning and testing information.

Access to Care
MHP has continued to work towards improving its member Access to Care for Children and Adults as part of a MDCH PIP statewide and was part of the Wayne County Access to Care Quality Improvement Project. MHP provided providers practice characteristics, measurement data in a number of key HEDIS measures, to better understand barriers to access within the MHP Network. The information was aggregated across SE Michigan Medicaid health plans as part of a Practice Size Exploratory Project (PSEP). In 2011 MHP made contract changes with providers that revised the pay for performance bonus program that provides additional payments to providers for a number of services, including preventive medicine services.

Reducing Disparities at the Practice Site (RDPS)
Building on information gained from PSEP, the State of Michigan and SE Michigan Medicaid health plans applied for and was awarded a 3-year grant from the Centers for Health Care Studies (CHCS) in 2008 for a Reducing Disparities at the Practice Site (RDPS). Midwest Health Plan is taking a lead role in the RDPS project and will continue working with MDCH, The Institute for Health Care Studies (IHCS), CHCS, SE Michigan health plans and 6 high-volume Medicaid practice sites to help implement changes that will enable the practice sites to achieve NCQA certification as a Patient-Centered Medical Home (PCMH). MHP worked with the Oakwood Healthcare System and Midwest Medical Center and they have been awarded Level 1 recognition as PCMH through December 2013. Concurrent with the pilot project, MHP will be investigating ways to encourage and support other practices to move toward the Patient-Centered Medical Home model.

EPSDT Reporting
Midwest Health Plan uses a variety of approaches to inform members of the need for EPSDT services, including education materials, transportation, and incentives. Educational materials about EPSDT services include member newsletters, preventive health guidelines, member handbook, as well as presentations at health fairs. MHP updates its transportation policy on an annual basis. Member incentives include $5 gift cards for every child who has completed their immunization vaccines by the age of two or age 13. MHP has a $5 gift card incentive for adolescent members who submit documentation of a well child visit between the ages of 12-21. In 2011, MHP will continue its Pay for Performance reimbursement approach which provides additional bonus payments for a variety

of HEDIS services, including well child visits and immunizations. MHP continues to provide transportation, either bus token or taxi (per medical referral), to members upon request.

ABCD Developmental Screening

Developmental screening has always been a part of EPSDT screening. In 2012 MHP will continue focused activities to educate members and providers not only on the importance of EPSDT screening but specifically on the importance of developmental screening as part of the well child visit. MHP will also monitor provider compliance with developmental screening guidelines by tracking claims and encounters submitted for CPT code 96110, developmental testing, limited with interpretation and report. MHP will provide information to providers about developmental screening tools and will promote accurate coding so providers can be compensated for the screenings. MHP will reimburse providers $75.00 when they submit proof of using approved screening forms.

Maternal Infant Health Program (MIHP) Coordination

In 2009, 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 refer all members identified as pregnant to MIHP and completed contracting activities in 2010 with all MIHP providers operating in the service area. 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. MHP will continue its referral process to contracted MIHP providers in 2012.

Body Mass Index (BMI) Measurement/ Weight Management

In light of the alarming rate of obesity among Americans, and the related increased risks of developing many diseases and health conditions from being overweight, it is important that as part of every health assessment, the patient's BMI be calculated and the patient advised if the BMI indicates he or she is overweight. During 2012 MHP will continue steps to educate providers on the importance of calculating and documenting patient BMIs and providing nutrition and physical activity counseling as needed. Beginning in 2009, MHP began to conduct hybrid medical record review for both the Adult BMI and Child Weight Assessment and Counseling for Nutrition and Physical Activity measures. Remeasurement will occur in 2012 with an evaluation of interventions. Results will be documented in a Performance Improvement Project (PIP) that will be submitted to the State's PIP Evaluation Vendor, HSAG. MHP will also promote healthy nutrition and physical activity for members in an effort to encourage self-management of health and raise awareness of the importance of lifestyle choices in weight management and health issues.

Smoking Cessation – I Can Quit Program

In late 2006, the Ceridian Corporation acquired Leade Health, MHP's vendor for its tobacco cessation program. The program is a behavior modification program based on a health coaching model. Enrollees receive 5 proactive calls from a coach over a 12 month period to develop a personalized plan for 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. MHP will continue to offer the I Can Quit Program in 2012 and will continue efforts to promote smoking cessation among its membership. MHP monitors the Advising Smokers to Quit and Smoking Cessation Strategies measures obtained from the CAHPS member survey.

E-Prescribing

MHP has initiated a project to promote the use of e-prescribing among our Primary Care Providers. Specific objectives include:

- Survey our providers about their use of e-prescribing
- Survey our providers about PCMH model (includes e-prescribe)
- Educate providers on the components of Patient Centered Medical Home

- Educate providers on the value, safety and quality of e-prescribing
- Ensure Pharmacy Benefits Manager supports e-prescribe
- Encourage providers to utilize e-prescribing
- Participate in Reducing Disparities at the Practice Site(RDPS)/ Patient Centered Medical Home (PCMH) grant
- MHP will continue efforts in 2012 to promote the use of e-prescribing among its provider network and will also continue to monitor usage of e-prescribing usage to evaluate the effectiveness of Plan interventions.

Health Information Technology (HIT)

MHP is taking active steps to advance provider adoption of health information technologies to improve care coordination, including the following:

- MHP is actively participating in the Reducing Disparities at the Practice Site (RDPS) grant project which is promoting Patient Centered Medical Home Principles (PCMH) across 6 practice sites in southeastern Michigan. MHP is working with Oakwood-Midwest Medical Center which adopted e-prescribe and the Wellcentive registry. The goal is to move practices toward PCMH certification by NCQA. Registries allow providers to capture and report health information to track key clinical conditions.
- At quarterly Provider Administrative, MHP continued to discuss PCMH, registries and e-prescribe.
- Provider monthly newsletters have information on PCHM and E-prescribe
- Opportunity reports (in pdf and excel) on our website allow providers to access administrative/clinical data through our secure website. These reports allow providers to view their members and see what services have been completed and what services are due for their members. These reports take into account lab services and some radiology reports as well as some information from MCIR.
- Our Provider satisfaction survey is conducted annually. The survey asks providers about their use of e-prescribe. In 2011, 36% of survey respondents stated they are using e-prescribe, an increase from 34% in 2010. The annual survey will be re-conducted in 2012. Our largest Provider, Midwest Medical Center, implemented e-prescribe in the fall of 2008. Oakwood-Midwest Medical Center cares for over 10% of our Medicaid members. Our other high volume providers (the U of M providers, Huron Valley Physicians Association and William Beaumont providers) along with some of our independent PCPs, IPAs and PHOs use e-prescribe.
- Our Pharmacy Benefits Manager, CVS Caremark supports e-prescribing. The number of electronic prescriptions sent to the pharmacy increased dramatically in the past year from 11,263 or 15% of total prescriptions in January 2011 to 39,139 or nearly 55% in September 2011. This is due in part to MHP's continued efforts aimed at promoting and educating providers about e-prescribe. Midwest understands the quality, value, and safety of electronic prescribing and continues to promote e-prescribe to our PCPs.

PROGRAM STRUCTURE

Authority

MHP's CQIP is commissioned by the Board of Directors and is accountable to the governing body. The Medical Director is delegated the responsibility and authority for establishing, maintaining and supporting the CQIP.

The Board of Directors, at each of its regular meetings, shall receive and address reports regarding the status of the ongoing CQIP, member complaints/grievances, credentialing information, policies and procedures, results of audits and surveys, and utilization management reports.

The Medical Director, through the Quality Improvement Committee (QIC), shall be accountable for:

- Overseeing the CQIP and assuring that all program functions are coordinated and integrated;
- Assuring that the CQIP is defined and understood by all those involved in the process;
- Developing and assuring proper documentation of the CQIP activities;

- The Behavioral Health Care Practitioner representative, through the QIC, shall be responsible for the implementation of the behavioral health care aspects of the QI program (such as guideline review and approval, peer review activities, consultant for utilization issues, etc.);
- Assisting with the activities required for coordination and continuity of care between PCPs and behavioral health care practitioners and providers as the liaison to the MDCH Behavioral Health Care Advisory Committee.

RESOURCES

The Sr. Director of Corporate Quality is committed full time to developing and implementing the QI Program. Additional support staff include: Director of Quality Improvement, HEDIS® Manager, Quality Improvement nurses, Director of Credentialing, the credentialing coordinator, Director of Health Management (which includes Disease Management Programs), Director of Network Development, the Sr. Director of Health Care Services, utilization management and case management staff, Sr. Director of Operations, Claims Manager, Director of Financial Operations, Customer Services Director, Customer Services representatives, the Medical Director, database administrator, Provider Service Manager and representatives, the Chief Information Officer and Director of Management Information Services Operations and staff, encounter data support staff. The Medical Director for Community Mental Health Services in Wayne County serves as our behavioral health care support. A data analyst and statistician are employed as a consultant for assistance and guidance in the CQIP activities. An expert panel of board certified consultants (PCP and specialists) are also utilized for guideline development (if necessary), peer review activities, and appeals. Hardware systems include desk top computers, laptop computers, copy machines, and routine office supplies. Software systems include Verisk Health for HEDIS® data collection and reporting, and McKesson Disease Monitor system for disease management and McKesson CCMS (case management). Microsoft Office, Excel, Power Point, and other standard computer programs are also used.

SUPPORT PROCESSES

Many processes assist in the development and implementation of the goals set forth in the CQIP. Member services support occurs through the monitoring of customer calls and member transfers. All member inquiries, complaints and appeals are tracked and followed-up. Service issues such as availability of practitioners and accessibility of services are addressed by the Quality Improvement Department through the network analysis, after-hours and wait time studies conducted on MHP contracted PCP providers. Member newsletters are mailed to adult members three times a year and annually to adolescent members. Member health fairs are held periodically throughout the year to help further the educational goals of the CQIP. All new members receive a welcome packet that includes the member handbook, directory of primary care physicians, benefits information, membership card, etc. All these activities are reported to the QIC.

Credentialing processes also support the CQIP by performance of credentialing and re-credentialing activities, performance of site visits and inspections, overseeing the performance of the delegated entities, and record reviews. These credentialing activities are reported to the QIC.

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, pharmacy issues, etc. The utilization management program, evaluation, and other related activities are reported to the QIC.

Support is also provided by the information entered by personnel on the encounters and claims submitted to the Plan. Once this information is entered, Information Systems assists in running yearly reports on top diagnoses, HEDIS reports, and various ad hoc reports as requested for QI.

The Health Management department (includes Disease Management) support the CQIP by providing educational programs and materials for persons with diabetes, hypertension, high cholesterol, depression, tobacco cessation,

high-risk and routine pregnancy, asthma, and to promote well child visits and immunizations. They also send reminders to members for mammograms, pap smears, lead screening, immunizations, annual physicals, and well child/adolescent visits. They also conduct health/educational programs for our members.

Provider Services assists with network analysis, provider satisfaction surveys (performed by a third party survey company), processing the monthly provider newsletters, quarterly provider meetings, provider education, and office staff education. These activities are also integral processes that support QI. Provider Administrative Manuals, directories, and newsletters are provided to the offices. Office staff orientation and Provider Administrative meetings are conducted to help educate and update our network providers and practitioners. These activities are reported to the QIC.

COMMITTEE STRUCTURE

The following committees assist in carrying out the duties and responsibilities to ensure our members are receiving quality care. These committees include representatives from the health plan, practitioners, and providers. The committee meetings occur as stated in the program. The practitioner participation is divided into four categories. Practitioners that are recorded in the minutes as "Present" are the practitioners who were physically present at the meeting. The second designation is "Participating". Practitioners that are recorded in the minutes as participating were not physically present at the meeting. They met with a committee designee and reviewed the information prior to the meeting. Their comments and suggestions were taken back to the committee via the committee designee. The third category is absent. These are the practitioners that were not present or

participating at the meetings. The fourth category is excused. This category is used for the practitioners who were invited to attend but could not do so due to other obligations and they notified the committee designee of their absence.

Committee minutes are recorded at each meeting and reflect key discussion points, decisions, rationale, planned actions, and follow-up. Minutes are maintained in confidential, secure files. The minutes are retained for a minimum of three (3) years, as required by the State of Michigan, Michigan Department of Community Health, and jurisdictions empowered to impose such requirements.

Quality Improvement Committee (QIC)

The Board of Directors, through the Medical Director, delegates to the QIC the responsibility for integrating the MHP Continuous Quality Improvement Program. The QIC is a coordinating, advisory body for all plans and programs which relate to monitoring and evaluating quality and appropriateness of member care and services. The activities of the QIC will be reported to MHP's Board of Directors by the Sr. Director of Corporate Quality.

Membership includes:

- MHP Medical Director
- Sr. Director of Corporate Quality
- Director of Quality Improvement
- Director of Health Services
- Credentialing Director
- Director of Customer Service
- Director of Finance
- Director of Health Management
- Provider Services Representative
- Practicing MHP practitioners (specialties include Family Practice, General Practice, Internal Medicine, Pediatrics, and Behavioral Health)

- Community Mental Health Representative
- Practitioners on the panel of board certified expert consultants, as needed
- Others, as deemed appropriate
-

Primary Committee Functions:

- Integration and evaluation of the MHP's CQIP;
- Reviews and evaluates the quality improvement activities;
- Institutes needed actions and ensures follow-up, as appropriate;
- Recommends policy decisions;
- Periodic and annual review of continuous monitoring activities;
- Annual review of all MHP policies and procedures (e.g. Grievance Policy, Member's Rights and Responsibilities Policy, Accessibility, etc.)
- Responsible for Confidentiality Policy. This includes:
    - Mechanisms to oversee the application of policies
    - Designate levels of user access
    - Identification of unnecessary personal data collection
    - An appeal process for confidentiality issues
    - Mechanisms to limit access to data
    - A process to review requests to use member data
- Annual review of CQIP, evaluation, calendar, as well as the Utilization Management Program, Credentialing/Recredentialing Program, and any other Plan-wide programs; and
- Other QI-related functions as delegated by the Board of Directors, the Medical Director, Sr. Director of Corporate Quality and the Director of Quality Improvement.

The QIC shall meet at least every other month with additional meetings as deemed necessary.

The Medical Director/designee will report the QIC activities in an ongoing manner to the Board of Directors. The reporting will become a part of the Board's meeting minutes.

The following committees report to the QIC:

1) Corporate Compliance (Fraud and Abuse) and Confidentiality/Privacy Subcommittee
2) Credentialing Subcommittee
3) Health Services (Peer Review/Provider Appeals/Utilization Management) Subcommittee
4) Pharmacy, Benefits and New Technology Subcommittee
5) Other committees, as deemed necessary

The following departments provide reports to the QIC:

1) Customer Services
2) Provider Services
3) Medical Services

<u>Corporate Compliance (Fraud and Abuse) and Confidentiality Subcommittee</u>
The Corporate Compliance and Confidentiality Subcommittee is a subcommittee of the QIC. The primary role of this subcommittee is to review the confidentiality and fraud and abuse policies and procedures and ensure that

the policies are implemented and make recommendations to the QIC. This Subcommittee meets bimonthly or on

an as needed basis. The minutes, recommendations, and actions of this committee are submitted to the QIC and then the Board of Directors for approval.

The members include:

- Medical Director
- Sr. Director of Corporate Quality
- Director of Quality Improvement
- Director of Health Services
- Director of Health Management
- Credentialing Director
- Provider Services Manager
- Practicing MHP practitioners on the QIC
- Others, as deemed appropriate

The primary duties of the Corporate Compliance and Confidentiality Subcommittee are as follows:

- Review and revision of fraud and abuse policies and procedures;
- Review of results of auditing activities of the different departments within Midwest Health Plan;
- Ensure implementation of the Fraud and Abuse policies and procedures;
- Ensures proper reporting to the State on potential fraud and abuse practices
- Review and revision of confidentiality policies
- Review of and HIPAA policies;
- Ensure the implementation of the Confidentiality Polices and HIPAA Policies
- Make recommendations to the QIC

The Corporate Compliance and Confidentiality Subcommittee shall meet bimonthly.

The Medical Director/designee will report the Corporate Compliance Subcommittee activities in an ongoing manner to the Board of Directors. The reporting will become a part of the Board's meeting minutes.

Credentialing Subcommittee

The Credentialing Subcommittee reports to the Quality Improvement Committee and meets monthly to consider candidates for credentialing or re-credentialing, including delegated credentialing/re-credentialing. Re-credentialing of practitioners and providers takes place every three years. Re-credentialing includes input from Customer Service, the Quality Improvement Department and Committee, Medical Services, Peer Review/Provider Appeals Subcommittee, Provider Services, and the Claims Department.

The minutes, recommendations, and actions of this committee are submitted to the Quality Improvement Committee and then the Board of Directors for its approval.

The members of the Credentialing Subcommittee include:

- MHP Medical Director
- Credentialing Director
- Credentialing Coordinator
- Sr. Director of Corporate Quality/Director of Quality Improvement
- Practitioners (one Family Practice, one Internal Medicine, one General Practice, an OB/GYN, at least one

specialist, and additional physicians if deemed necessary)

- Provider Services Representative
- Practitioners on the panel of board certified expert consultants as needed
- Others, as deemed appropriate

The primary committee functions are:

- Establish the standards for the credentialing and re-credentialing program;
- Conduct a quality review of the information contained in the application, determine whether providers and practitioners meet Plan standards or not, and recommend Plan participation or denial to the Board of Directors based on their quality review;
- Review of the delegated credentialing agreements, and the results of delegated credentialing activities (oversight, monitoring and quality review), and make recommendations based on the results;
- Yearly review of credentialing, re-credentialing policies and procedures; and
- Review any credentialing continuous monitor results and make recommendations based on the results.

The Credentialing Subcommittee shall meet at least quarterly with additional meetings as deemed necessary.

The Medical Director/designee will report the Credentialing Subcommittee activities in an ongoing manner to QIC.

<u>Health Services Subcommittee</u>
The Health Services Subcommittee is inclusive of Utilization Management and Review, Peer Review and Provider Appeals. It is a multi-disciplinary committee whose purpose is to identify, monitor, analyze, and report utilization patterns as well as review quality of care and/or service issues and make corrective action plan recommendations to the QIC. The committee meets on a bi-monthly basis. The minutes, recommendations, and actions of this committee are submitted to the Quality Improvement Committee and then the Board of Directors for its approval.

The members of the Health Services Committee include:

- MHP Medical Director (Chairperson)
- Director of Health Services
- Sr. Director of Corporate Quality
- Director of Quality Improvement
- Credentialing Director
- Director of Finance and Accounting
- Director of Customer Service
- Provider Services Manager
- Practitioners (one Internal Medicine/ Pediatrician and one Family Practice)
- Practitioners on the panel of board certified expert consultants as needed
- Practicing MHP practitioners (one specialist- i.e., OB/GYN or other specialty, three PCPs- i.e., Family Practice, Pediatrician, General Practice or Internal Medicine, and one Behavioral Health Care Practitioner i.e., Psychiatrist, social worker).
- Representative from Community Mental Health
- Others, as deemed appropriate and appointed by the QIC

The primary committee functions include:

- Monitoring health care management, i.e., high cost, high volume, greatest risk, and those areas with greatest potential for change

- Promoting efficient provision of services in a quality setting appropriate to the needs of our members

- Review and approve evidence-based clinical criteria sets for decision making; assure its consistent application
- Implementing all other quality review procedures required within the Health Services Department to ensure appropriate use of services along with review for potential fraud and abuse
- Focusing resources on problem resolution in an efficient, effective manner
- Review and revision of practice guidelines/standards of care
- Review of member complaints about care or services rendered, by physicians, practitioners or other providers
- Review and determination of provider appeals, including health services and credentialing appeals
- Quality of care and service concerns as identified by the Customer Services, Medical Services, Provider Services and Claims Departments
- Upon request, to review and analyze practice patterns, including issues of under and over utilization;
- Review referrals from the Credentialing Subcommittee based on questionable credentialing information on a provider
- Review of issues from the Utilization Management and Pharmacy Subcommittees
- Referral of issues to the "expert panel"
- Assists in monitoring provider quality of care and service concerns, resulting in recommendations to the QIC for corrective action: corrective action plans are developed and monitored by the Medical Director and reported to the QIC.

The Health Services Subcommittee shall meet at least bi-annually with additional meetings as deemed necessary.

The Medical Director/designee will report the Health Services Subcommittee activities in an ongoing manner to the QIC and the Board of Directors. The reporting will become a part of the Board's meeting minutes.

Pharmacy and Benefits Subcommittee

The Pharmacy and Benefits Subcommittee meets monthly to monitor pharmaceutical utilization for possible quality concerns and makes recommendations on drug utilization and evaluation. The MHP formulary is the State of Michigan's Medicaid formulary and is updated when changes are made by the State. As a Medicaid plan, MHP follows the benefits outlined by the State. The State is responsible for evaluating new technology for inclusion in the Medicaid benefit package. This Subcommittee would review the new benefit or new uses of existing technologies for inclusion in the benefit package. The Subcommittee also assists in ensuring that communication with members correctly and thoroughly represents the benefits and operating procedures of MHP. The minutes, recommendations, and actions of the committee are submitted to the QIC for its approval.

The members of the Pharmacy, Benefits and New Technologies Subcommittee include:

- MHP Medical Director
- Health Services Director
- Director of Finance and Accounting
- Sr. Director of Corporate Quality/Director of Quality Improvement
- Three Practitioners
- One Pharmacist
- Customer Services Manager
- Representative from the Pharmacy Benefits Management company
- Others, as deemed appropriate

The duties and functions of the committee are as follows:

- Preferred drug list development and maintenance.
- Benefit specifications definition.
- Pharmacy network development and administration.
- Drug utilization review and to make recommendations based on results
- Evaluate the use of new medical technologies and the new application of existing technologies in the benefit package
- Oversight of Pharmacy Benefit Manager

The Pharmacy and Benefits Subcommittee shall meet at least quarterly with additional meetings as deemed necessary. The Medical Director/designee will report the Pharmacy and Benefits Subcommittee activities in an ongoing manner to QIC.

CORRECTIVE ACTION

If QI monitors and evaluations reveal the need, MHP will employ various levels of corrective action. In addition, MHP will report any fraudulent and abusive provider practices to the appropriate agencies.

Corrective Action Plans

Corrective action plans (CAP) are developed based on findings resulting from medical and/or service reviews. MHP s committees or the Medical Director can recommend the development of a corrective action plan.

A corrective action plan may consist of focused education to an individual provider; service site administrative manager, or all medical or management staff. The Plan will address the use of documentation, clinical protocols, continuity of care, QIP procedures, conduct with members, or other aspects of health care or administrative practices that impact the delivery of health services to MHP members.

Depending upon the issue, interdisciplinary teams of professionals who are operationally involved with the issue in question may be assembled to begin a Quality Improvement process to resolve identified deficiencies. This structured process relies upon the selected interdisciplinary team to fully understand the issue, identify the magnitude of the problem, develop strategies to improve the situation, pilot the recommendations, and monitor the outcomes in order to fully assess and realize achievable benefits.

All corrective action plans include the following:

1) A description of findings to be addressed;
2) The individuals responsible for each action;
3) Specific actions to be taken;
4) A timetable for correction;
5) An alternative approach if improvements do not occur;
6) Completion date;
7) Date of outcomes reported to the QIC and all parties affected by the corrective action plan; and
8) Follow-up to re-evaluate the situation and determine the degree to which the corrective action plan was effective. Follow-up is to be performed at a minimum of every six (6) months, and more frequently depending upon the issue and actions to be implemented.

If the issue requiring correction involves a provider, the Medical Director meets with the appropriate provider as necessary to discuss the nature of the problem and the recommended solution. The Medical Director offers technical assistance in support of the provider’s effort to resolve the problem. The Medical Director also stipulates the frequency with which the provider(s) formally assesses the implementation process. The Medical Director or the QI Director is responsible for monitoring the effectiveness of the corrective action plan and for determining

whether plan revisions are warranted. If upon review the provider did not follow the CAP, the Medical Director will

meet with the provider and discuss future steps, including termination from the network, if the provider fails to comply with the CAP. The Medical Director reports this activity to the QI Committee.

FRAUD AND ABUSE

Any and all fraudulent or abusive practices regarding a provider, member or employee that are identified by MHP will be reported to the Program Investigation Section at MDCH, Office of Investigator General (OIG), and all other appropriate regulatory agencies. MHP will cooperate with any investigation into the identified fraudulent or abusive action, and provide information, as requested. When appropriate, MHP will also inform the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB).

DELEGATED ACTIVITIES

When MHP delegates any component of the Quality Improvement Program, which includes Credentialing, Utilization Management, Management Information Systems, Behavioral Health Services, Quality Improvement studies and/or outcomes analysis, the following will apply:

1) The State will approve all delegation activities.
2) A pre-delegation review of activities will be conducted.
3) MHP retains absolute authority and accountability for decisions relating to the following:
4) Credentialing and re-credentialing standards and procedures, as outlined in the MHP "Credentialing Program" discussion in this document; and
5) Utilization of health services; case management procedures, quality of care, quality of service and standards of care.

Each delegated entity will name an individual who will work with and report to MHP. All oversight, monitoring, and quality review activities will be reported to the Quality Improvement Committee and the Board of Directors. Any delegated activity will be audited no less than annually to ensure compliance with MHP's standards.

WORK PLAN

The QI Work Plan includes all the planned activities for the year. It is developed annually. The work plan is not a static document; rather it is updated frequently to reflect progress on QI activities throughout the year. The Work Plan includes:

A. The objectives for the year;
B. Scope of the program, including both the quality and safety of clinical care and services;
C. Written measurable objectives for each activity scheduled, including MHP's approach to patient safety;
D. For each objective, the activities that will be done, time frames, and the responsible person,
E. The planned monitoring of previously identified issues;
F. As items are completed, they will be so noted in the activities grid,
G. Annual evaluation of the work plan; and
H. Reports to the Board through the QIC.

EVALUATION

MHP will complete an evaluation of the QI work plan and the Continuous Quality Improvement Program. Results will be submitted to the QI Committee and Board. Results will become the basis for the next year's work plan. The CQI Program, Workplan and Annual Evaluation are made available to members and providers upon request and are also found on our website of www.midwesthealthplan.com.

APPROVAL

The annual revisions to the CQI Program description and the QI Work Plan will be approved by the Medical

Director, the Quality Improvement Committee, and Board of Directors.

CONFIDENTIALITY OF COMMITTEE INFORMATION

MHP is responsible for implementing mechanisms to protect the confidentiality of all information obtained or generated in the course of committee meetings. This includes results of record reviews and other information MHP obtains from facilities and providers on the health care services received by covered persons.

Procedure

Personnel and reviewing physicians who participate in committee activities sign confidentiality statements. The Plan will maintain a record of each person's acknowledgment for a period of at least seven years. Committee sign-in sheets also include a statement regarding confidentiality of information.

Obligation to Maintain Confidentiality

Confidential information must not be disclosed to anyone except for whom the information was intended. Confidential information includes any of the following:

1) Data, reports, records or other information that explicitly or implicitly identifies an individual patient, provider or reviewer ("implicitly identifies" is defined as data unique or small enough to identify an individual patient, provider or reviewer);
2) Reports and recommendations relative to a Utilization Management and Quality Improvement investigation/studies/outcomes;
3) Quality Improvement proceedings (discussions and communications authorized by a committee, including review notes, meeting minutes and other records or review matters);
4) All MHP policies and guidelines, or other relevant documents discussed during the UM/QI process:
   - The providers are requested to have all employees who come in contact with our enrollees, or their charts, sign a statement of confidentiality.
   - All Board members and their families, officers, vendors and consultants are required to report via the conflict of interest reports at least annually or at the time said occurrence should develop.
5) Refer to MHP's Confidentiality Policy Statement regarding the Confidentiality of Individual Member/Patient Records Information.