

Midwest Health Plan

Annual Evaluation of the Continuous Quality Improvement Program for 2007

During the calendar year 2007, MHP has continued to make improvements in the quality and safety of the care our members receive. We serve members in Wayne, Washtenaw, Livingston, Macomb, Oakland (as of 10/1/07), and St. Clair counties. At the beginning of the year our membership was 61,014 and our year end membership is 64,550. 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. We are extremely pleased to report that we continued our “Excellent” accreditation from NCQA, based on HEDIS results.

A review of our provider and practitioner network is performed annually. In 2005, we have changed our PCP to member ratio from 1 PCP/2,000 members to 1 PCP/750 members based on the State’s requirements. We have met our standards for PCPs and Specialists in each county, however, in looking at the maps of provider locations, it was felt we needed to continue to target northern Macomb and St. Clair counties for additional providers and practitioners. Our Network Development department has been actively working to recruit providers in Macomb and St. Clair counties. The problem that is encountered in trying to increase our network is that many of the PCPs and specialists contacted do not want to accept Medicaid. Our standards for PCPs and Specialists is realistic for the community, our delivery system and clinical safety. We continue to contract with more urgent care centers to increase our members’ access to care after hours instead of using the Emergency Room for non-emergent conditions. We have added ten urgent care centers during 2007 going from 40 to 50 and we continue to send letters to members who have used the emergency room for non-emergency conditions. Goals for 2008 are to continue to expand the network in Macomb, Livingston, and St. Clair counties and continue to increase membership.

The 2007 Activities Work Plan

The 2007 Activities Work Plan is attached. The goals and objectives are listed. The items shaded have been completed or are ongoing activities. The 2008 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.

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 2008. Trends and patterns are discussed at the QIC. Examples include: claims turnaround time is meeting the 30 day time frame, the increase in number of providers is due to new product lines being offered, the increase in abandonment and wait times on the phone is correlated to the addition of a new product line (Oakland ABW) and the start of the Midwest Advantage (Medicare) program January 1, 2006 as well as the problem with having open positions and some new staff. The number of PCPs and specialist credentialed meet our standards, our pharmacy costs remain high, and our membership increased 4% over the course of the year. Based on departmental needs and practitioner feedback, some monitors will be revised to make them more meaningful.

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 has addressed patient safety via our PCP newsletter, member newsletter, member handbook and PCP directory to our members. Articles and information on taking medications appropriately has been included in our member handbook and newsletters as well as distributed at our Member Health Seminars. MHP continues to monitor PCP compliance to OSHA, accessibility in their offices, medication and vaccine storage, reporting of vaccines to the Michigan Childhood Immunization Registry (MCIR) and medical record keeping practices. The 2007 audit of 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 (99%), no risk due to quality of care issues (99%), past medical history documented (96%), and consultation note in record (91%). Areas of deficiencies included; not having a problem list in the record (85%) and not listing allergies prominently (88%). MHP has worked with our largest health care system (Oakwood) to provide inpatient information back to non-Oakwood 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 2008. MHP worked with its largest primary care provider, Midwest Health Center (MHC) to implement an "Adult Medicine Problem List" into their records. MHC has approximately 10% of our population. An audit conducted in the fall of 2005 showed that only 30% of the records had the problem list included. The barriers encountered in the Center to not meeting the goal of 90% of records having problem lists included lack of time to complete the form (have to review entire record to complete the form) and numerous staffing changes without having additional in-services on use of the form. Re-education and in-servicing will occur when MHC hires a new nurse administrator and operations director. MHP is making some progress towards influencing network wide safe clinical practices through our efforts described above, and have expanded the focus to other providers (hospitals). MHP has worked with our largest (volume of admissions) hospital system (Oakwood) to promote continuity of care. In the past, if the PCP was not on staff at the hospital, they did not get the member's discharge summary and would not know their patient was in the hospital. MHP developed a process whereby all members' discharge summaries are sent to the PCPs-even if they are not on staff at that hospital. In 2007, over 300 discharge summaries were sent to PCPs that did not have privileges at Oakwood sites. 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 our newsletters and manuals/handbooks.

CQIP Committee Structure

The CQIP structure for MHP stayed the same in 2007. Peer Review consultants are used to review criteria and cases and the QIC can review and approve the UM program and associated reports. It was decided that the UM information will be presented directly to the QIC. 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 and Provider Appeals subcommittees met once this year to review a UM case. The Infrastructure Subcommittee is rolled up into the management team committee (the same persons attended both). The management team at MHP meets approximately weekly and any pertinent issues are reported to the QIC. The structure of the QI Program has been functioning well and as discussed above, the UM Subcommittee was disband and the information is presented directly to the QIC. Other than the change discussed above, the structure

remains the same. The Medical Director is chairman of the QIC, 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 \$125 incentive 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 good. The Behavioral Health Care provider is an active member of the QIC. The participation on the Credentialing Subcommittee has remained constant with good physician participation. The Pharmacy and Therapeutics Subcommittee participation has been constant as the committee has been meeting monthly in 2007.

Adequacy of Resources

While MHP experienced some staff turnover, there has been difficulty in filling the vacancies. This is due to lack of qualified individuals responding to the ads, as well as lack of physical space to house any new positions. 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.

Our staffing in 2007 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. They have additional open positions, but the work space will not accommodate any additional work stations. MHP continues to investigate additional work space. The Quality Improvement Department increased a part time position to full time in Health Outreach to focus on Women’s Health. They also hired a new Health Outreach Coordinator as a result of a resignation. The Health Services (UM) Department hired a full time pharmacist in 2006, they had the Manager resign in October, (just replaced in Jan 2008 with a case management manager), but have been able to continue their routine activities, however, they also want to expand their services and conduct more case management activities.

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 these carve out of services, the State of Michigan mandated that health plans must 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.

Stating this, MHP has implemented a Continuity of Care process flow with one of the County CMH Boards in 2007 in an effort to improve member care. This model will be explored with other County CMH Boards in 2008 so that CMH information and physical health information can be more readily exchanged between PCP's and behavioral health.

Health Outreach/Disease Management

The Health Outreach and Disease Management programs continued in 2007. These include the following:

Health Outreach Programs

Rosebud Prenatal Management Program

A 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 2007, 68 members were referred for enrollment. Of those 68 members, 15 were enrolled in the Special Delivery (low risk) program, 13 were determined to be at high risk and enrolled in Case Management, and 40 members were either unable to be contacted, or 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. Results were not available at this time.

Childhood Immunization Incentive Program

MHP has an incentive program in place for members and provider office staff 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. The physician's office name is also entered into a drawing for a \$100 gift certificate to a location of the office's choice. Our immunization rates have steadily increased and there is positive feedback from members and providers regarding the incentive program. Adolescent

immunizations were taken out of the incentive program due to it not being a HEDIS measure for CY 2007.

Maternal Support Services (MSS) and Infant Support Services (ISS) **MSS/ISS Screening Program**

The process for screening and referring members to MSS/ISS services continued in 2007. Members identified with a MSS or ISS screening are forwarded to the Claims Department to be entered into the system as having an encounter for the screening. Midwest Health Plan had 196 MSS referrals this past year and 116 ISS. These members are also monitored to ensure that they are referred to a MSS/ISS provider for further assessment and services. MHP works with five main MSS vendors, 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 MSS 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 2007. 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. When we began this quarterly mailing, our lead testing rate was at 41% in 2003. By the end of 2004 it was 55% for Total Enrollment and 62% for Continuous Enrollment. By December 2005 it was 64% for Total Enrollment and 75% for Continuous Enrollment. By December 2006 it was 71% for Total Enrollment and 79% for Continuous Enrollment. By December 2007 it was 75% for Total Enrollment and 84% for Continuous Enrollment. The State has established goals of 80% for both Total Enrollment and Continuous Enrollment, so we have exceeded the current Continuous 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 2007. 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 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 2007, 202 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 2007 Leade Health outcomes report, 89% of our "I Can Quit" program participants used pharmacotherapy and 81% that used medications preferred to use nicotine replacement therapy. Over the year 3.4% of the members were tobacco free, 11% indicated improved eating habits, 11% indicated improved physical activity, and 11% indicated improved stress coping.

Disease Management Programs

Midwest has purchased McKesson software for Disease Management (DM). The implementation began in the fall and should be fully implemented for Diabetes and Asthma by July, 2007. MHP also purchased the Case Management and Interqual software so coordination will occur between DM and Case Management.

Diabetes Control Network Program

The Diabetes Disease Management Program combines in-house information and the Diabetes Control Network (DCN) program. The Disease Management Program is stratified into three levels; General, Premium, and High Risk. Members are enrolled in the General program on an “opt-out” basis, the Premium program is on an “opt-in” basis, and the High Risk is on an “opt-out” basis. The General program involves a series of bi-monthly educational materials and other interventions around monitoring of their condition, adherence, lifestyle issues and other health conditions. The Premium program does mailings each month for 12 months designed to help members with Diabetes properly self-manage their condition and maintain a healthy lifestyle. The High Risk program includes a contact from the Disease Management staff to further assess clinical, medical equipment and supplies. As of December 2007, there were 1662 in the General program, 241 in the Premium program and 96 in the High Risk program. 241 members enrolled in the program. We also had 25 enrolled physicians. A follow-up survey is sent to all members on a monthly basis to assess their level of knowledge after the last fulfillment mailing is sent. Of the 2,088 surveys sent out in 2007, 251 responded, for a 12% response rate. Twenty (20%) percent indicated they didn’t have diabetes. Sixty-one (61%) of the members are smokers, 69% state they have high blood pressure, and 65% state they have high cholesterol. The large majority responding, 83%, were adults over the age of 40. Ninety-seven (97%) percent indicated the program improved their overall health and helped them. 88% reported improved blood pressure, 80% indicated improved cholesterol, and 83% indicated improved blood sugar. Ninety (90%) percent rated the information they received as excellent or good. 98% said they would recommend the program to others.

“Healthy At Heart” Program

Members identified with hypertension, high cholesterol, and/or diabetes receive an invitation to join the free Healthy At Heart Program. This program has been in place since 2004 and kept the same basic focus on hypertension, cholesterol, and diabetes even though some of the formal program subset names have changed. The program, now referred to as “Reducing Your Cardiovascular Risk” is sponsored by Pfizer Pharmaceuticals. There are three components to the program:

- Counting Cholesterol Down - management of members with dyslipidemia
- In Charge - management of members with hypertension
- Diabetes Control Network - management of members with diabetes

Members and providers are made aware of the program via direct mail, newsletter articles, and health classes or meetings. Once members enroll they receive monthly newsletters and other incentives to support their efforts to reach established goals and comply with their medication regimen. The PCP is notified of member enrollment in the program via a patient registry and receives a quarterly newsletter with clinical updates, industry trends and practice tips. There were 148 members enrolled in the Counting Cholesterol Down program, 117 of which were on Cholesterol medication. 161 members were enrolled in the In Charge program for high blood pressure. 241 members were registered in the Diabetes Control Network. Seven (7) members opted out during the course of the year. We continue

to increase enrollment through increased awareness of the program. HEDIS scores have improved in some of the diabetes and cardiac measures (see Performance Results section).

Asthma

The focus for our asthma program is on patient education and resources for the physician including guidelines and management updates. Members are identified for inclusion via claims data and where applicable, drug 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 within 7 days of discharge. In 2007 there were 261 admissions, up from 195 in 2006, with 95 seeing their PCP within 7 days, or 36%. All members receive educational mailings at least twice a year. Members identified as high risk or in need, receive additional clinical interventions. These may include educational classes or home care visits that center on intensive instruction to the patient and family. These interventions are done only with PCP notification and approval.

Physicians receive asthma specific patient registries. These registries include patient demographics as well as data on inpatient, emergency, and outpatient utilization. Whenever applicable, drug utilization and laboratory data is included. Further emphasis is on evidence-based practice guidelines and management tools.

MHP has developed a survey to measure the satisfaction of the members in the program for 2007. Those results are not complete at this time, but will be reported on within the first quarter of 2008.

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 were sent directly to all physicians in 2005 and 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.

A mailing with Depression educational materials was sent to all members with a diagnosis of depression from claims data in 2005. On an ongoing basis, educational materials are sent to newly diagnosed members with depression, approximately 1500 during 2007. 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% for Effective Acute Treatment and Effective Continuation Treatment. This is the first time this measure was submitted as part of the MHP HEDIS submission.

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 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

Lead Screening

Midwest Health Plan continued its re-measurement of the Lead Screening PIP Initiative in 2007, evaluating information received monthly from MDCH, creating quarterly registries for PCP's, creating quarterly mailings to members, and updating the Michigan Lead Registry with additional data that may have come to the Health Plan. MHP saw its rate improve from 71% for Total Enrollment and 79% for Continuous Enrollment in January 2007, to 75% for Total Enrollment and 83% for Continuous Enrollment in October 2007, meeting the State goal of 80% for Continuous Enrollment. Our rates continue to improve to 75% for Total Enrollment and 84% for Continuous Enrollment in December 2007.

Cultural Disparities

A review of our membership demographic information in 2007 indicates approximately one-third of our membership are of Arabic decent, and 5% of our members have Spanish surnames. Seventy-one percent (71%) of our members are under the age of 19 years old, based on enrollment by member months. Twenty-two percent (20%) speak a foreign language at home and 67% have a high school diploma or less. These numbers have traditionally been the highest of all the Medicaid plans in Michigan. This data is backed up by the fact that 30% of the members completing the adult CAHPS survey in 2007, indicated they translated questions for the person responding.

Midwest Health Plan has a number of Arabic speaking staff including Customer Service staff and the Provider Relations staff. We have an Arabic phone que that members may select. All of its member handbooks are printed in Arabic, in addition to a number of the health outreach and disease management educational materials.

MHP has increased its focus on Women's Health with the addition of staff in this area, in an attempt to get more Arabic women in for preventive screening tests. In addition, we developed a Performance Improvement Project in late 2007 focused on Cultural Disparities and Cervical Cancer Screening due to its low HEDIS rates in this area. Changes will be reported on in future re-measurement years.

Access to Care

MHP was part of the Wayne County Access to Care project in 2005, along with the other southeastern Michigan health plans. We shared 2005 HEDIS ® Access to Care data (Wayne County only) with the MDCH, as well as Lead Screening data. After analysis of results we focused our efforts on those PCP offices that were low in access and low in lead screening in the Wayne County area. Meetings were held with hi-volume PCP's explaining the results and working to reduce barriers that they indicated were problematic.

In 2007, the 2006 HEDIS ® Access to Care data (all areas) were shared with MDCH and results were compiled and reported back to the health plans at the October 2007 Clinical Advisory Committee meeting. MHP is working in a coordinated effort with MDCH to focus improvement initiatives on those PCP's who have low access. Those initiatives will be clarified in 2008. MHP continues to cooperate with MDCH and other health plans on this project.

In addition to the project above, in order to assist with ease in accessing care for our members, Customer Service no longer requires a "Transfer Form" to be completed when a member wishes to transfer. Instead of filling out a form and sending it back, the member now just calls Customer Service and their PCP can be changed. This expedites the process for both the member, the Provider and for Customer 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. Over 700 gift cards were mailed to members. In 2006 all ABAD members (approximately 8,200 members) were sent letters and 400 gift cards were mailed to members who made PCP visits.

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 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 2007

Areas of Improvement that met the 75th Goal

- Childhood Immunization Combo#2 increased from 76% to 81% (Goal of 68%)
- Adolescent Immunizations Combo #2 increase from 55% to 64% (Goal of 46%)
- Chlamydia Screening Combined from 43% to 56% (Goal of 53%)
- Diabetes eye exams increased from 49% to 54% (Goal of 52%)
- Well Child visits first 15 mos. (six or more) from 51% to 57% (Goal of 53%)
- Well Child 3-6 years old increased from 73% to 75% (Goal of 67%)
- Adolescent Well Care visits increased from 49% to 50% (Goal of 44%)
- LDL Screening after Acute CV event increase from 63% to 77% (Goal of 58%)

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

- Cervical Cancer Screening increased from 62% to 64% (Goal of 74%)
- Childhood Immunization Combo#3 increased from 33% to 58% (Michigan Avg 62%)
- Timely Prenatal Care increased from 68% to 76% (Goal 82%)
- Post Partum Care increased from 46% to 51% (Goal of 62%)

- Use of Appropriate Asthma meds increased from 81% to 84% (Goal of 90%)

Areas Where Little or No Improvement Was Observed

- Controlling Blood Pressure stayed the same at 53% (Goal of 61%)
- Diabetes Care HbA1c testing decreased from 72% to 70% (Goal 78%)
- Diabetes Care LDL-C screening decreased from 80% to 72% (Goal 69%)
- Diabetes Care HbA1c testing decreased from 72% to 70% (Goal 78%)
- Diabetes Care LDL-C levels under 100 decreased from 40% to 30% (Michigan Avg 37%)
- Breast Cancer Screening decreased from 58% to 55% (Goal of 59%)

Midwest Health Plan had the highest rate of all the Medicaid health plans in Michigan in Well Child 3-6 year olds. Even though these results increased in the majority of measures, we remain in the lower third of all health plans in Michigan in the following measures: Childhood Immunizations Combo 3, Adolescent Immunizations Combo 2, Appropriate Treatment for Children with Upper Respiratory Infection, Cervical Cancer Screening, Prenatal Care, Post Partum Care, Diabetes HbA1c testing, LDL-C -Screening, LDL-C levels below 100, Nephropathy screening, Asthma Combined, Appropriate Testing for Children with Pharyngitis, and Advising Smokers to Quit. We continue to make progress in these areas as evidenced by the improvements in results due to the initiatives we have implemented. While these areas have shown improvement, we are continuing all our initiatives (refer to attached action plans) to continually improve care and one day meet the 90% NCQA benchmark. We revised the PCP QIP bonus for 2007 to include criteria related to improvement in HEDIS scores, attaining rates in NCQA's 75th percentile, encounters and Risk Scores (capturing all diagnoses).

Adult CAHPS Survey

We again contracted with The Myers Group (TMG) to conduct our Adult CAHPS survey. There were large changes to the CAHPS survey from 2006 to 2007, resulting in a number of measures being dropped or not trendable. We had a 26% response rate to the questionnaire. The results from 2007 showed no 'statistically significant improvements' from the previous year's survey in the four composite areas or the four rating areas. Improvements were seen with individual questions (doctors listening carefully), and the Getting Care Quickly Composite, although none statistically significant. The results showed one area of decrease that was statistically significant Rating of Health Care (69% to 61%). We also had decreases in satisfaction including: Rating a Personal Doctor (76% to 71%) and Obtaining Needed Care Right Away (80% to 73%), although not statistically significant.

Opportunities to investigate and improve were identified as Customer Service (20th%), Getting Needed Care (29th%), and How Well Doctors Communicate. These are considered key drivers of satisfaction and fell below the NCQA 50th% on the Quality Compass Public Report.

Since CAHPS results are not provider or member specific, targeted interventions and follow up is general in nature. The Customer Service Department is emphasizing more staff training around satisfying the customer, closing the call, and changing some on-line messaging. 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. We have clarified the referral/authorization process in the member handbook, done education around generic medications, listed Urgent Care sites in the member handbook, and conducted a health fair as ways of helping members 'get needed care'.

Child CAHPS Survey

The State of Michigan contracted with The Myers Group to conduct the Child CAHPS survey in 2007 it had not been done since 2005, since its on an every other year cycle. The survey was still CAHPS 3.0 so measures were still trendable. MHP had a 23% response rate on the survey. No statistically significant increases or decreases were seen in the demographic data, composites, measures, or four rating areas from 2005. Increases were seen in Getting Needed Care composite, How Well Doctors Communicate composite, Customer Service composite, Courteous and Helpful Office Staff composite, Rating a Personal Doctor, Rating a Specialist, Rating of Health Plan. Decreases were seen in the Getting Care Quickly composite. No changes were seen in Rating of Health Care. Key drivers were identified as being significantly above/below Medicaid benchmark mean summary scores. A number of areas were ranked significantly below the NCQA benchmark and indicate areas for improvement: How Well Doctors Communicate composite, Getting Care Quickly composite, and Rating of Health Care.

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.

Annual Provider Satisfaction Survey

MHP providers were surveyed between January and May 2007 by The Myers Group, 141 responses were received out of 459 physicians for a 31% response rate. Due to significant changes in the survey tool in 2005, comparisons were only able to be made back to the 2005 data. Only one measure showed 'statistically significant' improvement from the previous year; 'the extent to which plan controls costs while maintaining a high quality of care'. A number of other measures showed improvement: Network composite and the Finance Issues composite. No measures decreased by a 'statistically significant' amount. Several measures did decrease: Provider Relations composite, Utilization & Quality Management composite, Pharmacy and Drug Benefit composite, and Overall Satisfaction and Loyalty composite. Compared to "all other plans" The Myers Group surveys, our results showed statistically significant positive difference in Provider Relations composite, phone access to Utilization staff, and timeliness of Utilization appeals process, and the extent to which plan controls costs while maintaining a high quality of care. No areas were significantly lower. When compared to 2006 The Myers Group Medicaid Book of Business we scored significantly higher in Provider Relations composite, Network composite, Utilization & Quality Management composite, and Pharmacy & Drug Benefit composite.

Physicians identified five drivers of overall satisfaction and strength with the plan: 1) quality of provider orientation process, 2) quality of practitioner educational meetings, 3) timeliness to answer questions and/or resolve problems, 4) responsiveness and courtesy of the health plan's provider relations representatives, and 5) the quality of written communications, policy bulletins, and manuals. 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 2006 to 2007, but

MHP was significantly higher than The Myers Group 2006 Medicaid Book of Business in this measure. Those 'indifferent' was significantly lower than the 2006 TMG Medicaid Book of Business. There have been very few Provider calls to MHP expressing their dissatisfaction. This is due in part to 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. None of the measures showed statistically significant increases or decreases from 2005 or 2006. The composite did decrease but improvement was seen in phone access to UM staff. Two areas measured (access to staff and timeliness of UM appeals process) were statistically significantly higher than 'other plans' surveyed by TMG. No areas were statistically significantly lower compared to 'other plans'. 'Phone access' was rated excellent/very good 58% of the time compared to 34% for 'all other plans'. 'Timeliness of the pre-certification process' was rated excellent/very good 45% of the time, compared to 42% for 'all other plans'. 'Sharing reasons for adverse determinations' was rated excellent/very good by 45% of the physicians, compared to 41% for 'all other plans'. "Consistency of review decisions" was rated excellent/very good by 51% of the physicians, compared to 40% for 'all other plans'. 'Appeal process timeliness' was rated excellent/very good by 55% of the physicians, compared to 32% for 'all other plans'. 'Timeliness of medical director resolution' was rated excellent/very good by 52% of the physicians, compared to 39% for 'all other plans'. The Health Services Department goal will be to explore strategies to demonstrate continual improvement in all of these areas.

This survey will be re-conducted by The Myers Group in February 2008.

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 2007, 106 sites representing 250 PCP's and 79% of the membership were surveyed. The urgent care level was met by 100% of the PCP's, routine care was met by 100% of the PCP's, and preventive care was met by 97% of the PCP's. All of the appointments averaged better than established timelines, < than 1 day for urgent care, < 1 day for routine care, and 3.4 days for preventive care. 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 2007, 103 sites representing 250 PCP's and 79% of the membership were surveyed. 78% of the PCP's answered the phone within 3 rings, 90% of the PCP's directed members to ER and other services, 72% of the members were given another number to call, 54% of the members were directed to leave a message, and 58% were directed to call back during normal office hours. Answering the phone promptly and directing members to call during office hours

improved over last year. Each PCP that did not meet the standard is 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 continue to monitor all calls into their department. The majority of calls into the department are inquiries about eligibility. Members had an increasing number of complaints about MHP this year, 4.7 per thousand, above the 3.5 goal established. 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. For 2007, there were no complaints, grievance or appeals from beneficiaries to Customer Service. The HPMS Complaint Tracking module also had no complaints in 2007. There were no Level II or Level III member grievances during 2007. They monitor 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 7.3% to 30.8%, the average speed of answering has ranged from 60 seconds to 386 seconds (goal of 30 seconds), average hold time has ranged from 60 seconds to 261 seconds (goal of 30 seconds). Due to the increase in call volume and the addition of the new County products our call abandonment rate and speed of answering have not met our goals. 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. With a new pharmacy benefit manager (Rx America) as of 1/1/07 we have held monthly Pharmacy meetings reviewing the formulary and pharmacy related complaints are going directly to RxAmerica. Customer Service continues its internal orientation program for new representatives, we currently have 4 temps in addition to regular staff. This ensures that the Customer Service Representatives are oriented to all the different product lines and benefits. The representatives are aware of the member's benefits and processes and procedures with other products and how they affect the members. Some of the other additional duties of the Customer Service Department have been transferred to other departments so the Customer Service Representatives will have the time to assist customers. 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 2007, 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. The weight of "HEDIS related measures" counts for 3 out of a possible 5 points in the 2007 Quality Improvement Plan bonus. The remaining two points concentrate on physicians documenting all the relevant diagnoses.

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 3 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.
- Feel their amount of capitation should be increased (despite budget deficits and cuts at the State). We annually review our QIP bonus to make it fair and keep offices financially healthy.
- 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.
- Many members with multiple chronic diseases that demand immediate attention: This takes time away from preventive services.

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.
- 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.
- Immunization incentive: There are approximately 15 respondents per month that send in the immunization records for the 2 year olds and 13 year olds who have completed their immunizations. The respondents name is put into a monthly drawing for a gift certificate worth \$100. The member who has their immunizations up to date is sent a \$5 gift certificate to Target.

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 to 800 PCPs and specialists. Oversight of the delegates continues.

Evaluation of Delegation

The only delegated function at MHP is credentialing. We delegate 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 and Rx America for pharmacy management and have had no issues or problems with them.

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 2008.

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 our health outreach and disease management programs, and have added some elements to evaluate their effectiveness. We will be implementing an all encompassing database 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. Approximately 70% of the Quality Improvement Program (QIP) bonus money is paid to the PCPs for complying with our QIP criteria (meeting HEDIS goals and showing HEDIS improvement, submission of encounters, improving risk scores). Due to State and regulatory requirements, as well as the need to improve the care our member's receive, the QIP bonus is being changed for 2008 to reflect an emphasis on PCP's quality of care (HEDIS) performance and documentation. 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

- 2007 Continuous Quality Improvement Program
- 2007 Quality Improvement Work Plan
- Action Plans for 2007
- Continuous Monitors
- HEDIS Results Comparison Grid
- MHP's HEDIS Provider Satisfaction Report
- Network Analysis Meeting Minutes
- Program Descriptions for Asthma Program
- Program Description for Diabetes Program
- Phone Abandonment Rate, Wait Time and Speed of Answering graphs