Michigan Complete Health (MCH)

2020
Quality
Program Description Summary

PURPOSE

Michigan Complete Health (MCH) is committed to the provision of a well-designed and well-implemented Quality Program. The health plan's culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, population health management, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative, member, and network services.

MCH recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate setting. MCH provides for the delivery of quality care with the primary goal of improving the health status of the members. When a member's condition is not amenable to improvement, the health plan implements measures to prevent any further decline in condition or deterioration of health status or provides for comfort measures as appropriate and requested by the member. The Quality Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, Michigan Complete Health's Quality Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members.

In order to fulfill its responsibility to members, the community and other key stakeholders, and regulatory and accreditation agencies, the health plan's Board of Directors has adopted the following Quality Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee and MCH Board of Directors.

SCOPE

The scope of the Quality Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to MCH members including medical, behavioral health, dental, and vision care as included in the health plan's benefits. MCH incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality improvement activities, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care (as applicable per the health plan's products), and ancillary services. MCH's Quality Program monitors the following:

- Acute, complex, and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices

- Member enrollment and disenrollment
- Member grievance and appeals system
- Member experience
- Member safety
- Primary care provider changes
- Pharmacy
- Primary care provider after-hours telephone accessibility
- Provider appointment availability
- Provider complaints
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Medical management
- Population health management
- Utilization management, including over- and under-utilization

GOALS

MCH 's primary quality goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered.

Quality Program **goals** include but are not limited to the following:

- A high level of health status and quality of life will be experienced by the members;
- Network quality of care and service will meet industry-accepted standards of performance;
- The health plan's services will meet industry-accepted standards of performance;
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across functional areas;
- Member satisfaction will meet MCH 's established performance targets;
- Preventive health and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with guidelines for immunizations, diabetes, asthma, medication adherence etc.;
- Compliance with all applicable regulatory requirements and accreditation standards is maintained.

MCH 's Quality Program **objectives** include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize management information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes;

- To allocate personnel and resources necessary to:
    - support the Quality Program, including data analysis and reporting;
    - meet the educational needs of members, providers, and staff relevant to quality improvement efforts;
    - meet all regulatory and accreditation requirements;
- To seek input and work with members, providers, and community resources to improve quality of care;
- To oversee peer review procedures that address deviations in medical management and health care practices and devise action plans to improve services;
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute focused quality studies in clinical and non-clinical areas, where appropriate;
- To serve members with complex health needs;
- Conduct and report annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) (Qualified Health Plan [QHP] Enrollee Experience survey for the Marketplace product line, when applicable) and certified Healthcare Effectiveness Data and Information Set (HEDIS®) results for members *(CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ); HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)*;
- Conduct and report Medicare- Medicaid Plan (MMP) for CMS' Core and the State of Michigan quality measures.
- Achieve and maintain CMS and State of Michigan MMP requirements; NCQA accreditation and/or other applicable accreditations for appropriate products;
- Monitor for compliance with regulatory and accreditation requirements.

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a member or provider. The Quality Improvement Committee (QIC) and its subcommittees have the responsibility to review quality of care and resource utilization, as well as conduct peer review activities as appropriate. The QIC and related peer review committees conduct such proceedings in accordance with MCH 's bylaws and applicable federal and state statutes and regulations.

The proceedings of the QIC, its subcommittees, work groups, and/or any ad hoc peer review committees are considered "Privileged and Confidential" and are treated as such. In this regard, all correspondence, worksheets, quality documents, minutes of meetings, findings, and recommendations for the programs are considered strictly confidential and therefore not legally discoverable.

Confidential quality findings are accessible only to the following individuals/groups:

- Board of Directors
- President and Chief Executive Officer (CEO)
- Chief Medical Director, Vice Presidents/Directors of Quality and Medical Management, and designated Quality Department staff

- Peer Review Committee
- External regulatory agencies, as mandated by applicable state/federal laws
- Plan legal executives
- Compliance leadership

QIC correspondence and documents may be made available to another health care entity's peer review committee, and/or any regulatory body as governed by law, for the purpose of carrying out or coordinating quality improvement/peer review activities; this may include a Quality and/or Credentialing Committee of a health plan-affiliated entity or that of a contracted medical group/independent physician association.

MCH has adopted the following confidentiality standards to ensure quality proceedings remain privileged:

- All peer review and quality related correspondence documents are appropriately labeled "Privileged and Confidential, Peer Review" and maintained in locked files/secure electronic files;
- Confidentiality policies and procedures comply with applicable state statutes that address protection of peer review documents and information;
- Committee members and employees responsible for Quality, Medical Management, Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents;
- The Quality Vice President (VP)/Director designates Quality Department staff responsible for taking minutes and maintaining confidentiality;
- For quality studies coordinated with, or provided to outside peer review committees, references to members are coded by identification number rather than a protected health information (PHI) identifier such as medical record number or ID number, with references to individual providers by provider code number;
- Records of review findings are maintained in secured files, which are made available only as required by law or specifically authorized in writing by the CEO, Chief Medical Director, Legal Counsel, VPMM, or the Board of Directors Chairman; and
- All participating providers and employees involved in peer review activities or who participate in quality activities or committees are required to sign confidentiality agreements.

CONFLICT OF INTEREST

MCH defines conflict of interest as participation in any review of cases when objectivity may not be maintained. No individual may participate in a quality of care or medical necessity decision regarding any case in which he or she has been professionally involved in the delivery of care. Peer reviewers may not participate in decisions on cases where the reviewer is the consulting practitioner or where the reviewer’s partner, associate, or relative is involved in the care of the member, or cases in which the practitioner or other consultant has previously reviewed the case. When a practitioner member of any committee perceives a conflict of interest related to voting on any provider-related or peer review issue, the individual in question is required to abstain from voting on that issue.

CULTURAL COMPETENCY

MCH endeavors to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. MCH is guided by requirements set by each respective state/federal contract and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) developed by the Office of Minority Health. Specifically, the Quality Program identifies and addresses clinical areas of health disparities. MCH assures communications are culturally sensitive, appropriate, and meet federal and state requirements. Population health management initiatives are reviewed to assure cultural issues and social determinants of health are identified, considered, and addressed. As part of the annual program evaluation, MCH also reviews member needs from a cultural competency standpoint, analyzes data for cultural, ethnic, race, and linguistic issues, and addresses identified barriers.

AUTHORITY

MCH Board of Directors has authority and oversight of the development, implementation, and evaluation of the Quality Program and is accountable for oversight of the quality of care and services provided to members. The Board of Directors supports the Quality Program by:

- Adopting the initial and annual Quality Program which requires regular reporting (at least annually) to the Board of Directors, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting QIC recommendations for proposed quality studies and other quality initiatives and actions taken;
- Providing the resources, support, and systems necessary for optimum performance of quality functions;
- Designating a senior staff member as the health plan's senior quality executive, defining the role of a physician in the Quality Program, and defining the role a behavioral health practitioner in the Quality Program; and
- Evaluating the Quality Program Description and Quality Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

The Board of Directors delegates the operating authority of the Quality Program to the QIC. MCH senior management staff, clinical staff, and network practitioners, who may include but are not limited to, primary, specialty, behavioral, dental, and vision health care practitioners, are involved in the implementation, monitoring, and directing of the relative aspects of the quality improvement program through the QIC, which is directly accountable to the Board of Directors.

The Chief Medical Director, or as designated by the MCH President/CEO, serves as the senior quality executive and is responsible for:

- Compliance with state, federal, and accreditation requirements and regulations;
- Chairing the QIC, or designating an appropriate alternate chair, and participating as appropriate;
- Monitoring and directing quality activities among personnel and among the various subcommittees reporting to the QIC;
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to QIC recommendations, subcommittee recommendations, and/or other stakeholder recommendations;

- Being actively involved in the MCH ’s Quality Program including: recommending quality study methodology, formulating topics for quality studies as they relate to accreditation and regulatory requirements and state and federal law, promoting participating practitioner compliance with medical necessity criteria and clinical practice guidelines, assisting in on-going patient care monitoring as it relates to preventive health/sponsored wellness programs, pharmacy, diagnostic-specific case reviews, and other focused studies, and directing credentialing and recredentialing activities in accordance with MCH ’s policies and procedures;
- Reporting the Quality Program activities and outcomes to the Board of Directors at least annually.

QUALITY PROGRAM STRUCTURE

Quality is integrated throughout MCH , and represents the strong commitment to the quality of care and services for members. The Board of Directors is the governing body designated for oversight of the Quality Program and has delegated the authority and responsibility for the development and implementation of the Quality Program to the QIC.