

MIDWEST HEALTH PLAN, INC.

2009

**CONTINUOUS QUALITY
IMPROVEMENT
PROGRAM**

Midwest Health Plan, Inc.
Dearborn, Michigan

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2009

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 enroll new members. 2008 CAHPS results indicate a diverse racial membership, including 34.1% Black / African-American, 17.1% “other” which presumably is Arabic, 6% Hispanic, and 6% Asian. Midwest also has a young membership population with over 71% in the 0-19 year age range.

We follow 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 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 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
- Hyperlipidemia
- 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 2009 include:

- Childhood immunizations
- Breast cancer screening
- Cervical cancer screening (including disparities)
- Chlamydia Screening
- Well child visits—Including lead screening and ABCD developmental screening
- Appropriate treatment for Children with URI
- Appropriate testing for Children with Pharyngitis
- Pregnancy (Prenatal care and postpartum care)

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 2009 include:

- Phone service in Customer Services
- Follow-up visit after delivery
- Evaluation of the network in all counties
- Cervical Cancer Screening Disparities (PIP)
- Access to urgent care centers
- Member access to care
- Maternal Support Services Screenings
- PCP availability after routine office hours
- Disparities Initiatives, including Reducing Disparities at the Practice Site (RDPS) Project
- 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

Utilization Management

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

Credentialing and Re-credentialing

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 (HVPA), and others as required.

Continuous Monitoring Activities

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.

Behavioral Health Care

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 (appropriate optimal practitioner contacts, effective acute phase treatment, and effective continuation phase 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)

Disparities Initiative – Cervical Cancer Screening

With approximately one-third of our membership from Arabic cultures, MHP has worked to ensure that language and communication with the Health Plan is not a barrier to members. We have consistently had at least one, often more, Customer Service staff who speak Arabic, so even from the first call to the Health Plan, member issues are addressed without a language barrier. Our Member Handbook is printed and distributed in Arabic, as are our Preventive Guidelines that are distributed annually. We have held annual health fairs spoken in Arabic since 2000, addressing health issues pertaining to the population. We continue to work with local community organizations around the issues of Keeping Kids Healthy. MHP takes part in the MDCH Disparities Initiative to determine ongoing parameters.

In late 2007 MHP developed a Performance Improvement Project addressing the issue of appropriate Cervical Cancer Screening among our Arabic population. We have traditionally had low HEDIS rates in this measure. With our large Arabic population we are focusing efforts on improving rates with this measure, as well as other Women's Health issues (breast cancer, chlamydia, prenatal/postpartum care). Registries, education, ongoing medical record review, are some of the initiatives developed to improve this vital service. During 2009 MHP will remeasure the Cervical Cancer Screening Disparities project to evaluate the effectiveness of 2008 interventions.

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 ranked in the top 3 Medicaid health plans in terms of compliance in this area for 3 year olds, and exceeded the State of Michigan's goal of 80% by October 2008 with a rate of 82% 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. MHP was part of the statewide Not In My Backyard (NIMBY) lead initiative. MHP works with Wayne County Public Health Department and local community groups in Wayne County on lead interventions. MHP has consistently submitted a Lead PIP

(Blood Lead Testing by Age 3) to the Department of Community Health the past 2 years outlining its improvement actions.

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 2008 MHP made contract changes with providers that included a pay for performance bonus program that provides additional payments to providers for a number of services, including preventive medicine services. MHP will continue to monitor its HEDIS Access to Care results in 2009 and continue member outreach efforts to improve access to care.

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 be 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. 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. MHP expects that contracting changes that provide pay for performance bonuses for a variety of HEDIS-related services will provide some financial incentives for practices to begin the move towards Patient-Centered Medical Home.

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, and a \$100 gift certificate for provider offices who submit completed member immunizations of these two age groups. All offices who submit records go in a raffle for the \$100 gift certificate. 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 2008, MHP replaced its Quality Improvement Program Bonus with a 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 2009 MHP will initiate 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.

Maternal Infant Health Program (MIHP) Coordination

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

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 2009 MHP will initiate steps to educate providers on the importance of calculating and documenting patient BMIs and providing nutrition and physical activity counseling as needed. MHP plans to report the new HEDIS hybrid measures for Adult BMI and Child Weight Assessment and Counseling for Nutrition and Physical Activity measures in 2009. 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

MHP has used Leade Health since March 2004 to run a tobacco cessation program. 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 2009 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.

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; and,
- 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/Accreditation, Director of Quality/ HEDIS, and nurse auditors, Director of Credentialing, the credentialing coordinator, Health Outreach Coordinator, Manager of Disease Management Programs and Coordinator of Disease Management Programs, Director of Network Development, the Sr. Director of Health Care Services, Manager of Case Management and utilization 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, and Q Mark software consultants. 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 TierMed 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 access and availability are addressed by the Quality Improvement Department through the PCPs after hours survey and the appointment availability survey. Member newsletters are sent out three times a year to adults and two times a year 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.

Health Outreach and 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 (Chairperson)
- Sr. Director of Corporate Quality
- Sr. Director of Health Services (Utilization Management)
- Credentialing Director

- Director of Quality/Accreditation
- Director of Quality/HEDIS
- Customer Services Director
- Finance & Accounting Director
- Manager of Health Outreach/Disease Management Programs
- Provider Services Manager
- Participating Practitioners (one specialist- i.e. OB/GYN or other specialty, three PCPs- ie, Family Practice, Pediatrician, General Practice or Internal Medicine, and one Behavioral Health Care Practitioner ie. Psychiatrist, social worker, etc.)
- Representative from Community Mental Health (see above)
- Others as deemed appropriate and appointed by the QIC
- Practitioners on the panel of board certified expert consultants as needed

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 and the QI Director.

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

The following departments provide reports to the QIC:

1. Customer Services
2. Provider Services
3. Medical Services including Utilization

Peer Review Subcommittee

The Peer Review Subcommittee is a subcommittee of the QIC. The primary role of the Peer Review Subcommittee is to review quality of care and/or service issues, and make corrective action plan recommendations to the QIC. The Peer Review Subcommittee meets 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:

- MHP Medical Director
- Sr. Director of Corporate Quality
- Health Services (Utilization) Director
- Credentialing Director
- * Practicing MHP practitioners
- Others as deemed appropriate
- Practitioners on the panel of board certified expert consultants as needed

The primary duties of the Peer Review Subcommittee are as follows:

- Review and revision of practice guidelines/standards of care;
- Review of member complaints about care or service rendered, by physicians, practitioners or other providers;
- 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;
- To 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 Peer Review Subcommittee shall meet as deemed necessary. The Medical Director/designee will report the Peer Review Subcommittee activities in an ongoing manner to the Board of Directors. The reporting will become a part of the Board’s meeting minutes.

Provider Appeals Subcommittee

The Provider Appeals Subcommittee is a subcommittee of the QIC. The primary role of the Provider Appeals Subcommittee is to review professional review activities in relation to provider appeals. The Provider Appeals Subcommittee meets on an as needed basis. The minutes, recommendations, and actions of this committee are submitted to the Quality Improvement Committee and then the Board of Directors for approval.

The members include:

- MHP Medical Director
- Sr. Director of Corporate Quality
- Credentialing Director
- Customer Services Director
- Provider Services Manager
- Practitioners (who have not participated previously in any case related decisions)
- Practitioners on the panel of board certified expert consultants as needed
- Others as deemed appropriate

The primary duties of the Provider Appeals Subcommittee are as follows:

- Review of professional review activity to ensure adherence to MHP policies and procedures;
- Review of Provider appeals
- To review provider appeals from the Credentialing Subcommittee
- Referral of issues to the “expert panel;”

The Provider Appeals Subcommittee shall meet as deemed necessary. The Medical Director/designee will report the Provider Appeals 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 or QI Director
- 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.

Health Services/ Utilization Management Subcommittee

The Health Services/ Utilization Management Subcommittee is a multi-disciplinary committee whose purpose is to identify, monitor, analyze, and report utilization patterns. The committee meets on an as needed 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)
- Sr. Director of Corporate Quality or QI Director
- Health Services Director
- Director of Finance and Accounting
- Health Services Manager
- Customer Services Manager
- Provider Services Manager
- Practitioners (one Internal Medicine/ Pediatrician and one Family Practice)
- Practitioners on the panel of board certified expert consultants as needed
- Others as deemed appropriate and appointed by the QIC

The primary committee functions include:

- Monitoring certain areas of 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.
- Ensuring that appropriate industry standards and Plan-approved utilization management criteria are consistently applied.
- Monitoring selected quality indicators, HEDIS measures and to ensure appropriate follow-up.

- 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.

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 QIC.

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
- 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.

Corporate Compliance (Fraud and Abuse) Subcommittee

The Corporate Compliance Subcommittee is a subcommittee of the QIC. The primary role of this subcommittee is to review the fraud and abuse policies and procedures and ensure that the policies are implemented. 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:

- MHP Medical Director
- Sr. Director of Corporate Quality
- Director of Quality/Accreditation
- Health Services (Utilization) Director
- Credentialing Director
- Provider Services Manager
- Practicing MHP practitioners on the QIC

- Others as deemed appropriate

The primary duties of the Corporate Compliance 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

The Corporate Compliance 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.

Confidentiality Subcommittee

The Confidentiality Subcommittee is a subcommittee of the QIC. The primary role of the Confidentiality Subcommittee is to review and update confidentiality policies, and make recommendations to the QIC. The Confidentiality Subcommittee meets quarterly or on an as needed basis. The minutes, recommendations, and actions of this committee are submitted to the Quality Improvement Committee and then the Board of Directors for approval.

The members include:

- MHP Medical Director
- Sr. Director of Corporate Quality
- Health Services (Utilization) Director
- Credentialing Director
- Provider Services Manager
- Practicing MHP practitioners on the QIC
- Others as deemed appropriate
- Practitioners on the panel of board certified expert consultants as needed

The primary duties of the Confidentiality Subcommittee are as follows:

- 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 Confidentiality Subcommittee shall meet bimonthly.

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

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:
 - Credentialing and re-credentialing standards and procedures, as outlined in the MHP “Credentialing Program” discussion in this document; and
 - 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.