HAP CareSource™

2024 Quality Improvement Program Description

QIC Approved June 2024

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Overview

As a leading nonprofit managed care company, HAP CareSource® is committed to providing the highest level of quality care and service to our members. A cornerstone of this commitment is the development of Quality Improvement (QI) programs that address the needs of specific HAP CareSource member populations and demonstrate improvement in health outcomes.

HAP CareSource is currently recognized as an accredited entity by the National Committee for Quality Assurance (NCQA).

The purpose of the HAP CareSource Quality Improvement Program is to ensure that HAP CareSource has the necessary infrastructure to:

- **Coordinate care using evidence-based tools.**
- **Improve the health outcomes of our member population.**
- **Promote quality care.**
- **Ensure performance and efficiency on an ongoing basis.**
- **Improve the quality, safety and equity of clinical care and services.**
- **Address health equity needs.**

There are two guiding tenants for the Program:

> **Our mission, which is our heartbeat, is to make a lasting difference in our *members' lives by improving their health and well*-being. Our vision is to transform lives through innovative health and life services.**
>
> **Quintuple Aim: Simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, reducing per capita cost of care for the benefit of communities, and improving provider satisfaction, and advancing health equity. The Quality Improvement Program encompasses both clinical and non-clinical services and is reviewed and revised as needed to remain responsive to:**

- **Member needs inclusive of health, safety, and welfare.**
- **Provider feedback.**
- **Evidence-based standards of care and best practices.**
- **Regulatory and business needs.**

HAP CareSource is a joint venture between CareSource, HAP Empowered, and MI Health Link further known as HAP CareSource and HAP CareSource MI Health Link.

HAP CareSource serves approximately 37,559 Medicaid enrollees and 4,241 MMP enrollees. HAP CareSource is invested in giving high-quality, low-cost care to Michigan residents. HAP CareSource consists of the following products:

- **HAP CareSource Medicaid**
- Children's Special Health Care Services (CSHCS)
- **HAP CareSource Healthy Michigan Plan**

- **HAP CareSource MI Health Link (for members dually enrolled in Medicare & Medicaid)**

MI Health Link Background

HAP CareSource Health Link is a Medicare-Medicaid Plan (MMP) jointly ran by Michigan and the federal government to provide better health care for individuals who have both Medicare and Michigan Medicaid. Under this program, the state and federal government are testing new ways to improve how members receive Medicare and Michigan Medicaid health care services. Members eligible for the plan are Michigan adults 21 years of age and older, enrolled in both Medicare and Medicaid, living in Macomb or Wayne County. The program operates under the MI Health Link Three-Way Contract, a capitated financial alignment model, signed by the Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and each Integrated Care Organization (ICO). In this model, each ICO is responsible for contracting payment terms directly with providers. Enrollment is open throughout the year, with the member's effective date beginning on the first day of the next **month if enrollment is approved 5 days prior to the end of the month. Individuals eligible for MI Health Link can voluntarily enroll or be passively enrolled by MDHHS.**

The program brings together services for members into one plan, one card and one care coordinator. Members receive single plan coverage for:

- **Medical care**
- **Behavioral health care**
- **Home and community-based services**
- **Nursing home care**
- **Medications**
- **Dental, Vision and Hearing**

The program also offers Care Coordinators and Care Teams to help members manage all their providers and services, ensuring they work together to provide the care the member needs.

PROGRAM SCOPE

The HAP CareSource Quality Improvement Program governs the quality assessment and improvement activities for HAP CareSource Michigan Medicaid and MI Health Link under the leadership of the Vice President, Market Chief Medical Officer to ensure coordination and program implementation. Requirements of the Program include the development of realistic and measurable objectives developed via consensus with medical and quality improvement team members. Additionally, CareSource Quality Improvement and Population Health Management (PHM) strategies are intertwined for both operation and oversight under the QI Department.

The program scope includes the following activities and ability to:

- **Meet the quality requirements of the Centers for Medicare and Medicaid Services (CMS), State and/or Federal regulators, the Michigan Strategic Plan and the Affordable Care Act (ACA), if applicable.**
- **Monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members.**
- **Incorporate an internal system for monitoring services, including:**
    - **Data collection and management for clinical studies.**
    - **Internal quality improvement activities.**

    - **Assessment of special needs populations.**
    - **Other quality improvement activities requested by the State or CMS including ad-hoc reporting to appropriate committees and subcommittees.**
- **Participate appropriately in clinical studies and use Healthcare Effectiveness Data and Information Set (HEDIS®) rate data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to HAP CareSource plan members. In assessing the quality and appropriateness of care provided to members under 21 years of age and in accordance with EPSDT/Health Watch requirements.**
- **Collect measurement indicator data for areas of clinical priority and quality of care as outlined by Michigan Department of Health and Human Services (MDHHS)**
- **Establish safe clinical practices throughout the network of practitioners and providers.**
- **Provide quality oversight of all clinical services.**
- **Monitor and evaluate member, practitioner, and provider satisfaction.**
- **Maintain written policies and procedures for quality assessment, utilization management, and continuous quality improvement, periodically validated for efficacy.**
- **Develop organizational competency in quality methodologies, including use of the Plan Do Study Act (PDSA) rapid cycle improvement model.**
- **Ensure HAP CareSource Programs are effectively serving members with culturally and linguistically diverse needs.**
- **Ensure effective and equitable care for members with varying levels of health, safety, or welfare needs, including complex health issues.**
- **Establish data availability to participate in performance and quality improvement projects, clinical studies, and External Quality Reviews.**
- **Assess specific population health characteristics and needs, including the social determinants of health.**
- **Utilize a PHM strategy of collaboration between members, providers, practitioners, community programs and services.**
- **Assess the geographic availability and accessibility of primary and specialty care providers.**
- **Participate in any state-sponsored prenatal care coordination programs.**
- **Develop and maintain a physician incentive program.**
- **Develop a member incentive program to encourage member responsibility for their healthcare and outcomes.**
- **Participate in clinical studies, as appropriate.**
- **Participate in any state-sponsored PIPs**
- **Submit quality improvement data, status and results of performance improvement projects** and information to complete the state's Quality Strategy Plan for CMS.
- **Maintain procedures for collecting and assuring accuracy, validity, and reliability of performance outcome rates consistent with protocols developed in the private/public sector.**
- **Perform annual quality improvement program evaluation.**

Goals and Objectives

HAP CareSource is a recognized leader in the health insurance industry as a provider of quality, evidence-based member-centric health care. Performance goals are determined and aligned with national benchmarks where available and developed to encompass our diverse member needs and enhance health outcomes.

The clinical aspects of the Quality Improvement program are derived from evidence based medical research and nationally recognized best practices and standards of care. The Quality Improvement program is designed to ensure quality and appropriate health care which is provided within the scope of population specific member needs, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and considers the influence of social determinants on health outcomes.

Key to improving health outcomes is understanding the populations we serve, encompassing an array of demographics, such as age, race/ethnicity, cultural health beliefs, and disease states, which may place members at risk and negatively impact health outcomes. Data analysis is significant in monitoring, evaluating, and actively pursuing opportunities for improvement.

Our goal is to meet the needs of our membership. The Quality Improvement Program goals and objectives are critical in assuring we meet member needs, and impact outcomes that include:

- **Obtaining a high level of performance in Healthcare Effectiveness Data and Information Set (HEDIS®).**
- **Earning a high rating on member, practitioner, and provider satisfaction survey results.**
- **Maintaining National Committee for Quality Assurance (NCQA) Accreditation.**
- **Carrying out a comprehensive Population Health Management Program to address member needs, including social determinants of health that contribute to health disparities.**
- **Serving members with complex health needs through the development of targeted interventions and focused programs.**
- **Fostering partnerships among members, caregivers, practitioners, providers, and the community to promote grassroots efforts for effective health management, health education, disease prevention, and overall improved health and quality of life.**
- **Ensuring a high-quality practitioner and provider network through a comprehensive credentialing, peer review, and contracting process.**
- **Seeking to improve member health through the development of targeted innovative initiatives.**
- **Ensuring adequate and appropriate resources are available to maintain and enhance ongoing QI Programs.**
- **Collaborating with practitioners and providers to implement strategies to improve coordination and continuity of care.**
- **Improving patient safety and monitoring outcomes using patient safety indicators.**
- **Implementing programs, such as Life Services JobConnect, that address the social determinants of health.**

Annual Program Work Plan

The Michigan Quality Improvement Committee (QIC) in conjunction with the VP, Market Chief Medical Officer is responsible for development of the Quality Improvement Program annual work plan and evaluation for HAP CareSource Michigan Medicaid and MI Health Link.

The Work Plan is a dynamic document covering a full year of planned activities with quarterly updates presented to the Michigan Market QIC includes the following sources of input:

1. **HEDIS measures**
2. **CAHPS results**
3. **Quality Withhold for Outcomes results.**
4. **External Quality Reviews**
5. **Accreditation**
6. **Compliance**
7. **Other identifiable areas for improvement identified by MDHHS/CMS**

Specific objectives for each quality improvement initiative are further defined in the Quality Improvement Work Plan and include yearly planned QI activities and objectives for improving:

- **Quality of clinical care.**
- **Safety of clinical care.**
- **Quality of service.**
- **Member experience.**

The work plan includes:

- **Timeframe for the completion of each QI activity.**
- **Staff members responsible for each QI activity.**
- **Monitoring of previously identified issues.**
- **Evaluation of the QI program.**

Annual Program Evaluation

On an annual basis HAP CareSource completes an annual written evaluation of the HAP CareSource Quality Improvement Program and Work Plan by examining the quality and safety of clinical care and quality of service. The annual evaluation:

- **Examines actual performance compared to goals.**
- **Eval**uates trends in the organization's performance.
- **Identifies barriers to improvement.**
- **Includes recommended interventions.**
- **Provides a summary of the effectiveness of the plan and activities.**

When analysis indicates and objectives have not been met, activities and goals are re-evaluated for potential inclusion in the subsequent calendar year program. The HAP Quality Improvement Committee (QIC) reviews and approves the Work Plan and Program Evaluation. The documents are also reviewed by the Quality Enterprise Committee for informational purposes only. A summary of the written evaluation is presented to the HAP CareSource Management Group Board of Trustees to ensure they remain informed of the organization's goals, and

performance improvement activities. All quality improvement activities are made available to federal, state, and accreditation entities if requested.

Accreditation Standards and Monitoring for Compliance

The Quality Improvement (QI) Department is responsible for ongoing auditing and monitoring of policies, procedures, and processes for compliance with the most current accreditation standards and requirements published by the Centers for Medicare and Medicaid (CMS), State and/or Federal regulators and the Affordable Care Act (ACA), if applicable. The QI Department actively works across the business areas to identify and correct deficiencies, and/or process shifts. The Enterprise Vice President of Quality and Performance Outcomes and the Senior Director of Quality Improvement and Population Health are responsible for monitoring these activities and presenting findings, as needed, to the individual market Quality Improvement Committee (QIC), and to the HAP CQMC. If significant deficiencies are identified, they are presented to the HAP CareSource Management Group Board.

Quality Improvement Organizational Structure, Responsibilities & Reporting Relationships

The HAP CareSource Board of Directors has ultimate authority and responsibility for the care and service delivered to HAP CareSource members. The HAP CareSource Board of Directors receives an annual summary of the HAP CareSource Quality Improvement Program. The Vice President of Quality and Performance Outcomes reports quality improvement activities to the Board of Directors. HAP CareSource as a joint venture also has bidirectional reporting structures to engage appropriate stakeholders from respective organizations. Additional details regarding role, function, membership, and reporting can be found in committee charters.

HAP CareSource Leadership Team

The HAP CareSource Leadership Team is an executive level body charged with providing enterprise level oversight in the areas of quality improvement and business operations. The Leadership Team serves as an enterprise-wide coordination and information sharing body for the areas of regulatory compliance, Enterprise risk management, and Enterprise crisis management. The Leadership Team oversees, coordinates, and monitors adherence to the annual HAP CareSource Business Plan and the annual Quality Improvement Program.

Market Committees

The 2024 QI Program Description will be amended throughout 2024 to reflect changes in structure.

Michigan Quality Improvement Committee (QIC)

Committee Function: The Michigan Quality Improvement Committee (QIC) chaired by the HAP CareSource Market Medical Director, provides leadership, oversight, and evaluation of the Quality Improvement Program and Work Plan for Michigan Medicaid and MI Health Link. to ensure adherence to state and federal regulations. The primary responsibility of the Committee is the strategic direction, development, and continuous monitoring of annual program activities

and quality and performance improvement projects. Information taken from QIC will be reported out in other venues, such as CQMC.

Frequency of Meetings: Quarterly

Scope of Committee:

- Oversee the QI Program and QI function in the organization for both HAP CareSource and MI Health Link.
- Review the QAPI program, its results and activities, and recommend changes on an ongoing basis
- Review and annual approval of the QI Program Descriptions, Work Plan, and evaluation.
- Review and approve Quality Improvement policies.
- Review and monitor key performance indicators.
- Develop, implement, and monitor corrective action plans for QI purposes.
- Provide guidance to staff on quality management priorities and projects.
- Evaluate the effectiveness of the Quality Management Improvement Program and projects/activities.
- Annual review of reports on the following committee and team activities:
    - Utilization Management by Market, Pharmacy and Therapeutics by Market, HEDIS® updates by Market, Integrated Care Management updates by Market
- Adopt clinical practice and preventive health guidelines and assess performance.
- Monitor the impact of member health, safety, and welfare interventions and outcomes to identify opportunities for improvement using quality methodologies. Based on outcome results, recommend and evaluate interventions.
- Review HEDIS and CAHPS results annually and make recommendations for improvement Monitor and promote continuity and coordination of behavioral and medical health care.
- Monitor and promote availability and accessibility of network practitioners and providers
- Evaluate oversight of appropriate delegated activities. Evaluate oversight of appropriate delegated activities.
- Review NCQA accreditation standards
- Monitor and access member health, safety, and welfare indicators, including:
    - Social determinants
    - Health equity initiatives
    - Continuity and coordination of care
    - Member education
    - Pharmaceutical management
    - Review utilization levels of medical services
    - Sentinel events by Market
    - Grievance & Appeals by Market
    - Quality of care grievances by Market

PROVIDER ADVISORY COMMITTEE (PAC)

Committee Function: **The purpose of the Provider Advisory Committee (Council-MI) is to make available a forum for market specific practicing healthcare providers and CareSource staff to discuss policy, programs, and quality initiatives. The Committee is comprised of practicing market-specific providers who are participating CareSource practitioners and is representative of the major clinical specialties that serve our members. This Committee fosters discussion among practicing healthcare providers to discuss, review and make recommendations related to CareSource new and revised medical policies, clinical practice guidelines and clinical operational decisions. Establish a forum for practicing health care providers to provide input and expertise regarding new program development and changes to existing programs, to ensure clinical operations remain relevant to practicing clinicians. Provide peer review assessment and recommendations regarding CareSource provider quality of care concerns, including health, safety, and welfare issues. Address ad hoc emergent Quality of Care and health, safety welfare issues. The Committee is chaired by the Market Medical Director. Participants include Medical and Behavioral Health Directors, Community Physicians, Dentists (if applicable) and a senior member of the Quality, Credentialing, and Health Services Departments.**

Frequency of Meetings: **No less than quarterly.**

Scope of Committee: **Recommends program and policy design enhancements, topics, or revisions. Provider focused quality of care review opinions and peer review assessment and recommendations. Address ad hoc emergency Quality of Care and health, safety welfare issues as needed.**

HAP Clinical Quality Management Committee (CQMC)

Committee Function: **The Vice President, Clinical Operations and Strategy chairs the CQMC. The CQMC is comprised of Henry Ford Health physicians, HAP network physicians, HAP Board members, HAP and HAP CareSource Medical Directors, and representatives from HAP's Utilization Management, Network Management, Credentialing, Appeals & Grievance, Coordinated Behavioral Health Management (CBHM) departments as well as the Medicare division. Members of the HAP Quality team also attend this meeting to bring any developments, action items or areas of opportunity/concern from MI QIC to a wider audience within the HAP side of the organization. The CQMC works alongside MI QIC to analyze, evaluate, and monitor progress toward meeting program goals and objectives, identifying needed actions and ensuring appropriate follow up.**

Frequency of Meetings: **Minimum 5 times annually.**

Scope of Committee: The CQMC oversees patient safety, clinical, administrative, and service quality improvement throughout HAP. Additionally, the CQMC utilizes information gathered from the interdepartmental attendees to recommend policy decisions and is accountable to the Board through its Quality Committee. Executive Summaries of CQMC outcomes are presented during

the Board meetings. CQMC also has several subcommittees, such as the Credentialing Committee.

Network Development and Management Plan Committee

Committee Function: **CareSource has a Network Development and Management Plan (NDMP) that delivers a robust provider network. The NDMP focuses on a sophisticated network that appropriately delivers different provider types, number of providers, and a geographical distributed provider network. This allows us to meet the needs of the anticipated number of members in the service area and ensures the provision of covered services. The network is managed to drive value-based, person-centered care. This document provides an overview of the approach used to achieve the Network Development and Management Plan.**

Frequency of Meetings: **Monthly**

Scope of Committee:

Core components of the approach focus:

V. Michigan Medicaid Strategy and Goals

VI. Network Development and Management Plan Goals

VII. Network Development and Management Plan Committee

VIII. Network Development and Management Plan Approach

IX. Health Partners – Provider Contracting and Network

X. Health Partners - Provider Relations and Engagement

XI. Behavioral Health

XII. Value-Based Approach - Collaboratively working with providers to shift from "Fee**-For-Service** (FFS) to Value" appr**oach focused on person-centered care**

XII. Appendix / Attachments

Enterprise Level Committees

The 2024 QI Program Description will be amended throughout 2024 to reflect changes in structure.

Quality Enterprise Committee (QEC)

Committee Function: **The QEC provides direction to and oversight of quality operations across the organization. The purpose is to ensure that the quality of care provided to CareSource members consistently meets evidence-based care, service, and health, safety, and welfare standards, and is provided in a timely and consistent manner. The QEC measures, monitors, reports, and develops best practices relative to quality of care. The Committee evaluates performance outcomes to assure continuous quality improvement. The QEC is a forum for review and discussion of quality initiatives and market performance. At this time, HAP CareSource will attend and report out information for informational purposes only.**

Frequency of Meetings: **Quarterly**

Scope of Committee:

- **Oversight of the Quality Improvement Programs.**
- **Oversight of the Quality Improvement Work Plans.**
- **Oversight of the Health, Safety, and Welfare program.**
- **Oversight of the Enterprise Provider Advisory Committees (PAC) activities.**
- **Provision of guidance on quality management priorities and projects.**
- **Oversight of Market quality improvement projects.**
- **Oversight of evaluating the effectiveness of the Market Quality Improvement Programs.**
- **Review of summarized reports with trending data from the Market Quality Committees, including but not limited to activities from the following areas:**
- **Credentialing, Utilization Management, Pharmacy and Therapeutics, HEDIS®, Service Operations and Network / Provider Services as applicable, Grievance & Appeals, Case Management, Disease Management, and Accreditation.**
- **Annual review and acceptance of the Market Quality Improvement Program Descriptions, and Work Plans.**
- **Annual review and acceptance of the Market Quality Improvement Program Evaluations.**
- **Approval of evidence-based clinical practice guidelines and nationally recognized standards of care, as well as preventive health guidelines.**
- **Review of NCQA standards.**

ENTERPRISE PROVIDER ADVISORY COMMITTEE

Committee Function: **The purpose of the Enterprise Provider Advisory Committee is to provide Chief Medical Officers, Clinical Quality, Policy & Appeals, Enterprise Medical Directors, Behavioral Health Medical Directors, Market Medical Directors, Enterprise Dental Director and representatives from Clinical Operations, Market Health Partners, Pharmacy, Program Integrity, Quality and Performance Outcomes, Utilization Management and other CareSource stakeholders a forum for discussions and determinations related to:**

- **Standards of Care/Evidence Based Care.**
- **Clinical Practice Guidelines and Preventive Guidelines.**
- **Standardization of the Quality of Care (QOC) Case Severity Leveling System and Review Processes.**
- **Review Clinical Quality of Care Grievances, Quality of Care Concerns and Health, Safety and Welfare case data and trends previously reviewed and addressed by CareSource Market Provider Advisory Committees.**
- **Policy & Procedures related to quality of care, sentinel events, and member safety concerns.**
- **Develop, review and approve standard operating procedures, quick tools and other processes related to internal and external quality reviews.**
- **Review trended reports and dashboards related to clinical quality of care concerns, sentinel events, and member safety cases. Review and make recommendations for provider performance based on quality of care, sentinel events, and member health, safety and welfare cases.**
- **Provide oversight and support the convening of rapid response teams for review of sentinel events and member health, safety and welfare cases.**

Frequency of Meetings: **Quarterly. The Committee reports to the Quality Improvement Committee (QIC).**

Scope of Committee:

- **Review trends in quality of care, sentinel events, and member safety. Provide recommendations based on this review to the appropriate committee(s).**
- **Review and provide final approval of the Clinical Practice/Preventive Health Guidelines.**
- **Establish criteria for leveling of Quality-of-Care Concerns, inclusive of sentinel events and member health, safety, and welfare cases. Ensure follow-up processes are established and followed.**

PHARMACY & THERAPEUTICS COMMITTEE

Committee Function: **The Pharmacy and Therapeutics (P &T) Committee provides for the plan administration of formulary management, including specialty drugs. The P &T Committee, which includes a physician review panel, will determine clinical policies and criteria, formulary selection, and clinical modifications to the formulary list. The formulary is reviewed annually and updated as appropriate to ensure the pharmaceuticals covered are effective and safe. Modifications may include addition or removal of formulary drugs, or addition or removal of utilization management tools (prior authorization, step therapy, quantity limits, etc.), due to state or federal regulations or plan specific contract requirements. New drugs and chemical entities, drug classes, new clinical**
indications, therapeutic advantages, and new safety information are reviewed within six (6) months of any new market launch or change. Recommendations for changes to the pharmacy benefit formulary are made using FDA-approved prescribing information, evidence-based literature, drug compendia, and treatment guidelines. The P&T Committee ensures that quality, cost-effective care is provided to CareSource members and that this care is consistent with local/regional/national standards of care and is provided timely and consistently.

Frequency of Meetings: **Quarterly. The Committee reports to the Quality Enterprise Committee.**

Scope of Committee:

- **Develop and maintain formulary(ies) to ensure the pharmaceuticals covered are effective and safe.**
- **Review the formulary(is) in their entirety at least annually.**
- **Review new drugs and chemical entities, drug classes, new clinical indications, therapeutic advantages, and new safety information within six (6) months of any new market launch or change.**
- **Make recommendations to the Value Assessment Committee (VAC) for placement determination on the formulary using FDA-approved prescribing information, evidence-based literature, drug compendia, and treatment guidelines. The committee will denote each pharmaceutical as: Included, Optional, and Exclude.**
- **Complete final review of the VAC formulary placement determinations**

CREDENTIALING COMMITTEE

Committee Function: **Credentialing Committee includes representation from a range of participating practitioners including One HAP CareSource Medical Director, One – Two primary care practitioners, one obstetrics and gynecology practitioner, several surgical specialties, one psychiatry practitioner** as well as any guests at the chairperson's discretion whose expertise

proves beneficial to the decision-making process. The Medical Director is the designated senior physician with direct responsibility for and participation in the credentialing program for HAP CareSource. The Medical Director oversees the activities of the Credentialing Department. The Medical Director ensures that all credentialing activities are in compliance with the HAP CareSource credentialing policies, NCQA standards, State of Michigan Department of Consumer and Industry Services Bureau of Health Services, Medicare Managed Care Manual, DIFS, and all other applicable laws and regulations. Terms of membership are at the discretion of the Medical Director. The Credentialing Committee reviews the credentials of practitioners that do not meet the minimum guidelines and makes decisions based on the information presented through thoughtful and meaningful discussion. Discussion and decisions are documented in the meeting minutes.

Frequency of Meetings: **At least 12 times per year.**

Scope of Committee: **Credentialing Committee is a regular subcommittee of the Clinical Quality Management Committee (CQMC), acts on behalf of the CQMC to establish practitioners and organizational providers credentialing policies and to make delegated credentialing decisions for HAP CareSource and its subsidiaries.**

UTILIZATION MANAGEMENT/CARE MANAGEMENT (UM/CM) COMMITTEE

Committee Function:

The committee is co-chaired by the Market Vice President, Clinical Operations and Vice President, and the Market Chief Medical Officer (CMO). Additional committee members include Directors and/or Managers of: UM, CM, Pharmacy, Transitions, Behavioral Health, Maternal Child Health, Triage Clinical Call Center, Disease Management, Quality Improvement and Data Compliance. This committee integrates both UM and CM, reporting its findings and activities to the QEC. Meetings have targeted agendas for both UM and CM teams.
UM/CM Committee is charged with review and approval decisions related to the CareSource UM/CM programs, including administrative and clinical direction, ensuring compliance with federal, state, and accreditation requirements.

Frequency of Meetings: **At least quarterly, more frequently if needed. The Committee reports to the Quality Enterprise Committee.**

Scope of Committee: The scope includes the oversite of the UM/CM Programs to include:

- Oversee the Integrated Care Management Program which is responsible for the utilization management and care management of the medical and behavioral health disorder members, including administrative and clinical direction
- Ensure compliance with federal and state regulatory contract standards and the National Committee for Quality Assurance (NCQA) requirements
- Ensure that the integrated utilization management and care management programs, and the program processes are developed to guarantee the quality of care provided to our members is consistent with standards of care, provided timely and consistently.
- Gather input and support from all key stakeholders while monitoring quality measures and outcomes

- Monitor and report utilization metrics, including any trends related to the over/under utilization of service data, outcomes related to the utilization management and care management processes and initiatives, including but not limited to, trends, Service Level Agreements (SLAs) and Key Performance Indicators (KPIs).
- Discuss identified trends detected within the utilization program data and determine root cause analysis
- Measure and monitor outcomes related to the care management programs and initiatives developed to address the needs of special populations
- Provide a forum for review and discussion of UM and CM activities
- Review all audit findings communicated by our team leads and internal audit processes, Compliance, vendor/delegate audits, NCQA, external quality reviews, and the Training and Auditing Department through Quality.
- Annual review, updates and approval of the UM Program Description, UM Work Plan and the UM Program Evaluation.
- Review impact of the care management program to include outcomes of interventions put in place to address specific population needs
- Provide recommendations regarding programmatic enhancements, process improvement and prior authorization requirements
- Review of the following key stakeholder reports for trends, outcomes, metrics, interventions, barriers, and challenges:
    - Utilization Management (PH, BH and Pharmacy)
    - Care Management
    - Transitions of Care
    - Clinical Call Center
    - Review of Delegated Oversight documents/reports for delegated entities
    - Quality initiatives
    - Other important State Regulatory Report Data

CORPORATE COMPLIANCE COMMITTEE

Committee Function: The Ethics & Compliance Committee's purpose is to provide oversight of CareSource's Ethics and Compliance Program and to help ensure CareSource has an effective **Ethics & Compliance Program and culture.**

***Frequency of Meetings*: Quarterly or more often as need dictates.**

Scope of Committee:

- Review and evaluate the Corporation's compliance program including the corporation's **compliance policies and procedures, reporting channels, significant regulatory audits and enforcement actions and proceedings as well as inquiries from government agencies involving compliance matters.**
- **Review Ethics & Compliance and Fraud, Waste, and Abuse training to ensure effectiveness and completion.**
- **Review the effectiveness of the compliance risk assessment process, including the identification and remediation of significant compliance risks or gaps.**
- **Review and approve the comprehensive risk assessment results and associated compliance work plans.**
- **Review and approve the compliance audit work plan and compliance monitoring plan.**

- **Ensure a system for employees and First Tier, Downstream and Related Entities (FDRs) (i.e., delegated entities) to ask compliance questions and report potential instances of program noncompliance confidentially or anonymously.**
- **Review the effectiveness of the Program Integrity Program**
- **Review, assess and take appropriate action regarding reports from Plan Compliance** Officer's and the following Sub**-Committees:**
    a. **Policies and Procedures Committee**
    b. **Delegation Oversight Committee**
    c. **Program Integrity Committee**
- **Review and approve all updates to the Corporate Ethics & Compliance Plan and the Code of Conduct.**
- **Review, assess and guide appropriate actions regarding reports from both internal and external compliance audits.**
- **Review and evaluate trended findings and recommendations from completed compliance activities and audits, including management responses and action plans.**
- **Review, approve and evaluate compliance effectiveness measures which shall be reported to the Committee on the appropriate frequency.**
- **Review and evaluate key compliance indicators or compliance performance of** CareSource's significant risks.
- **Provide support and advice to the Corporate Compliance Officer to help ensure appropriate resources, actions, information, and personnel are engaged to support an effective program.**
- **Review and address results of reports of monitoring and auditing of areas in which the sponsor is at risk for program noncompliance or potential FWA and ensure that corrective action plans are implemented and monitored for effectiveness.**
- **Report to the CSMG Board Audit Committee at least quarterly to provide written and oral** reports on CareSource's Compliance Program effectiveness, issues, and risks.

DELEGATION OVERSIGHT COMMITTEE

***Committee Function*:** The Delegation Oversight Committee's purpose is to enhance the **oversight of entities that provide delegation of service for any State, Federal, or Accreditation requirements. The committee will function as a central area for informing and approving new delegation of service, delegation audit requirements, and delegation corrective action plans and deficiencies.**

***Frequency of Meetings*: Quarterly or more often as need dictates.**

Scope of Committee:

- **Review monthly and approve or deny proposed new delegated entities, delegated services, service changes and delegation terminations.**
- **Review monthly and approve or deny any delegated entity corrective action plans (CAPs) closures.**
- **Review quarterly summaries of delegated service performance including any deficiencies or corrective action plans.**
- **Review quarterly summaries of delegated annual audit performance.**
- **Review quarterly summaries of delegated annual risk reviews and any risk acceptances.**

- **Any urgent approvals needed by the Delegation Oversight Committee can be sent for email vote requiring the same quorum approval.**

CLINICAL POLICY GOVERNANCE COMMITTEE (CPGC)

Committee Function: **CPGC provides oversight and approval for external provider facing Medical Policy Statements developed and maintained to conform to Federal and State regulations, and which are supported by medical evidence in compliance with benefit design and which are aligned with medical necessity supporting the utilization review and care management functions of CareSource across all markets and products.**

Frequency of Meetings**: Monthly or more often as need dictates.**

Scope of Committee:

CareSource Clinical Policy Governance Committee (CPGC) is the official governing body charged with the approval of new or revised clinical policies that relate to medical necessity determinations. The CPGC is responsible for determining whether the proposed clinical policy is clearly defined, is clinically evidence-based, assures a high level of member safety and quality of care, and articulates a business value. The CPGC reports up through the Quality Improvement Committee (QIC) which then reports to the CareSource Board of Directors.

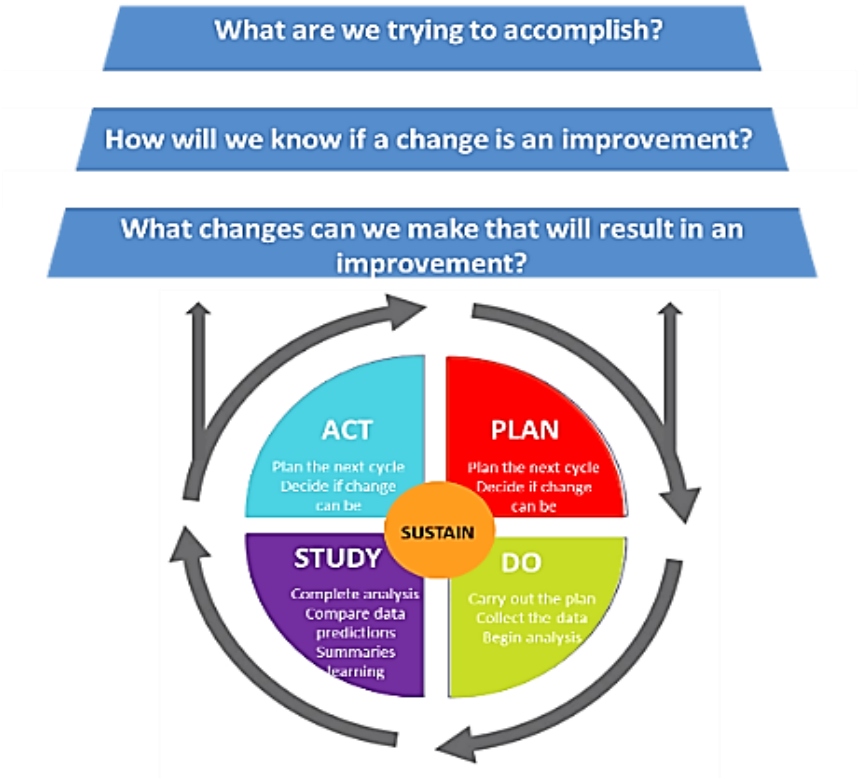
In addition, the New Medical Technology Subcommittee as part of the CPGC, will evaluate new or emerging technologies. The Subcommittee will conduct a quality & safety assessment of the proposed technology. Recommendations from this group will follow the current workflow of CPGC.

COMMUNICATION BETWEEN COMMITTEES

Central to the committee structure is reporting alignment between key committees and ultimately the HAP CareSource Management Group Board. Committee chairs are responsible for agendas, formal meeting minutes, identifying variances, and reporting of those variances up to the Quality Enterprise Committee. The chair is responsible for making recommendations to the Executive Council regarding outstanding committee variances for further discussion, recommendations, and/or resolution.

Quality Strategy and Improvement Process

HAP CareSource utilizes the Institute of Healthcare Improvement (IHI) model as a tool for implementing quality improvement activities. The model has been used successfully by numerous health care organizations worldwide to improve processes and outcomes. The Plan-Do-Study-Act (PDSA) cycle allows for rapid testing of change in the actual work setting and determines whether change(s) made resulted in actual process improvement and positive outcomes.



PLAN: Plan the next cycle
Decide if change can be

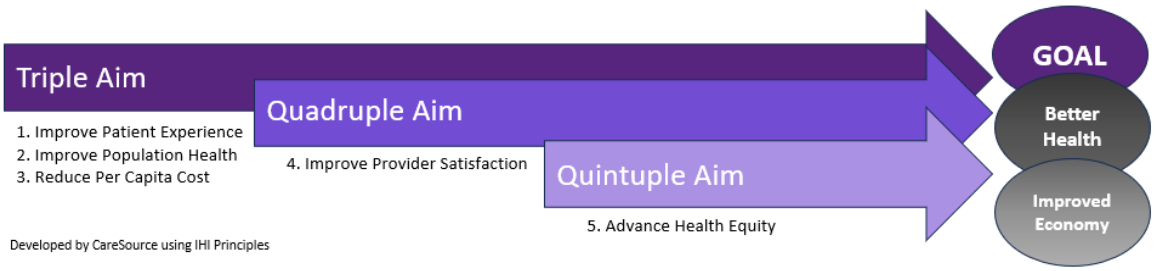
DO: Carry out the plan
Collect the data
Begin analysis

STUDY: Complete analysis
Compare data predictions
Summaries Learning

ACT: Plan the next cycle.
Decide if change can be.

Through use of the IHI Model for Improvement, teams at HAP CareSource can leverage the following benefits:

- **Enable rapid testing and learning.**
- **Increase belief that the change will result in improvement.**
- **Decide which of several proposed changes will lead to the desired improvement.**
- **Quantify the estimated potential for improvement resulting from a change.**
- **Decide whether the proposed change will work in the actual environment of interest.**
- **Decide which combinations of changes will have the desired effects on the important measures of quality.**
- **Evaluate costs, impact, and side effects from a proposed change.**
- **Align with the Quintuple Aim which also supports CMS Quality Strategy Goals:**



The Quality Strategy aligns with the CMS Quality Strategy Goals:

- **Make care safer by reducing harm caused in the delivery of care.**
- **Strengthen person and family engagement as partners in their care.**
- **Promote effective communication and coordination of care.**
- **Promote effective prevention and treatment of chronic disease.**
- **Advance Equity.**
  - **Advance health equity by addressing the health disparities that underlie our health system.**
- **Expand Access.**
  - **Build on the Affordable Care Act and expand access to quality, affordable health coverage and care.**
- **Engage Partners.**
  - **Engage our partners and the communities we serve throughout the policymaking and implementation process.**
- **Drive Innovation.**
  - **Drive innovation to tackle our health system challenges and promote value-based, person-centered care.**
- **Protect Programs.**
  - Protect our programs' sustainability for future **generations by serving as a responsible steward of public funds.**
- **Foster Excellence.**
  - **Foster a positive and inclusive workplace and workforce, and promote excellence in** all aspects of CMS's operations[1]

Detailed processes and methodology are used to determine the overall efficacy of performance improvement activities and programs. The monitoring of specific quality indicators is designed, measured, and analyzed by relevant departments and services to reveal trends and performance improvement opportunities to improve organizational performance.

Prioritization of Opportunities for Improvement

HAP CareSource employs a process to prioritize opportunities for improvement to appropriately allocate resources and efforts. The process is implemented throughout the Quality Improvement

CMS. (2022, November 4). CMS Strategic Plan. Retrieved from cms.gov/cme-strategic-plan[1]

committee structure, either (a) on an ad hoc basis, (b) for routine monitoring, or (c) for formal consideration as an Enterprise quality improvement project.

Data Sources

Data from the following sources are analyzed, where applicable, according to product, and used to identify opportunities for improvement:

- Member/Provider Grievances and Appeals.
- Member Satisfaction Surveys
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®).
- Provider Satisfaction Surveys.
- Utilization Management.
- Claims/Encounter Data.
- Medical Record Review.
- Provider Access and Availability Surveys.
- Provider Site Visits.
- Annual HEDIS reports.
- Delegated Entities Performance data.
- Pharmacy Utilization data.
- Phone Statistics (Average Speed of Answer-ASA).
- Access and Availability data (Geo Access).
- Nurse line data reports.
- Health Risk Assessment (HRA) data and reports.
- Feedback from external regulatory and accrediting agencies.
- Other data as required

The following process and outcome measures are collected and reported with various frequencies depending on the nature of the indicator. The measures are collected, analyzed, and reported by a data analytics team. Benchmarks and goals are established for all measures in each market. In instances of publicly reported measures, national and regional benchmarks are utilized, and goals are set based on these benchmarks and current plan performance. Results are reviewed by various committees depending on the indicators and shared as appropriate with members and practitioners/providers.

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures designed to ensure consumers have the information needed to compare the performance of health care plans. The performance measures are related to many significant public health issues, such as asthma, diabetes, cancer, and heart disease. HEDIS® rates are reported to NCQA and/or CMS.

Annually, HAP CareSource participates in HEDIS® reporting for all products. Data is collected, analyzed, evaluated, and compared to regional and national benchmarks. Based on the results

and comparison data, HAP CareSource, through quality team analysis, can identify opportunities for improvement.

The Consumer Experience team assesses member & provider satisfaction and overall experience through a variety of surveys and qualitative research. This research helps the organization identify key opportunities for improvement and build interventions centered on member & provider feedback. Research includes:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®): CAHPS® is a member satisfaction survey and a component of HEDIS® scores. The CAHPS® survey is a measurement tool used to report and evaluate the members experience with health care in the areas of service, access to care, claims processing, and provider interactions. The survey is conducted by an NCQA certified vendor.**
- **CAHPS Drill Down - Annual survey with drill down questions to better** understand members' CAHPS scores to drive action plans. Key areas of **improvement are identified from the CAHPS survey and additional questions to investigate the root cause of opportunities and clarify perceptions are made to understand the concerns voiced.**
- **New Member Satisfaction - Annual survey that targets new members and measures the onboarding process experience. It considers understanding of plan benefits, navigating health care resources, and the authorization process. Results are used to identify improvement opportunities and may result in enhancements to printed or online materials, phone scripting, and benefits.**
- **Care Management Satisfaction - Annual survey that measures member satisfaction with our care management team. Results help to inform improvement opportunities and initiatives to improve the care and service delivered. Engagement talking points, processes, and interpersonal interactions are adjusted based upon the data produced from this report and the needs of the vulnerable population covered.**
- **Member Advisory Councils – Focus group style meetings conducted on a quarterly basis and are used to gather member feedback on a variety of topics throughout the year.**
- **Provider Satisfaction- Designed to measure the satisfaction of providers with the health plan. This feedback provides actionable insights to guide initiatives to improve the provider experience and to support NCQA accreditation.**
- **Provider Focus Groups & Ad Hoc Research – We also conduct Ad Hoc surveys and provider focus groups for a deeper dive into what providers want when working with a MCO and any insight they may have on daily tasks and member care. Provider feedback sessions are also held to test designs (such as the new provider portal) so that providers can weigh in and provide suggestions for execution and implementation.**

Other Process/Outcome Measures

Examples of other measures used to assess effectiveness of the quality of care and service provided to HAP CareSource members include the following quality indicators:

- **ER/1,000 members.**
- **ASA/Call Abandonment rate, blockage rate, call type analysis, repeat caller analysis for Customer Care Call Center & Clinical Call Center**
- **Grievance & appeals in the 5 NCQA required buckets:**
  - **Quality of Care**
  - **Quality of Provider Office Site**
  - **Financial/Billing**
  - **Attitude/Service and**
  - **Access**

Quality Improvement Program Components

Patient Safety program

HAP CareSource recognizes that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our Patient Safety Program evaluates patient safety trends with the goal of reducing avoidable harm. The program is developed in the context of our population health management approach and includes regulatory/accreditation, policies and procedures, training and implementation, continuous monitoring and program evaluation and improvement. Safety events are monitored through retrospective review of quality-of-care concerns and real-time reporting of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, reviewed, and mitigated by a proactive corrective action, or performance improvement steps.

Medication Therapy Management (MTM)

HAP CareSource partners with Clarest Health to execute our Medication Therapy Management (MTM) Program to help members receive the maximum benefit from their medications. Clarest Health identifies members with opportunities to prevent or address medication-related problems, gaps in care, duplication of therapies, cost opportunities, non-adherence, and numerous other quality-focused interventions. CareSource can also identify members internally and supply to Clarest Health for targeted interventions. A pharmacist (community or CareSource) invites the member to participate in the program, at which time the member has the option to decline participation.

Medical and prescription claims are evaluated by Clarest Health AI to trigger MTM events. All interventions are documented in the Clarest Health AI platform, MTMPath, with follow-up sent directly to the member's primary care physician. Clarest Health AI re**imburses retail pharmacies that complete MTM interventions within 60 days of the completed activity. Elements of our MTM Program include:**

- **Comprehensive Medication Review (CMR) – an interactive, person-to-person medication review and consultation of the p**atient's medications (including **prescriptions, over the counter (OTC) medications, herbal therapies, and dietary supplements) performed at least annually in real time by a pharmacist with a**

summary of the results of the review provided to the patient in the standardized format.

- **Targeted Medication Review (TMR) – specific recommendations performed at least quarterly sent to prescribers or pharmacists based on type of action that focus on the following categories:**
    - **Adverse Drug Event – sent to prescribers to identify and resolve an order with a drug interaction risk significant enough to render the therapy unsafe in** which the prescriber's approval for a change in therapy is required.
    - **Care Coordination – sent to prescribers to identify and resolve a gap in** care in which the prescriber's approval is required (includes but not limited to **health tests, lab monitoring, immunizations, well child visits, polypharmacy, antipsychotic monitoring, and upper respiratory infections).**
    - **Cost-effective alternatives – sent to prescribers to identify and resolve an order for a drug product where a more cost-effective therapeutic alternative is** available in which the prescriber's approval for a change in therapy is **required.**
    - **Inappropriate therapy – sent to prescribers to identify and resolve an order to initiate or continue drug therapy at a dose or duration unlikely to be** safe, effective, or not indicated in which the prescriber's approval for a **change in therapy is required.**
    - **Patient adherence consultations – an interactive, person-to-person consultation between a pharmacist and a patient to identify, resolve, and/or prevent the occurrence of medication overuse, medication underuse, or inappropriate medication administration.**
    - **Patient education and monitoring – an interactive, person-to-person consultation between a pharmacist and a patient to provide education and monitoring under circumstances where the patient has received a new medication or change to an existing medication to identify, resolve, and/or prevent the occurrence of one or more medication-related problems.**
    Members of our MTM program receive a Welcome Letter that includes information regarding the safe disposal of opioids as well as TMRs for proper usage and education of opioids and naloxone.
    - **Suboptimal drug therapy – sent to prescribers to identify and resolve an order to initiate or continue drug therapy with suboptimal efficacy or an** untreated indication for prescription therapy in which the prescriber's approval **for a change in therapy is required (includes but not limited to asthma step therapy, statin use for diabetic members, and uncontrolled blood pressure).**

TRANSITIONS PROGRAM

The Transitions Program is designed to safely transition members from an inpatient admission in an acute care or skilled nursing facility back to home or a community setting. Effective and comprehensive care coordination and management of transitions of care between settings is vital to prevent unnecessary readmissions, emergency department visits, and/or adverse outcomes.

HAP CareSource's Transition of Care (TOC) program, based on the industry recognized, evidence-based "Coleman Model," promotes timely, **coordinated, and safe transitions**

between health care settings to help prevent unnecessary readmissions, emergency department visits, and/or adverse outcomes. Case managers and TOC-case managers help members with issues that arise during and after discharge from a health care event.

TOC program includes Discharge Planning to support members at risk of readmission or with identified needs who require additional support to coordinate their transition beyond that offered by the hospital discharge planning team. Through communication and collaboration between physical and behavioral health partners, members receive seamless coordination of care as early as possible during an inpatient admission or course of treatment. Together, utilization management and care management departments identify resources needed to facilitate smooth and timely transition between levels of care, and coordination of services including home and community-based services, and ongoing case management intervention as appropriate.

Clinical Call Center/Triage CareSource 24

HAP CareSource24® provides around-the-clock nursing triage services to members. The Clinical Call Center/Triage has an ongoing Quality Improvement Activity (QIA) to ensure consumer safety for members calling the HAP CareSource24® Nurse Advice Line. Triage nurses assess member symptom severity and guide the member to the appropriate level of care. Triage nurses may also assist a member in navigating the health care system. The QIA ensures consumer safety through evaluation and audit of nursing interactions with members to assure the correct protocol for the symptom/health condition presented was followed, the documentation meets established guidelines, and the appropriate disposition occurred.

Clinical Practice Guidelines

HAP CareSource Michigan Medicaid and MI Health Link approves and adopts evidence-based nationally accepted standards and guidelines to help inform and guide providers about their clinical care of members. Clinical Practice Guidelines (CPGs) are available to providers on the provider website CareSource.com and may be communicated to practitioners through newsletters, direct mailings, our provider manual, and focused meetings with Health Partner Engagement Specialists.

Health literate member clinical practice guidelines and other health resources are available on the member website, covering a broad range of health and wellness topics. Information may also be shared via newsletters or upon member request.

CPGs are reviewed every 2 years, or more often and updated if indicated. CPGs are available at CareSource.com by navigating to the Patient Care listing in the Provider menu under education, and then selecting the appropriate market and product and choosing the Health Care Links option. These guidelines assist in improving member health outcomes. Review and approval of CPGs are completed by the Michigan Medicaid and MI Health Link Provider Advisory Committee (PAC), with final approval by the Enterprise PAC. The Quality Enterprise Committee is notified of guideline approval.

CPG topics are chosen through analysis of our Michigan Medicaid and MI Health Link member population demographics and state/national health priorities. Guidelines focus on key chronic diseases, preventive health measures and recommended screenings for both medical and behavioral health concerns.

CARE COORDINATION PROGRAM

HAP CareSource's Integrated Care Management Program focuses on evidence**-based, best practice interventions to optimize member health and wellness outcomes. HAP CareSource empowers members of all ages and their families to direct their own care through provision of access to care coordination services, on-demand tools to learn about a condition, and connection to local services and resources.**

Our integrated care management model emphasizes early identification through use of proprietary risk stratification methodology and predictive analytics to prioritize outreach to the highest need members and ensure they receive the right care at the right time and in the least restrictive setting.

Our care managers utilize motivational interviewing techniques to engage the members and understand what matters most to them to develop person-centered care and service plans that are member- and family-centered and assist them with self-management of their physical and/or behavioral conditions, as well as social determinants of health (SDoH), to help them achieve the best possible health outcomes and life journey goals. The community health workers and care guides are embedded in the communities of the members they serve to ensure a strong knowledge of local resources which enables them to better meet the cultural, spiritual, linguistic, literacy and health literacy needs of our members and ensure equitable access to care. The Integrated Care Management and specialty teams are comprised of licensed professionals including nurses, social workers, and counselors, as well as other allied health care professionals such as community health workers and other disciplines. Staff are trained to provide trauma informed care and demonstrate cultural competency for the members we serve.

POPULATION HEALTH MANAGEMENT

The HAP CareSource Population Health Management (PHM) Program seeks to address member health needs at all points along the continuum of care through the provision of evidence-based quality health care and services. Comprehensive, person-centered care is critical to a population health management strategy. Our HAP CareSource strategy is focused on the NCQA four areas of:

- **Keeping members healthy**
- **Managing members with emerging risks**
- **Addressing patient safety and/or outcomes across settings**
- **Managing chronic health conditions and promoting preventive health services**

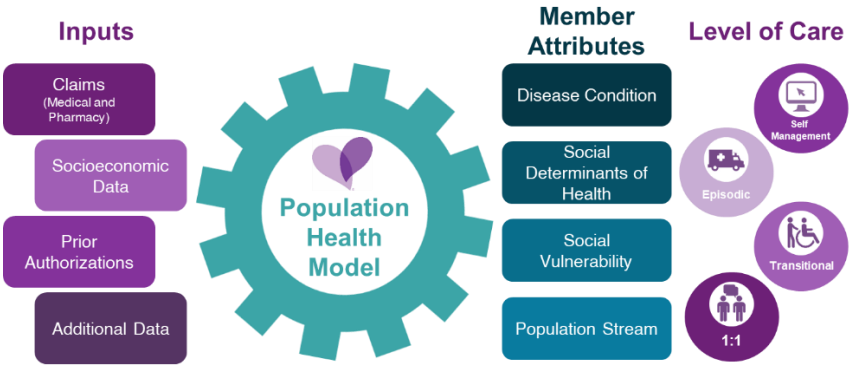
Our strategy in each area of focus describes:

1. The goals and our target populations.

2. HAP CareSource programs and services offered to our members.
3. HAP CareSource intervention activities that are not directed at members.
4. How HAP CareSource members are informed about our PHM programs and how our PHM programs are coordinated.
6. How the HAP CareSource promotes health equity and address other social determinants of health which impact health outcomes and quality of life.

HAP CareSource conducts a comprehensive member population analysis, which includes population stratification and a risk stratification-level for each member. Integrated data sources are used to assess population health. Using various internal data sources assists in understanding population characteristics, member needs and identification of relevant subpopulations. HAP CareSource utilizes predictive modeling tools to assist in member stratification.

The graphic below details the components of our Population Health Model. In addition to internal data sources, we supplement our data with federal and state data, such as census data. Combining integrated data sources with member attributes allows for appropriate risk stratification and development of member-centric interventions and care plans, in conjunction with practitioners/providers. We encourage a patient-centered medical home approach with all members.



HAP CareSource assesses member social determinants of health to evaluate non-health needs that may significantly impact member health outcomes and overall quality of life. Member centric interventions are developed based on the results of our analyses. To evaluate the impact of our strategy, HAP CareSource measures quality, cost and utilization and member experience. As noted previously, we use the IHI Quintuple Aim as a basis for our work. This includes use of science-based quality methodologies to measure the impact of interventions and other initiatives. HAP CareSource defines our outcome measures based on our prioritized population health goals. We employ quality methodologies, such as the development of SMART (specific, measurable, achievable, relevant, time bound) goals to provide clarity for activities and ensure a methodical process for creating objectives. Use of the PDSA (plan, do, study, act) cycle is

another tool that tests change and allows for rapid cycle evaluation of initiatives. Opportunities for improvement can then be integrated into the process. Ongoing use of PDSA process provides a mechanism for improving processes and achieving those results that positively impact member outcomes and quality of life.

Member Wellness

The goal of HAP CareSource is to help members maintain a healthy lifestyle. HAP CareSource provides member wellness programs through our Population Health Management Strategy to increase member well-being and achieve optimum wellness. Program materials are provided for subjects including, but not limited to, immunizations, screening tests, exercise programs, and pregnancy.

Disease Management

See 2023 Disease Management Program Description.

Behavioral Health

In order to achieve quality health outcomes for our behavioral health (BH) membership, HAP CareSource utilizes behavioral health expertise to drive optimal access to care and promotes integrated health to enhance our care systems. HAP CareSource understands that behavioral and physical health are inextricably related. An integrated approach to total clinical management (behavioral, physical, and pharmacy) results in significant cost reductions and improved member outcomes in overall physical and behavioral health services. Although Behavioral Health services are carved out through the Michigan Pre-Paid Inpatient Health Plans (PIHP), HAP CareSource will monitor and evaluate the effectiveness of joint expectations to improve FUH and FUA metrics. In accordance with the MDHHS MHP Provider agreement, HAP CareSource follows the following requirements for scoring.

Requirement	Max Points (scoring)
Collaboration between entities for the ongoing coordination and integration of services as required per the State	35 Points
Implementation of Joint Care Management processes narrative (no more than 3 pgs.) submission	0 Points
FUH must meet set standards for each rate (ages 6-17 and ages 18+). Measurement period will be calendar year 2022	40 Points
FUA has no benchmark and plans will be scored on racial disparities only. Measurement period will be calendar year 2023	25 Points

HAP CareSource tracks and measures key behavioral health data to determine progress in achieving desired member behavioral health outcomes. Behavioral Health and Quality teams will meet regularly to review and evaluate results as well as discuss potential vendor partnerships, improvement activities, or other areas of opportunity based on a data-driven strategy. Initiatives and interventions are modified as required to ensure member behavioral health needs are met.

Key components of the Behavioral Health Program philosophy include:

- **Behavioral health is critical to overall health.**
- **Behavioral health and physical health are integrated.**
- **Engagement in behavioral health treatment improves member experience, cost, and quality of care.**
- **Access to a continuum of behavioral health services reduces disease burden and improves outcomes.**

To address the behavioral health needs of our members the BH program includes key components:

- **Enhance clinical programs.**
- **Improve practitioner/provider services to drive outcomes.**
- **Ensure behavioral health quality outcomes.**
- **Lead advocacy efforts in each market.**
- **Provide internal support to HAP CareSource teams with Behavioral Health subject matter expertise.**
- **Partner with providers to improve access and outcomes.**
- **Share and using data across systems of care, to ensure quality and compliance.**
- **Care Coordination programs that engage members in care and retention in treatment.**
- **Promote prevention and education initiatives and approaches that reduce potential harm.**

HAP CareSource objectives:

- **Ensure appropriate resource allocation by improving overall Per Member Per Month (PMPM) for members with behavioral health conditions.**
- Develop staff behavioral health competency in addressing the "whole person" needs of **members.**
- **Facilitate policy alignment through advocacy, initiative, and strong leadership.**
- **Strive to assist our Behavioral Health providers navigate, create, and implement operational and programmatic initiatives.**

In accordance with NCQA requirements, the Behavioral Health (BH) Medical Director is involved in all aspects of the BH Program including QI and UM activities. Our dedicated BH Medical Director provides oversight for clinical pre-service determinations for members, participates in committee meetings and is instrumental in the design of improvement initiatives to monitor and improve behavioral health outcomes.

UTILIZATION MANAGEMENT

See 2024 Utilization Management Program Description as well as Policies and Procedures.

PHARMACY PROGRAM

See 2024 Pharmacy Program Description.

CREDENTIALING AND RE-CREDENTIALING

See 2024 Credentialing Program Description.

DELEGATION OVERSIGHT

HAP CareSource contracts with vendors and providers for a variety of services. While certain contract provisions may adequately define a vendor or provider's responsibilities for establishing **service, HAP CareSource must ensure that the relationships with its existing and potential vendors and providers do not have a negative impact on HAP CareSource**'s members, **employees, or reputation; as well as no legal, financial, or regulatory ramifications. This policy defines the HAP CareSource Delegated Vendor and Provider Oversight program and includes enterprise responsibility to comply with all State, Federal, accrediting bodies (e.g., NCQA, URAC) and/or other HAP CareSource-designated requirements related to the delegation of services. HAP CareSource ensures that the delegated functions a vendor or provider performs, delegation oversight requirements (pre-delegation vendor assessments, ongoing monitoring, issue resolution, risk mitigation, annual auditing, and other requirements), and appropriate risk mitigation, are all executed in accordance with applicable standards and requirements. Furthermore, HAP CareSource ensures that every vendor is evaluated and assigned inherent and residual risk levels to better understand HAP CareSource**'s risk position in the relationship. **See QEC Program Description.**

CUSTOMER CARE

The Customer Care department provides telephonic, chat, app, and web support to HAP CareSource members and practitioners/providers. Our member services teams recognize that each member has a unique need and deserves to be treated with dignity, kindness, and care. Our training program, Interactions with Heart, is designed to support our team members in building personal relationships that empower our members to manage their health and build trust in us as a health partner. Member services teams' partner with clinical operations to ensure **that we maximize every opportunity when a member calls in. Our Customer Relationship Management software prompts our team to remind members about gaps in care, care management, and health needs assessments. Our provider services teams have a specialized** knowledge of our providers' needs and are trained to provide firs**t call resolution for our providers. From the beginning of their training, all of our customer care specialists are trained to serve as ambassadors of the company and their handling of each call must reflect the HAP CareSource mission.**

To ensure adherence to answer timeliness standards, our Workforce Management team ensures that the phone queues are optimally staffed. This is accomplished by forecasting staffing requirements by month, day, and half-hour, and by creating a set of schedules to meet those defined needs. The Workforce Management team continuously monitors the queues in real-time and makes any necessary adjustments to staffing. This team also keeps Market Leaders and Compliance apprised of progress toward meeting monthly requirements. The Service Quality team is responsible for assessing whether the Customer Care Specialist are following their policies and procedures and providing excellent service. We also receive feedback from customers via post call surveys, which provide guidance into how we are serving members and identifies not only our strengths, but our areas of opportunity. Finally, through use of Speech Analytics, we can identify and resolve issues that might point to a broader experience gap. Regular partnership occurs across the organization to review contact reasons to proactively identify opportunities to address root cause. Our goal is to continuously improve the experience and resolve issues that cause members and providers to call for assistance.

NETWORK MANAGEMENT

Network Management monitors the adequacy of practitioner/provider networks to ensure networks meet the geographic distance and time standards prescribed by the markets, state-specific guidelines, and/or CMS, whichever is the most stringent. Industry standard software is used to compare practitioner/provider networks against the standards and report any adequacy gaps to the appropriate market, and as required, to the regulatory bodies. Additionally, HAP CareSource utilizes the CAHPS survey to ensure adequate appointment availability with providers.

HAP CareSource works to include practitioners/providers who meet our members' cultural **needs and represent these practitioners/providers in our data with alternate language information in the practitioner/provider directories. Customer Care uses Language Line services to assist members when English is not the preferred language. Data is gathered and analyzed to ensure our networks meet these needs and can deliver quality health care to our members. Monitoring and outreach include the following:**

- **Analysis of both member and practitioner/provider data, using CAHPS® survey results, information received by practitioners/providers in onboarding documentation and Language Line reports.**

HEALTH EQUITY PROGRAM

See 2024 Health Equity Program Description & Strategy

Addressing Culturally & Linguistically Diverse Populations

Providing equitable and culturally competent care and services is a HAP CareSource core value. We maintain active processes to ensure the care and services we provide satisfy state, federal and other regulatory standards for Culturally and Linguistically Appropriate Services (CLAS).

- **Provide culturally and linguistically appropriate care and services consistent with CLAS standards.**
- **Focus on initiatives to help eliminate disparities and advance health equity.**
- **Identify and address the social determinants of health (SDOH) that impact HAP CareSource member populations, including those with cultural and linguistic needs.**
- **Identify member preferred language, cultural health beliefs and ensure health literate communication that encompasses language and culture.**
- **Offer education and information on our culturally and linguistically diverse populations to HAP CareSource employees and participating network practitioners/ providers.**
- **Ensure services are delivered in a respectful, understandable, effective, and equitable manner.**
- **Regularly review and evaluate programs and processes.**

Strategies for continuous improvement were performed relevant to Cultural Competency, SDOH to improve member outcomes, quality of life and advance health equity. Examples of activities include:

- **Quarterly Member Advisory Councils.**
- **Adoption of the HAP CareSource Health, Safety and Welfare Program.**
- **Employee Engagement Assessment.**
- **HAP CareSource University Courses.**
- **HAP CareSource Foundation.**
- **Availability of Member Materials in required languages.**
- **Interpreters available for Limited English Proficiency and Special Needs populations**
- **Availability of health literate written materials.**
- **Health Literacy Advisor (HLA) software to measure readability and ease of understanding written materials.**
- **Teleprinter or Teletype Services.**
- **Monitoring and evaluation of Spoken Language Preference.**
- **Diverse Practitioner/Provider Network.**
- **Contracts with Minority, Women, and Veteran-owned Business Enterprises.**
- **Americans with Disabilities Act.**

Resources Dedicated to Quality Improvement

ENTERPRISE RESOURCES

EXECUTIVE VICE PRESIDENT (EVP), CHIEF MEDICAL OFFICER

The EVP and Chief Medical Officer is responsible for the overall direction of all clinical programs, including the Quality Improvement Program, and is also a member of or provides oversight to the Executive Council, Physician Advisory, Credentialing, and Pharmacy and Therapeutics Committees. The EVP and Chief Medical Officer has responsibility to oversee the activities of the Market Medical Directors and all Physical Health and Behavioral Health Medical Directors for all markets and products and is responsible for oversight and direction of all physician reviewers and those serving on peer committees. The EVP and Chief Medical Officer facilitates participation of practitioners/providers in its overall quality improvement program through the various committees they chair or those for which they provide oversight.

VICE PRESIDENT (VP) QUALITY AND PERFORMANCE OUTCOMES

The VP Quality and Performance Outcomes oversees the operations of the Enterprise Quality Improvement Department and is responsible for the execution and coordination of quality improvement activities at the Enterprise level. It is the Vice President's responsibility to interface **with other departments on quality improvement issues and report any areas of concern to the Chief Operating Officer and Executive Leadership Team.**

ASSOCIATE VICE PRESIDENT (AVP) ENTERPRISE QUALITY

The Associate Vice President, Enterprise Quality is responsible for ensuring effective oversight of Enterprise systems and resources to support the execution of market-based Quality Programs that achieve organizational goals, advancing accreditation compliance and organizational excellence, and effectively aligning industry innovations with organizational

needs. The Associate Vice President supports internal and external-facing stakeholder relationships including NCQA and state regulators, vendor oversight and management, surveillance of emerging industry best practices, and the design and implementation of performance improvement strategies using methodology aimed to achieve results and improve outcomes.

ASSOCIATE VICE PRESIDENT (AVP) MARKET QUALITY

The Associate Vice President, Market Quality is responsible for ensuring effective execution of Market-based Quality Programs and their respective Work Plans to achieve Enterprise Quality goals. It is the Associate Vice President's responsibility to influence quality outcomes through **assisting in the development, implementation, and monitoring of remediation strategies to improve HEDIS, NCQA, and Star program results. The Associate Vice President develops Market-wide Provider Engagement strategies toward optimizing the efficacy of the Health Partner and Market-based clinical interactions to close gaps in care.**

DIRECTOR, ENTERPRISE QUALITY IMPROVEMENT

Oversight of the Enterprise Quality Advisor staff, which provides department-wide support for IHI projects and training. Development of IHI improvement tools and other Quality templates. Facilitation of the Quality Enterprise Committee and the New Medical Technology Committee. Provides guidance on enterprise-wide best practices. Works with Markets to scale adopted improvement strategies. Manages Quality Innovation team which maintains relationships with Vendors utilized to close member gaps in care.

SENIOR DIRECTOR ENTERPRISE HEDIS OPERATIONS & ANALYTICS

The Senior Director of Regulatory Analysis provides strategic leadership to a team of Analysts and Managers responsible for all aspects of HEDIS® and Medicare Advantage Stars measures and analytics. The Senior Director leads HEDIS®, CAHPS®, and Stars reporting projects for multiple markets with year-round monitoring and annual required reporting. The Senior Director supports state required non-HEDIS® quality management (QM) metric reporting. S/he serves as enterprise Subject Matter Expert for HEDIS®, Stars, and performance measurement. The Senior Director collaborates with Executive Management on enterprise and market goals with targeted focus on state pay-for-performance programs, NCQA accreditation requirements, and CMS Stars. Using improvement science, the Senior Director Isolates and implements opportunities to improve rates or efficiency of data collection, including identifying alternative sources for data, including electronic clinical data systems (ECDS), and health information exchanges (HIE). The Senior Director maintains NCQA-certified HEDIS® software and evaluates state-specific measurement methodology.

DIRECTOR, UTILIZATION MANAGEMENT

The Directors of Utilization Management are required to have a current unrestricted RN license or other appropriate professional license leading and managing the oversight of all UM functions for all the CareSource lines of business to ensure consistent, efficient delivery of services throughout the healthcare continuum. Responsible for monitoring utilization and cost of care data developing and implementing processes to address identified trends.

Manager, Enterprise Accreditation

The manager of Accreditation is responsible for the oversight of the Enterprise Accreditation Specialist staff for all aspects of accreditation. Management of the accreditation applications, documentation preparation and submission, and all correspondence with the accreditation organization staff. Manages quality improvement activities related to accreditation, including the development of detailed work plans, setting deadlines, the development and implementation of action plans with Market and Enterprise business owners to mitigate risks, and monitoring progress.

Enterprise Quality Improvement Advisors

The Enterprise QI Advisor role is responsible for providing expert consultation and project management for a wide range of improvement projects across the enterprise, which are critical to the implementation of the quality improvement program. The advisors provide training and education around quality improvement tools, resources, and the IHI Model for Improvement to the organization. They also share best practices identified within individual markets to find scalable solutions that all our lines of business and products can benefit from.

Market resources

VP, Market Chief Medical Officer

The VP, Market Chief Medical Officer is a physician with an active medical license in the state of Michigan and is responsible for the coordination and implementation of the Quality Management Improvement Program and all aspects of health services utilization and clinical strategies. The VP, Market CMO chairs the quarterly QIC, PAC, Population Health, UM/CM, and is an active participant in various enterprise-wide subcommittees (IMSC, CPC, etc.). The VP, Market CMO reviews and makes recommendations on all medical policies.

Senior Director, Quality and Population Health

This role is assigned as Co-Chair Michigan Quality Improvement Committee and PAC. Monitors performance and outcomes across the Michigan Market to identify opportunities for improvement, leverage best practices, and share knowledge. The Senior Director oversees the development, organization, and continuously monitors the Quality Improvement Plan and QAPI annually and guides the implementation and collaboration with the Population Health Program Director. The goal is to improve health outcomes through standardization of evidence–based practices. Develops, organizes, implements, and monitors the Quality Improvement Work Plan, QIP/PIP/CCIP, and QAPI. Reviews, revises, and communicates the Quality Improvement Work Plan, QIP/PIP/CCIP, and QAPI to appropriate stakeholders. Analyzes HEDIS performance and quality data to improve delivery of quality care and outcomes for members across all enterprise lines of business. The Senior Director completes quarterly reviews of the Quality Improvement program and the QAPI) to appropriate stakeholders by defined timeframes. They annually evaluate the previous year's Quality Improvement Program to develop the work plan for the upcoming year.

Behavioral Health (BH) Medical Director

The BH Medical Director serves as an advisor for behavioral health programs within the health plan, which includes the behavioral health aspects of the Quality Improvement Program. The BH Medical Director actively participates in various committees (IMSC, CPC, PAC, etc.) and is responsible for review and recommendations on all behavioral health policies and procedures. The BH Medical Director provides guidance regarding the Behavioral Health Strategy.

Market Quality Managers and Team Leads

Managers and Team Leads are essential to the success of continuous quality improvement, as they drive the day-to-day work for the organization. Managers and Team Leads support the improvement efforts by continually seeking to identify opportunities in their daily work and in the work of their teams. HAP CareSource complies with state requirements to support dedicated Quality Improvement management to facilitate the overall coordination of quality improvement strategies within the market.

Market Quality Improvement Staff

Under the leadership of the Michigan Market Senior Director of Quality Improvement and Population Health, clinical and non-clinical staff trained in effective continuous improvement methodology coordinate, facilitate and/or support improvement initiatives and projects, lead improvement workgroups and facilitate completion of the annual work plan and program evaluation.

Other Quality Improvement Staff and Resources

The Quality Improvement Department maintains a multidisciplinary team who carry out the various aspects of relevant QI functions, which include:

- HEDIS® annual submission.
- Regular review and follow-up of performance outcomes.
- Accreditation activities.
- Clinical quality monitoring.
- Clinical Quality of Care Concerns, Quality of Service Concerns, Clinical Grievance and Sentinel Events.

Regulatory Compliance

Regulatory Compliance is responsible for ensuring compliance and tracking of applicable State and Federal requirements related to clinical, service, and operational quality improvement activities that include annual review and update of the Compliance Plan. The Enterprise Compliance Officer is responsible for oversight and direction of Regulatory Compliance to the Senior Leadership Team.

Senior Leadership Team

The Senior Leadership Team is integral to the success of performance improvement by leading the creation of an organizational culture that supports improvement efforts, using management practices that sustain improvement efforts and creating an environment where all staff can develop their potential.

Department Directors

Through the leadership of the Senior Management Team, each department is expected to participate and work collaboratively on quality improvement activities that are a priority throughout the organization. At the departmental level, the goal is to improve clinical care, services delivered, operation effectiveness, and efficiency.

Managers and Team Leads

Managers and Team Leads are essential to the success of continuous quality improvement, as they drive the day-to-day work for the organization. Managers and Team Leads support the improvement efforts by continually seeking to identify opportunities in their daily work and in the work of their teams.

Individual Contributors

Quality improvement lives at the point of care and service. All HAP CareSource employees are responsible for ensuring safe, high-quality care for each member. Individual contributors are essential to the success of improvement efforts, as they complete the day-to-day delivery of care and services.

Health Information Systems

The Health Information Systems are used to collect, analyze, and integrate data that informs the Quality Management Improvement Program on areas of opportunity to pursue. Data integrity is maintained to ensure that data for informational and decision-making purposes is as accurate and complete as possible. HAP CareSource maintains health information for CMS and state review as requested. Data sources are monitored and audited on a regular basis. These data sources include but are not limited to:

- **Enrollment files.**
- **Claims processing system (Medical and Dental).**
- **Pharmacy and Dental claims from vendor.**
- **Provider credentialing database.**
- **Encounter data submissions to regulatory entities, including state and federal as requested.**
- **Analytic data view.**
- **Encounter data view.**
- **Enterprise Data Warehouse.**
- **Clinical authorization and care management data.**

HAP CareSource operates a framework of internal IT controls and information security policies and procedures to maintain the health information system's compliance with HIPAA and other **privacy laws, as well as commonly accepted professional standards of health information management. Key quality-related infrastructure components include:**

- **Tools to track, analyze, and report performance measures and data from our quality improvement programs (QIP), focused studies, incentive programs, our value-based reimbursement (VBR) Program, and other quality-related initiatives.**

- Interface with market specific Health Information Exchange (HIE) entities, to share data and information, and maximize integration of provider electronic health record (EHR) systems.
- Integration of state reporting HIE and immunizations registries to obtain file extracts for compiling more complete vaccination histories.
- Provider Portal is used to communicate with providers, conduct provider satisfaction surveys, and inform HAP CareSource network providers about quality requirements, gaps in care and provider incentives.
- Member Portal used to assist members with tracking and managing care gaps and incentive points and soliciting feedback on network providers.

Member and Provider Communication and Education

Member Education

HAP CareSource has several methods of educating members on their rights and responsibilities, how to obtain services, how to submit a complaint or appeal, benefits under the plan, and improvements in care management. These methods include, but are not limited to, telephonic reminders addressing preventive care, on-hold messaging, and HAP CareSource printed materials via direct member mailings. Examples of mailings include newsletters, member handbooks, evidence of coverage, new member packets, and direct member mailings. HAP CareSource also provides direct interaction with members via HAP CareSource marketing staff, HAP CareSource sales staff, and HAP CareSource websites.

HAP CareSource has established Member Councils to secure input from members on various aspects of benefit design, potential programs impacting members, and the member experience.

Practitioner/Provider Education

HAP CareSource educates practitioners/providers regarding plan specific requirements, including evidence based clinical practice guidelines and criteria used in health plan decision making, nationally recognized protocols, ongoing programs such as Care Management and HAP CareSource 24 triage/nurse advice line, as well as improvements in care management resulting from its overall quality improvement program. This ongoing education is provided in a variety of ways, including practitioner/provider orientation, practitioner/provider manual, practitioner/provider portal internet site, and direct communication via Health Partners (Provider Relations) representatives, including joint operating committees, Service Center, practitioner/provider newsletters, network notifications, pharmacy alerts via the PBM and EOP and EOB inserts. HAP CareSource also has several practitioner/provider-facing quality initiatives including Care Treatment Plans and Member and Pharmacy Profiles.

Communication on QI Program with Stakeholders and Community Partners

HAP CareSource facilitates the participation of stakeholders and community partners in its overall Quality Improvement Program. Participation includes the Provider Advisory Committee, which is a committee of participating HAP CareSource practitioners/providers who provide input regarding the Quality Improvement Program through review of medical policy statements,

evaluation of innovative technology and review of clinical initiatives. This committee receives ongoing updates regarding the QI Program throughout the year and reviews the QI Program annual evaluation. QI Program updates are published in member and health partner newsletters throughout the year with topics that are focused on key quality initiatives.

Policies and Procedures

Enterprise Policy and Procedure Committee

At HAP CareSource all Enterprise policies are submitted for review and approval by the business owner's Senior Leadership no less than annually and revised as necessary to ensure compliance with Enterprise, NCQA Accreditation, and State and Federal requirements for all HAP CareSource plans and all lines of business. The Committee meets quarterly to review the previous quarter's P&P metrics and review selected high risk items to ensure compliance with business operations, accreditation, and State and Federal requirements. The HAP CareSource Policy and Procedure Committee reports to the Compliance Committee and semi-annually provides a formal report to the Compliance Committee containing information relevant to the work of the Committee.

Confidentiality and Conflict of Interest

All quality improvement activities, including correspondence, documentation, and files, are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889 and the Health Information Portability and Accountability Act (HIPAA) for members' confidentiality. All HAP CareSource permanent and contracted employees, board members, and vendors are required to sign a confidentiality agreement upon employment and annually thereafter. Only designated employees, by the nature of their position, have access to member health information as outlined in policies and procedures. No one is to participate in the review process of quality improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer is designated. There is a separation of medical/financial decision-making. All committee members, committee chairs, the Vice President Enterprise Medical Director and the Chief Clinical Officer sign a statement of this understanding.

Quality Improvement Program Development and Evaluation

On an annual basis, HAP CareSource completes an evaluation of the HAP CareSource Quality Improvement Program. The Quality Improvement Program Evaluation examines actual performance compared to goals, evaluates trends in the organization's performance, identifies barriers/challenges which made improvement difficult to attain, includes recommended interventions, and provides a summary of the effectiveness of the plan and activities. Where analysis indicates that objectives have not been met, activities and goals are re-evaluated for

potential inclusion in the subsequent calendar year program. The HAP CareSource Quality Enterprise Committee approves the annual Quality Improvement Program Evaluation. A summary of the written evaluation is presented to the HAP CareSource Management Group to ensure that the Group is kept apprised of the organization's goals and performance **improvement activities.**

Contact Information

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