Quality Assessment

and

Performance Improvement Program

Medicaid (MSA)

Including
Children’s Special Health Care Services (CSHCS)

and

Healthy Michigan Plan (HMP)

2016
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Quality Assessment and Improvement Program Description

The QAPI is a program 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, HAP 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 HAP MHP to validate improvements by measuring service and delivery system enhancements. Approved by the HAP MHP Board of Directors, the QAPI is updated as necessary and reviewed annually, at a minimum, to accommodate revisions that may be necessary to accommodate changing needs.

Mission Statement

HAP Midwest Health Plan (HAP MHP) is committed to providing excellence in managed care product lines to the residents of the State of Michigan, through fiscally responsible programs that assure access to and the delivery of cost effective and/quality medical services.
INTRODUCTION AND PURPOSE

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

This comprehensive QAPI is a program that institutionalizes HAP 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, HAP MHP examines the components of its managed care service and delivery system, identifies opportunities for improvement, and recommends changes to impact those improvements. After recommendations are implemented, a re-examination of affected components enables HAP MHP to validate improvements by measuring service and delivery system enhancements. Approved by the HAP MHP Board of Directors, the QAPI 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.

HAP MHP makes available to members and practitioners upon request the QAPI and the annual evaluation. This information is also found on our website of www.hap.org/midwest.

HAP MHP is a Medicaid health plan serving St. Clair, Huron, Tuscola, Lapeer, Shiawassee, Genesee, and Sanilac counties. HAP MHP is heavily regulated by the state of Michigan. Member enrollment occurs through Michigan Enrolls, a contracted vendor for the state. HAP MHP cannot market to prospective members nor can it enroll new members.

HAP MHP will follow the Michigan Medicaid Managed Care Common Formulary beginning on June 1, 2016. The Michigan Medicaid Managed Care Common Formulary includes specific step therapy and prior authorization (PA) criteria. When members need to be transitioned on to non-formulary medications or medications that require a PA a state approved template letter is sent out to the member and the physician. They can switch to a covered medication or submit a PA. There are certain exceptions such as anti-neoplastics, immunosuppressant’s, and disease modifying medications for multiple sclerosis that will be grandfathered. The state is responsible for performing new technology assessment for drugs.

The Michigan Medicaid health plan contract states that each Medicaid health plan oversees 20 ambulatory behavioral health visits annually to treat mild to moderate symptoms with minor or
temporary functional impairments. HAP MHP members may access the behavioral health services directly by seeing a network or non-network provider, or by obtaining a referral from their Primary Care Physician (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 (CMHB) 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 CMHB’s. Substance abuse services are also a benefit exclusion under the Medicaid contract. In addition to the carve out of services, the state of Michigan has elected to expand the pharmacy carve-out to include all antidepressants, anti-anxiety drugs, anti-psychotics, sedatives, hypnotics, Selective Serotonin Receptor Inhibitors (SSRIs), anticonvulsants, Monoamine Oxidase Inhibitors (MAOIs), Attention Deficit Hyperactivity Disorder (ADHD) drugs, disulfiram, and bipolar disorder medications.

In summary, the Medicaid Behavioral Health structure and delivery system creates challenges to coordinator care between behavioral health and physical medicine. As a result, HAP MHP collaborates with PIHP organizations to improve the communication and coordination of care between behavioral health and physical medicine. Members have open access to Community Mental Health (CMH) providers. Upon member or practitioner request, HAP MHP issues a referral for behavioral services to facilitate prompt payment.

**OBJECTIVES**

HAP MHP’s QAPI is ongoing, organized, and 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. HAP MHP is committed to delivering high quality health care. The following information is provided to give an overview of HAP MHP’s goals. This may include activities, start dates, persons responsible for activities, and activities in the QI Work Plan.

**Quality Management and Improvement**

The following conditions targeted for care improvement are:

- Persistent asthma by monitoring medication management and appropriate use of asthma medication
- Diseases related to unimmunized children by monitoring childhood, adolescent and HPV vaccines in adolescents
- Comprehensive diabetes care
- Prevention of breast, cervical and colorectal cancer due to preventive screening
- Chlamydia screening in women
- Uncontrolled hypertension in adults
- Overweight and obesity with PCP counseling for physical activity and nutrition
- Lead screening for selected members exposed to city of Flint water: all children less than age 21 years of age and all pregnant women
- Lead screening for all members under 2 years old
- Tobacco use and abuse
- Behavioral health conditions through integration with Prepaid Inpatient Hospital Program (PIHP)
- Initiatives included in Governor Snyder’s 4 x 4 Health and Wellness Plan

These clinical areas were chosen based on needs of previous service area of HAP MHP and may need
The preventive health care topics targeted for 2016 include:

- Provider and member education on appropriate asthma management
- Education on immunizations for both children and adolescents
- Instruction on HPV vaccine for female adolescents
- Promotion of well-visits for all ages
- Encourage blood lead screening for all Medicaid children age 2 and under, as required by law
- Targeted Case Management for lead exposure in Flint
- Developmental Screening in first 3 years of life
- Weight assessments/BMI percentile for children, adolescents and BMI value for adults
- Counseling for nutrition and physical activity for children, adolescents and adults
- Breast, cervical and colorectal cancer screening
- Chlamydia screening
- Perinatal care (Prenatal and postpartum)
- Tobacco Cessation

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

Service
The following areas will be the focus for monitoring and improvement activities during 2016:

Non-Clinical

- Phone service in Customer Services
- Evaluation of the network in all servicing counties
- Member access to care
- Maternal Infant Health Program (MIHP) referrals
- PCP availability after routine office hours
- Health Equity project for race/ethnicity
- Behavioral Health Care Coordination
- E-prescribing
- Health Information Technology (HIT)
- Other Performance Improvement Projects (PIP), as directed by MDHHS

Clinical

- Comprehensive diabetes care
- Appropriate treatment for asthma
- Postpartum care after delivery
- Preventive screening for breast, cervical and colorectal cancer
- Screening for chlamydia
- Tobacco cessation
- Other Performance Improvement Projects (PIP), as directed by MDHHS
**Satisfaction**
To determine the level of satisfaction our adult members and providers have with HAP MHP, annual surveys are performed, including a CAHPS adult member satisfaction survey and a Provider satisfaction survey with HAP MHP. Member grievances and complaints are investigated. Complaints and grievances are tracked for trends, particularly as they relate to quality issues. Based on the results, activities are undertaken to improve the areas where results do not meet HAP MHP’s goals.

**Continuity and Coordination of Care**
HAP MHP members are assigned to a PCP; however, members 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 HAP MHP’s network of providers. The following areas will be monitored to help ensure continuity and coordination of care:

- Continuity and coordination of care with regard to a follow-up office visit with the PCP, within 14 days of discharge from an acute care facility, for members who were admitted for treatment of asthma.
- Continuity and coordination of care with regard to a follow-up office visit with the PCP, within 14 days of discharge from an acute care facility, for members who were admitted for treatment of COPD.
- Medication management for members with a diagnosis of persistent asthma
- Continuity of perinatal care with regard to coordinating postpartum care within 21 to 56 days after delivery.
- Physician feedback through the annual PCP Satisfaction survey on satisfaction with receiving information/reports from organizational providers: hospital, home health agencies, specialists, skilled nursing facilities, nursing homes and behavioral healthcare providers

**Patient Safety**
HAP MHP fosters a supportive environment to help practitioners and providers improve the safety of their practice. HAP MHP informs members what can be done to insure the delivery of safe clinical care. This is 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 tools to assist with care and services
- Site visits that monitor for safe practices
- Conducting annual audits of medical record keeping practices
- Updating web site to include links to safety related information
- Ongoing monitoring of member complaints related to quality of care issues
- Development and implement processes to have ancillary medical and behavioral reports sent to primary care providers
- Notifying members and providers about FDA drug recalls
Culturally and Linguistically Appropriate Services (CLAS)

The state of Michigan collects member race and ethnicity data from members at the time of enrollment and reports the information to HAP MHP on the monthly enrollment files. Unfortunately, standard race and ethnicity categories do not include specific languages in these counties. To supplement the race and ethnicity data obtained from the state of Michigan, HAP MHP also analyzes census data from its service area. The table below reflects the cultural and Linguistic percentage per country based on 2010 census.

<table>
<thead>
<tr>
<th></th>
<th>White (1)</th>
<th>Black (2)</th>
<th>*NA/AN (3)</th>
<th>Asian (4)</th>
<th>Hispanic (5)</th>
<th>Two or more races (6)</th>
<th>Languages other than English spoken (7)</th>
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</tr>
</tbody>
</table>

*Native American (NA) / Alaska Native (AN)

HAP MHP has a number of activities and targeted initiatives to promote multicultural health care and reduce racial and ethnic health disparities, including:
- Annually assesses the cultural, ethnic, racial and linguistic needs of its membership and adjusts services (such as bi-lingual materials) and its practitioner network as needed;
- Captures race and ethnicity data from the state of Michigan’s enrollment file;
- Provides information in HAP Midwest Provider Directory on languages spoken in physician offices;
- Incorporates culturally appropriate messages, including culturally appropriate photos, in member materials;
- Analyzes the existence of health care disparities and takes action as needed
- In 2016, HAP MHP will continue to work with MDHHS in the Health Equity project.

Utilization Management
HAP MHP works to provide appropriate care and services for its members. HAP 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
• Adverse determinations
• Member appeals

Case Management
The purpose of Case Management (CM) is to assist members/caregivers adhere with HAP MHP of care prescribed by their provider(s). The HAP MHP CM program is designed to assist these members reach their optimum level of wellness, self-management, and functional capability at the appropriate level of care while maintaining cost-effectiveness, quality, and continuity of care. Participation is voluntary and may be terminated at any time. The CM program is telephonic. The CM program is dependent upon the cooperative participation of HAP MHP, its contracted providers, hospitals, and members/caregivers to ensure timely, effective, and realistic goals. Information about HAP MHP’s CM program and how to access is located in the member handbook, member newsletter, provider newsletter, provider administrative manual, and the HAP MHP web site.

Cases may be closed when the goals are met or when the member declines further case management services. Additionally, at the discretion of the case manager in consultation with the Chief Medical Officer the case management case may be closed due to member noncompliance.

A final evaluation of CM services is determined through satisfaction surveys sent when a member is discharged from the CM program. The Case Management Program document is part of the UM Program.

Credentialing and Re-credentialing
HAP MHP ensures that members have access to providers that have passed credentialing and re-credentialing standards. In 2015, HAP MHP completed the transitioning of credentialing activities to Health Alliance Plan (HAP). HAP is NCQA certified and performs the following activities:

• Utilizes CACTUS credentialing database
• Verifies credentials through primary source verification by Professional Credentials Verification Service (PCVS)
• Collects application data with the Council on Affordable Quality Healthcare (CAQH)
• Provides oversight of the following delegated credentialing entities:
  o PCVS (CVO)
  o Genesys PHO
  o Huron Valley Physician Associations (HVPA)
  o Integrated Healthcare Associates (IHA)
  o William Beaumont Hospital System
  o Henry Ford Health System
  o University of Michigan Health System
  o St. Joseph Mercy Health System (IHA and HVPA)
  o University Physicians Group (Wayne State University)
  o United Physicians, Inc.
Continuous Monitoring Activities
HAP MHP has developed and revised 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
Members have open access to CMH providers. The behavioral health benefit through HAP MHP is limited to 20 outpatient visits per year. A behavioral healthcare practitioner participates on the QIC and provides input and advises the QIC in the behavioral health care aspects discussed below.

The following activities occur:
- Review of the guidelines for the “Management of Adults with Major Depression”, “Screening, Diagnosis and Referral for Substance Use Disorders”, and “Management of Diabetes Mellitus – Screen for depression”.
- Annual review of HEDIS® Antidepressant Medication Management (effective acute treatment and effective continuation treatment)
- Annual review of HEDIS® Follow-Up Care for Children Prescribed ADHD Medication
- Maintain the current network of behavioral healthcare providers to provide PCPs with a referral network and help ensure adequate access (even though there is open access)
- Continue to participate in MDHHS Behavioral Health Care Advisory Committee of health plans to work on coordination of care issues
- Continue attending/participating in Coordination of Care Council CMH/Substance Abuse Coordinating Agency
- Assist in transferring information from CMHB (continuity of care form) to PCPs when received from CMHB
- Review of data regarding behavioral health care—network analysis component, cultural diversity of providers, location

Review of the HAP MHP 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, results of HEDIS® measures that relate to behavioral health care, and results of PCP satisfaction survey in area of continuity of care of receiving reports from behavioral health care specialists

Michigan Department of Health and Human Services Initiatives (MDHHS)

Well Child/Early, Periodic Screening, Diagnosis and Testing (EPSDT)
Developmental screening has always been a part of child and adolescent care, from birth to age 21. In 2016, HAP MHP will continue focused activities to educate members and providers not only on the importance of child and adolescent care, including EPSDT screening, but specifically on the importance of developmental screening as part of the well child visit. HAP MHP will provide information to providers about developmental screening tools and will promote accurate coding so providers can be compensated for the screenings.
HAP MHP has processes in place to ensure its members receive the recommended childhood and adolescent immunizations within the appropriate time frame, as outlined by the Centers for Disease Control and Prevention. Each year HAP MHP provides members with updated guidelines via annual mailings, articles in Member newsletters and posted on the HAP MHP web site. Monthly HAP MHP determines which members may be due for immunizations and mails notification with financial incentive information to the member’s parent or guardian. Providers are educated via QM staff, Provider newsletter, and the Opportunities Report on the provider portal.

Access to Care

HAP MHP provided providers practice characteristics, measurement data in a number of key HEDIS measures, to better understand barriers to access within the HAP MHP Network.

Childhood is a rapid time of growth and change. Well-visits schedules are adjusted based on when children are developing the fastest until annual preventive visits (later childhood and adolescents) are considered adequate. Well-visits include services such as:

- Age appropriate screening, testing, laboratory services and vaccinations
- Age appropriate physical examination (unclothed)
- Hearing and vision screenings
- Past medical history, including developmental history
- Height, weight and BMI percentile for age
- Nutritional assessment
- Oral examination
- Developmental screening
- Health education and participatory guidance
- Counseling for child/adolescent and parents/guardian

HAP MHP has had Lead Testing in Children as Preventive Health Indicator for several years and continues to monitor it on a monthly basis. HAP MHP ensures all new members receive health guidelines for lead testing. Reminder mailings are sent to parents on a monthly basis, as opposed to quarterly in years prior. Providers are notified of children due for lead screening via the Opportunities Reports, which is updated each month. All new moms receive lead poisoning and testing information.

CSHCS Care Coordination

- The MHP CSHCS CM program is designed to assist members to reach their optimum level of wellness, self-management, and functional capability at the appropriate level of care while maintaining cost-effectiveness, quality, and continuity of care.
- The goal of Case management is to provide seamless care to this population to remove barriers to care and services as the families’ transition to the Managed Care Health Arena.
- CSHCS Case Managers work with members to link them with covered medical services and provide direction to assist in obtaining eligible non-medical resources.
- Once the member is identified as possibly being a candidate for case management, the member is to be contacted by phone and must agree to case management services. When the member has no phone available, letters may be sent to the address of record requesting a return call. The local health department is also utilized to assist in contact of the member and coordination of care for case management.
• Services are bridged to ensure coordination of care, deletion of care fragmentation and ensure there is no duplication of services.

Case Management

HAP Midwest Health Plan assesses the characteristics and needs of the member population and subpopulation annually in order to update the program based on identified needs and findings. The population assessment includes:

• Assessing the needs of children and adolescents
• Assessing the needs of individuals with disabilities
• Assessing the needs of individuals with serious and persistent mental illness
• Reviewing the needs of individuals with multiple co-morbid conditions.
• Reviewing complex case management processes and updating them to meet member’s needs based on these findings
• Reviewing complex case management resources and updating them to meet member’s needs based on these findings

The assessment is used to identify eligible members for complex case management as well as link the member to services needed.

Levels of Case Management

Once members are identified as being a potential candidate for Case Management Services the HAP Midwest Health Plan Case Manager completes an initial assessment as expeditiously as the member’s condition requires but no later than thirty (30) calendar days from the date the member was identified as eligible for complex case management services. The date the member is eligible for case management services is documented in CCMS. The CM makes three (3) attempts to contact the member within two (2) weeks of being notified of the member’s eligibility for case management. If the CM is unable to contact the member, the CM sends a letter to the member requesting them to contact the CM to set up CM services. If the CM is unsuccessful in receiving a phone call from the letter sent, the file is closed. All phone contacts and letters sent to the member are documented in CCMS.

The assessment may also be derived from data from care or encounters occurring up to thirty (30) calendar days prior to determining the member’s eligibility for complex case management if the information is related to the current episode of care. Assessment components may be completed by other members of the care team and with the assistance of the member’s family or caregiver.

If the member is unable to communicate because of infirmity, the assessment may be completed by professionals on the care team, with the assistance from the member’s family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than thirty (30) days, a new assessment will be performed by the CM if the member is still eligible for complex case management services. The CM:

• Determinations the accessibility of the member (reachable)
• Determinations the member’s ability to follow a prescribed plan of care (teachable)
• Determines the level of care required
• Obtains the member’s permission to contact
• Initiates assessment and implements a self-management plan of care with the member prioritizing goals and identifying attainable goals in conjunction with all health care providers
• Modifies the plan as necessary through monitoring and re-evaluation with the member to accommodate changes in treatment or progress

Complex Case Management

Members identified for complex case management have needs which are determined to be serious and complex. The level of services needed is typically intensive and the resources needed to regain optimum health are typically extensive. The condition, for which case management is required, is persistent and disabling or may be life threatening. The condition can impact several systems such as respiratory, cardiac, gastrointestinal; etc. The needs of the member include a broad scope of services including: medical, social, and mental health. Several specialties or services may need to be coordinated to provide the best care and to achieve the desired outcome.

Complex Cases:
• Greater than 60 days of management
• Identification of multiple barriers to care and compliance
• May require greater than once a week contact to move the case forward

Intermittent Case Management

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

Intermittent Cases:
• Less than 60 days of management
• Are medical condition specific
• Have identifiable barriers
• May require weekly contact

Coordination Case Management

Members identified for Coordination Case Management are in need of assistance with coordination of care. Members will be given help with making appointments, arranging transportation, obtaining prescribed medications, and obtaining appropriate medical supplies.

Coordination Cases:
• Less than 30 days
• Have identifiable barriers
• Once or twice per month contact

Cases may be closed when the goals are met or when the member declines further case management. Members who have exhausted all efforts to change behavior or when the Case Manager in conjunction with the PCP and MHP Medical Director determine the member is not making any changes in behavior the case may be closed.
Community Based Organizations:

HAP MHP maintains its commitment to the communities it serves by completely integrating its outreach initiatives into strategic planning, goal setting, budgeting and performance metrics of the managed care population. This is carried out by delegating sufficient resources to institute and maintain a constant infrastructure designed to:

- Identify specific health needs within the communities it serves
- Develop and report on activity and outcome metrics on key community health initiatives
- Develop key community partnerships with providers, vendors, and other business partners

The Case Management team is knowledgeable of community resources and refers members to appropriate agencies and organizations to enhance and supplement services for the member. Examples include: Community Mental Health, AA, transportation, MIHP, WIC, LHD, school based programs, and others.

Healthy Michigan Plan Health Risk Assessment

HAP Midwest Health Plan implements and operates healthy behavior incentives and assessments in accordance with the MDHHS Contract and the CMS approved Operational Protocol for Healthy Behaviors. HAP Midwest Health Plan educates members on the HRA completion process and conducts outreach to encourage HMP members to schedule an appointment within 60 days, complete the HRA with their provider, and assist with transportation information. HAP Midwest provides outreach and follow up based on member’s responses to the healthy behavior section of the HRA.

Flint Waiver

Flint Water Crisis Interventions are indicated below as proposed by MDHHS and city of Flint Leaders:

- Information regarding expectations and any educational materials provided to Medicaid Health Plans (MHPs) should be immediately disseminated to all levels of MHP staff and the MHP provider network upon distribution by MDHHS.

- Outreach to all members in Flint to provide health counseling and encourage testing of children under the age of 6 years old. At the time of outreach and testing, plans should be educating and encouraging families to go to their primary care physician to follow-up since most likely lead exposure occurred several months ago and will not show up on tests today. Record and be able to report all outreach efforts/outcomes.

- If conducting health fairs/mass screening events, utilize any and all standardized education materials approved for use and coordinate events whenever possible across plans.

- Encourage providers to expand hours and encourage testing and follow-up through their offices.

- Offer Case Management to families served by Flint water as appropriate based on risk/need through telephonic care management and/or Community Health Workers.

- Utilize Community Health Workers as available in addition to or instead of case management, as appropriate.
• Remove all transportation barriers and waiting periods and share transportation assistance information whenever possible.

• Ensure provision of confirmatory venous tests for any children who have a BLL test result ≥ 5 mcg/dL.

• Educate provider networks in the Flint area. Providers should be educated that all children exposed to Flint water should be suspected of elevated blood lead levels and followed closely even if a current test is normal, how to prevent lead exposure, the potential effects of exposure, importance of nutritious foods for children exposed to lead and the continued/long term role they play in following and monitoring their patients.

• Educate Flint members on preventing lead exposure (filters, changing filter cartridges and aerators, bottled water, etc.), nutrition, mental health resources, following up with PCP, etc.

• Conduct outreach to pregnant women to ensure they have access to bottled water, have the proper filters and are using them properly, are receiving the proper prenatal care and lead abatement if necessary.

• Update Flint providers regarding which members are enrolled with providers often and in a timely manner. The lists should be broken down by age from each plan. Include name and contact info. Age range 0-6, 6-14, and 14-18.

• Encourage Flint area providers to attend weekly provider training hosted by Dr. Eden Wells.

Race/Ethnicity and Preferred Language Data Collection
HAP MHP fully and accurately reports the following on the HEDIS ® Interactive Data Submission System (IDSS):

- Race/Ethnicity Diversity of the HAP MHP membership
- Language Diversity of HAP MHP membership

Provider Network
HAP MHP maintains a provider network of qualified providers in sufficient numbers and locations within its servicing counties. An annual network analysis is performed to ensure the network is sufficient for the HAP MHP membership. All PCPs and Specialty Care Physicians (SCPs) are reviewed to determine they are within 30 miles or 30 minutes of all members. Contracted hospitals are also within 30 miles or 30 minutes of members. All PCPs must be available, or make arrangements for alternative care, 24 hours per day, seven days per week, and 365 days per year.

HAP MHP collects and reports on race/ethnicity/language (R/E/L) proficiency for network providers. HAP MHP publishes practitioner language information in the Provider Directory and supplies this information to MDHHS with the Consolidated Annual Report by March 1st each year.

HAP MHP notifies network providers, including hospitals, on an annual basis at minimum, that written and spoken language services are available to members in any setting (ambulatory, inpatient, and outpatient).

HAP MHP collects and reports the following:
• Number of members requesting language translation/interpretation services
• Number of members receiving language translation/interpretation services. HAP MHP reports this information to the MDHHS by August 15th each year.

Health Equity Project
To support the Health Equity project, HAP MHP submits HEDIS® data broken down by Race/Ethnicity to MDHHS for specified HEDIS® measures and submits completed template to MDHHS by August 15th each year.

Maternal Infant Health Program (MIHP) Coordination
HAP MHP continues to refer all members identified as pregnant to the Maternal Infant Health Program (MIHP) with all contracted MIHP providers operating in the service area. In addition, information is sent to the member encouraging them to enroll in the HAP MHP Rosebud Prenatal/Neonatal Program. HAP MHP continues to be part of a workgroup, collaborating with other health plans to increase MIHP participation. HAP MHP will continue its referral process to contracted MIHP providers in 2016.

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 member’s BMI be calculated and advised if the BMI indicates the member is overweight. HAP MHP conducts medical record review for BMI in adults, children and adolescents as well as reviewing for counseling for nutrition and physical activity in children and adolescents. HAP 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. During 2016, HAP MHP will continue steps to educate providers on the importance of calculating and documenting patient BMIs and providing nutrition and physical activity counseling as needed.

Tobacco Cessation
HAP MHP has several strategies in place to identify tobacco users within its membership and assist those who have a desire to quit. Annually, HAP MHP monitors the Medical Assistance with Smoking and Tobacco Use Cessation measures obtained from the adult CAHPS member survey. These measures include self-reported results for the following:
  • Advising smokers and tobacco users to quit;
  • Discussing cessation medications; and
  • Discussing cessation strategies.

HAP MHP has contracted with National Jewish Health Michigan Tobacco Quit line Partner for its structured tobacco cessation program (Smoking Cession Program) available to members. The Quitline will offer up to 4 proactive coaching sessions with the opportunity for additional tobacco cessation support calls to those who enroll, and the provision of Nicotine Replacement Therapy (NRT) for those qualified. Each coaching session is personalized for the participant based on the stage of change. Callers often move back and forth among stages, and coaches are trained to tailor their intervention specifically for each call. Participants enrolled in this program, who are medically eligible, are typically offered 4-weeks of free NRT (patches.) All participants over the age of 18, who meet the medical
screening criteria, will be sent 4-weeks of NRT patches, gum, or lozenges upon completion of the first coaching call. The Quitline provides services seven days a week.

Additionally, HAP MHP follows the Medicaid contractual requirements. Effective 1/1/2016, Medicaid contractual changes require HAP MHP to provide the following to promote tobacco use cessation:

- Intensive tobacco use treatment through a MDHHS approved telephone quit line
- Group and/or individual counseling/coaching separate from the 20 outpatient mental health visits;
- Counseling/coaching in conjunction with nicotine replacement medication
- Nicotine replacement patches, gum, lozenges, inhaler or spray
- At least one prescription of non-nicotine medication; i.e. Wellbutrin
- Medication combination therapy

HAP MHP will continue to offer the Smoking Cession Program in 2016 and continue efforts to promote tobacco cessation among its membership.

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

- Ensure Pharmacy Benefits Manager supports e-prescribe.
- Continue to monitor usage of e-prescribing.
- E-prescribing is an aspect of the Pay for Performance Program (P4P)

Health Information Technology (HIT)
HAP MHP is taking active steps to advance provider adoption of health information technologies to improve care coordination, including the following:

- HAP MHP is actively participating in the Health Equity project. HAP MHP reports information on Race/Ethnicity/Language on its members and providers. Monthly provider directories are updated on the HAP MHP website to allow members to search for providers by race, ethnicity, or language spoken.
- The Provider satisfaction survey is conducted annually. The survey asks providers about their use of e-prescribing. In 2015, 92% of survey respondents stated they are using e-prescribing. The annual survey will be re-conducted in 2016.
- The Pharmacy Benefits Manager supports e-prescribing. The number of electronic prescriptions represents 48% of all prescriptions filled in 2015. HAP MHP continues its efforts aimed at promoting and educating providers about e-prescribe. HAP MHP understands the quality, value, and safety of electronic prescribing and continues to promote e-prescribing.

Population Health and Health Equity

Health Equity Program

HAP Midwest will utilize various measures to identify community health disparities to meet the needs and improve health equity within our population. These tools use demographics, care patterns, medical
conditions and resource utilization to stratify patients into five main categories namely episode of care patients; high risk patients; chronically ill patients; healthy patients but with conditions and healthy patients. This information is used by medical providers in healthcare management and decision making. Progress against plan is measured and interventions are updated annually. There will be ongoing community collaboration with other groups, coalitions, and task forces that address health care disparities.

**Chlamydia Screening**
Through HAP MHP’s quality improvement program Chlamydia is a population health equity indicator for measuring. Currently, through the HEDIS collected data which indicates screening rates for female’s ages 16-20 years old and 21-25 years old. Moving forward the recommendation is to include males in this equity data collection.

**Chlamydia Screening Racial/Ethnic Health Disparities**
One priority in addressing health disparities in this measured screening is the prospect to engage leadership, assessing of barriers and opportunities for improvement. Targeting populations for racial/ethnic disparities for Chlamydia screening is also a top priority. HAP MHP has been seeking solutions to continue to improve Chlamydia screening rates by targeting clinical outreach, partnering with healthcare agencies, and providing needed educational information for all needed parties.

**Population Health Management**
An individual’s health is shaped profoundly by life circumstances that fall outside the traditional purview of the health care system. Housing, nutrition, transportation and other dynamics are referred to as “social determinants of health” (SDH). SDH are cited as factors that collectively have the most significant influence on health outcomes. To address the social determinants of health impacting Michigan Medicaid beneficiaries, HAP MHP will develop and implement a multi-year plan and policies/procedures to address beneficiary’s health outcomes.

**Addressing Health Disparities**
HAP MHP reviews and identifies members with social determinants of health from data analysis information including race/ethnicity. HAP MHP is able to identify and reduce barriers to healthcare access and root cause analysis application. HAP MHP utilizes race and ethnicity data contained in Medicaid enrollment files with the highest-risk populations as scored from Agile risk model. This allows us to identify cultural disparities and develop targeted interventions linked to race, ethnicity, and gender. Our plan also identifies subpopulations that have disparities due to barriers such as housing, food, transportation etc. One example includes identifying areas of highest geographic disparities from ED utilization reports for a specific zip code and utilizing Community Health Workers (CHW) for communicating and encouraging screening and follow up care management. Our plan also collaborates with community based groups such as faith based organizations and neighborhood associations.

**Community Collaboration Project**
To improve population health HAP MHP patriciates in community led initiatives. For example in partnership with HAP and Henry Ford Health System (HFHS), HAP MHP has a community project in Genesee County. This is a comprehensive and broad-based community project in Flint around the water crisis. It includes resources from HAP, HAP MHP, and HFHS employees and activities are planned...
throughout the year. We are working closely with the Red Cross, the United Way of Genesee County and the Community Foundation of Greater Flint. Our goal is meeting both short and long-term community needs.

Community Health Worker Program
HAP MHP maintains its obligation to the communities it serves by completely integrating its outreach initiatives into strategic planning, goal setting, budgeting and performance metrics of the managed care population. The plan provides targeted goals to identify and support opportunities to improve health disparity populations by providing a non-clinical professional advocating for members in a community based healthcare setting. HAP MHP partners with community health agencies to implement the Community Health Worker program.

The CHW program functions to institute and maintain a constant infrastructure designed to increase health information, engage and assist members in managing healthcare needs and utilizing resources to advocate on behalf of the member. The CHW can develop a trusting relationship that enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

HAP MHP initiates the CHW program to combine the gaps between medical and social services, providing members with information and resources necessary to promote best health practices, self-management, and health maintenance. The program will also encourage wellness programs, avoidance of injury, and disability.

Non-Emergency Medical Transportation (NEMT)
HAP MHP is committed to the facilitation of any NEMT to members within adequate time for healthcare medical appointments to PCP’s. Customer service monitors and facilitates all transportation requests.

Tobacco Cessation Programs
HAP MHP is committed to the Tobacco Cessation Program which is a telephonic health coaching program. Participants that enroll in the tobacco cessation program receive a telephone call from a Health Coach who collects the participant’s individual health information. Health Coaches offer strategies to increase self-efficacy, identify barriers to change and provide techniques to cope with and overcome barriers. Each enrolled participant receives a specified number of calls from their dedicated Health Coach during the program.

Integration of Behavioral Health and Physical Health Services
In an effort to ensure collaboration and integration between health plans and Pre-paid Inpatient Health Plans (PIHPs), HAP MHP in conjunction with the PIHPs is creating policies and procedures to engage in integration and collaboration of these services.

It is the policy of HAP Midwest Health Plan, as a Medicaid Health Plan responsible for services to individuals enrolled in Medicaid, to coordinate care provided to individuals with the PIHP also managing services for those individuals. It is further the policy of HAP MHP to work cooperatively with other PIHPs to jointly identify priority need populations for purposes of care coordination. In support of this policy, HAP MHP shall work to secure appropriate consents, share necessary electronic data, and conduct routine care coordination activities necessary to fulfill this policy. In furtherance of this policy, we will:
At least monthly, identify which members are assigned to an MHP and have sought services through the PIHP
- Receive information from electronic sources
- Participate in MiHIN (Michigan Health Information Network)
- Establish and implement joint care plan management standards and processes to ensure appropriate communication exists and sufficient efforts are being made to support success in integration. The joint care plans will foster an environment of collaboration between HAP MHP and the PIHPS for the ongoing coordination and integration of services.

**ED Utilization Project**
HAP MHP is committed to the ED Utilization project through developing an in-depth understanding of ED Utilization relative to the member population and designing interventions that move towards a more systematic approach to addressing complex issues that impact member utilization.

**PCMH (Patient-Centered Medical Homes)**
HAP MHP is committed to promoting PCMH programs to integrate the transformation of primary care practices into PCMH to improve the delivery care system and to increase the membership of these primary care practices. HAP MHP has established a P4P incentive program for providers that are PCMH certified through NCQA accreditation or BCBSM PGIP PCMH designation. HAP MHP will continue to coordinate with practice-based and Michigan Primary Care Transformation (MiPCT) care managers for members. HAP MHP will report to MDHHS the number of members receiving services from PCMH practices.

**PROGRAM STRUCTURE**

**Authority**
HAP MHP’s QAPI is commissioned by the Board of Directors and is accountable to the governing body. The Chief Medical Officer or designee will delegate the responsibility and authority for establishing, maintaining and supporting the QAPI.

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

The Chief Medical Officer, through the Quality Improvement Committee (QIC), shall be accountable for:
- Overseeing the QAPI and assuring that all program functions are coordinated and integrated;
- Assuring that the QAPI is defined and understood by all those involved in the process;
- Developing, reviewing, and assuring proper documentation of the QAPI activities;
- The Behavioral Health Care Practitioner representative, through the QIC, shall be responsible for advising the QIC on behavioral health care activities such as guideline review and approval, peer review activities, and consultant for utilization issues
- 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 MDHHS Behavioral Health Care Advisory Committee.

**RESOURCES**
The Manager of Quality Improvement is committed full time to developing and implementing the QAPI.
Additional support staff include: Chief Medical Officer, Vice President (VP) Clinical Services, Corporate Compliance Officer, Director of Quality Improvement, Manager of Quality Improvement, Quality Coordinator, Clinical Quality Coordinator, Quality Analyst, Disease Management Nurse, Director of Health Services, CM/UM staff, VP Director of Operations, Claims Manager, Director of Finance, Customer Services Manager, Customer Services Representatives, Medical Director, Chief Information Officer, and Management Information Services Operations and staff. The Medical Director for one of the PIHP’s in the service area of Region 6 will serve as the behavioral health care consultant. An expert panel of board certified consultants PCP’s and SCP’s are also utilized for guideline development, peer review activities, and appeals. Hardware systems include desk top computers, laptop computers, copy machines, and routine office supplies. Software systems include Verisk Health for HEDIS ® data collection and reporting, and McKesson Disease Monitor system for disease management and McKesson CCMS (case management). Microsoft Office, Excel, Power Point, and other standard computer programs are also used.

**SUPPORT PROCESSES**

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

QAPI supports and addresses findings of compliance reviews (annual, onsite, and ad hoc) by MDHHS, external quality reviews, and statewide focus studies.

Credentialing processes also support the QAPI by performance of credentialing and re-credentialing activities, performance of site visits and inspections as necessary, 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, and pharmacy issues. 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 HAP MHP. Once this information is entered, Information Systems assists in running yearly reports on top diagnoses, HEDIS ® reports, and various ad hoc reports as requested for QI.

The Health Outreach Department supports the QAPI by providing educational programs and materials for persons with asthma, diabetes, hypertension, depression, tobacco cessation, high-risk and routine pregnancy and to promote well child visits and immunizations. Reminders are also sent to members.
for mammograms, pap smears, lead screening, immunizations, annual physicals, and well child/adolescent visits. They also conduct health/educational fairs for our members in collaboration with the community outreach department. The Health Outreach Department in conjunction with QI is responsible for submitting an annual report to MDHHS on health promotion and disease prevention programs; outreach, referral, and follow-up activities related to enrollee uptake and participation rates.

HAP MHP completes a network analysis and a provider satisfaction survey annually. HAP MHP also oversees the monthly provider newsletters, provider education, and office staff education. These activities are also integral processes that support the Quality Management Program. Access to the Provider Administrative Manuals, directories, and newsletters is available on the HAP MHP website. Office staff orientation is conducted to help educate and update the 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.

- **Present**: Practitioners who participate via physical presence or conference call
- **Participating**: Practitioners that are recorded in the minutes as participating are not physically present at the meeting, but met with a committee designee and reviewed the information prior to the meeting. Their comments and suggestions are taken back to the committee via the committee designee
- **Absent**: Practitioners that are not present or participating at the meeting
- **Excused**: Practitioners who are invited to attend but could not do so due to other obligations and have 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, MDHHS, and jurisdictions empowered to impose such requirements.

**Quality Improvement Committee (QIC)**

The Board of Directors, through the Chief Medical Officer, delegates to the QIC the responsibility for integrating the HAP 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 HAP MHP’s Board of Directors by Chief Medical Officer.

Membership includes:

- Chief Medical Officer (chairperson)
- VP Clinical Services
- Director of Quality Management
- Manager of Quality Management
• Director of Health Services
• Director of Pharmacy
• Director of Finance
• Practicing HAP MHP practitioners (specialties include Family Practice, General Practice, Internal Medicine, and Pediatrics)
• Behavioral Health Representative
• Practitioners on the panel of board certified expert consultants, as needed
• Others, as deemed appropriate

Primary Committee Functions:
• Integration and evaluation of the HAP MHP’s QAPI;
• 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 HAP MHP QI, Health Services, Member Rights, and Compliance policies and procedures
• Responsible for Confidentiality Policy. This includes:
  o Mechanisms to oversee the application of policies
  o Designate levels of user access
  o Identification of unnecessary personal data collection
  o An appeal process for confidentiality issues
  o Mechanisms to limit access to data
  o A process to review requests to use member data

Annual review of:
• QAPI: Program, evaluation, work plan, and calendar
• Health Services: UM/CM Programs and evaluations
• Credentialing/Re-credentialing: Program
• Pharmacy: Program and evaluation
• Any other plan-wide programs

Other QI-related functions as delegated by the Board of Directors, the Chief Medical Officer, Medical Director, and the Director of Quality Management.

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

The Chief Medical Officer/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:
• Corporate Compliance (Fraud and Abuse) and Confidentiality/Privacy Subcommittee
• Credentialing Subcommittee
• Health Services (Peer Review/Provider Appeals/Utilization Management) Subcommittee
• Pharmacy, Benefits and New Technology Subcommittee
• Other committees, as deemed necessary

The following departments provide reports to the QIC:

• Customer Services
• Provider Services
• Medical Services

Corporate Compliance (Fraud and Abuse) and Confidentiality Subcommittee
The Corporate Compliance and Confidentiality Subcommittee is a subcommittee of the QIC. The primary role of this subcommittee is to review the confidentiality and fraud and abuse policies and procedures and ensure that the policies are implemented and make recommendations to the QIC. This Subcommittee meets bimonthly or on an as needed basis. The minutes, recommendations, and actions of this committee are submitted to the QIC and then the Board of Directors for approval.

The members include:
• Chief Medical Officer
• VP Clinical Services
• Director of Quality Management
• Director of Health Services
• Director of Pharmacy
• Practicing HAP MHP practitioners
• Compliance Officer
• Others, as deemed appropriate

The primary duties of the Corporate Compliance and Confidentiality Subcommittee are as follows:
• Review and revision of fraud and abuse policies and procedures;
• Review of results of auditing activities of the different departments within HAP MHP;
• Ensure implementation of the Fraud and Abuse policies and procedures;
• Ensure proper reporting to the state on potential fraud and abuse practices
• Review and revision of Confidentiality policies
• Review of Confidentiality and HIPAA Policies
• Ensure the implementation of the Confidentiality and HIPAA Policies
• Make recommendations to the QIC

The Corporate Compliance and Confidentiality Subcommittee shall meet bimonthly.

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

Credentialing Subcommittee
The Credentialing Subcommittee reports to the Quality Improvement Committee and meets semimonthly to consider candidates for credentialing or re-credentialing, including delegated credentialing/re-credentialing. Re-credentialing of practitioners and providers takes place every three
years. The re-credentialing process includes a review of practitioner sanctions, complaints, and important quality and safety issues if applicable.

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:
- Chief Medical Officer
- HAP Credentialing Manager
- Practicing HAP MHP practitioners (additional physicians if deemed necessary)
- 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 HAP MHP standards or not, and recommend HAP MHP 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 Chief Medical Officer/Medical Director/designee will report the Credentialing Subcommittee activities in an ongoing manner to QIC.

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

The members of the Health Services Committee include:
- Chief Medical Office (Chairperson)
- VP Clinical Services
- Director of Health Services
- Director of Quality Management
- Director of Pharmacy
- Director of Finance and Accounting
- Practitioners on the panel of board certified expert consultants as needed
- Practicing HAP MHP practitioners (specialties include Family Practice, General Practice, Internal Medicine, and Pediatrics)
• Representative from Behavioral Health
• Others, as deemed appropriate and appointed by the QIC

The primary committee functions include:
• Monitoring health care management, i.e., high cost, high volume, greatest risk, and those areas with greatest potential for change
• Promoting efficient provision of services in a quality setting appropriate to the needs of the members
• Review and approve evidence-based clinical criteria sets for decision making; assure its consistent application
• Implementing all other quality review procedures required within the Health Services Department to ensure appropriate use of services along with review for potential fraud and abuse
• Focusing resources on problem resolution in an efficient, effective manner
• Review and revision of practice guidelines/standards of care
• Review of member complaints about care or services rendered, by physicians, practitioners or other providers
• Quality of care and service concerns as identified by the Customer Services, Medical Services, Provider Services and Claims Departments
• Upon request, to review and analyze practice patterns, including issues of under and over utilization;
• Review of issues from the Health Services, Credentialing, Compliance, and Pharmacy Subcommittees
• Referral of issues to the “expert panel” as needed
• Assist 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 Chief Medical Officer or designee and reported to the QIC.

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

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

Pharmacy Benefits and Therapeutics Subcommittee
The Pharmacy Benefits and Therapeutics Subcommittee meet regularly to monitor pharmaceutical utilization for possible quality concerns and makes recommendations on drug utilization and evaluation. The HAP MHP formulary is the state of Michigan’s Medicaid formulary and is updated when changes are made by the state. As a Medicaid plan, HAP 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 HAP 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:

- Chief Medical Officer
- VP Clinical Services
- Director of Pharmacy
- Director of Health Services
- Director of Finance and Accounting
- Director of Quality Improvement
- Practicing HAP MHP practitioners (specialties include Family Practice, General Practice, Internal Medicine, and Pediatrics)
- Practitioners on the panel of board certified expert consultants as needed
- Pharmacist(s)
- 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 Chief Medical Officer/designee will report the Pharmacy and Benefits Subcommittee activities in an ongoing manner to QIC.

**CORRECTIVE ACTION**

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

**Corrective Action Plans (CAP)**

A CAP is developed based on findings resulting from medical, service, or MDHHS compliance reviews. HAP MHP’s committees or the Chief Medical Officer/designee can recommend the development of a corrective action plan.

A CAP may consist of focused education to an individual provider, service site administrative manager, or all medical or management staff. HAP MHP will address the use of documentation, clinical protocols, coordination and continuity of care, QI procedures, conduct with members, or other aspects of health care or administrative practices that impact the delivery of health services to HAP 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 QI 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:

- A description of findings to be addressed;
- The individuals responsible for each action;
- Specific actions to be taken;
- A timetable for correction;
- An alternative approach if improvements do not occur;
- Completion date;
- Date of outcomes reported to the QIC and all parties affected by the corrective action plan; and
- 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 Chief Medical Officer or designee will meet with the appropriate provider as necessary to discuss the nature of the problem and the recommended solution. The Chief Medical Officer or designee will offer technical assistance in support of the provider’s effort to resolve the problem. The Chief Medical Officer or designee also stipulates the frequency with which the provider(s) formally assesses the implementation process. The Chief Medical Officer or the QI Manager 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 Chief Medical Officer or designee will meet with the provider and discuss future steps, which may include termination from the network, if the provider fails to comply with the CAP. The Chief Medical Officer or designee will report this activity to the QIC.

**FRAUD AND ABUSE**

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

**DELEGATED ACTIVITIES**

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

- The state will approve all delegation activities.
- A pre-delegation review of activities will be conducted.
- HAP MHP retains absolute authority and accountability for decisions relating to the following:
  - Credentialing and re-credentialing standards and procedures,
  - Utilization of health services; case management procedures, quality of care, quality of service and standards of care
• Maintain adherence to all applicable NCQA standards for delegated activities

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

WORK PLAN
The QI Work Plan includes all HAP MHP 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:

• The objectives for the year;
• Scope of the program, including both the quality and safety of clinical care and services;
• Written measurable objectives for each activity scheduled, including HAP MHP’s approach to patient safety;
• For each objective, the activities that will be done, time frames, and the responsible person department
• HAP MHP planned monitoring of previously identified issues;
• As items are completed, they will be so noted in the activities grid,
• Annual evaluation of the Work Plan; and
• Reports to the Board through the QIC.

EVALUATION
HAP MHP will complete an evaluation of the QI Work Plan and the QAPI. Results will be submitted to the QIC and Board of Directors. Results will become the basis for the next year’s Work Plan. The QAPI, and Annual Evaluation are made available to members and providers upon request and are also found on the website at hap.org/Midwest.

APPROVAL
The annual revisions to the QAPI and the QI Work Plan will be approved by the Chief Medical Officer/designee, the QIC, and Board of Directors.

CONFIDENTIALITY OF COMMITTEE INFORMATION
HAP 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 HAP 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. HAP MHP 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:

- 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);
- Reports and recommendations relative to a Utilization Management and Quality Improvement investigation/studies/outcomes;
- Quality Improvement proceedings (discussions and communications authorized by a committee, including review notes, meeting minutes and other records or review matters);
- All HAP 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.
- Refer to HAP MHP’s Confidentiality Policy Statement regarding the Confidentiality of Individual Member/Patient Records Information.
References: