McLaren Health Plan
Quality Improvement Update 2015

Since the incorporation of McLaren Health Plan (MHP) in November 1997, the staff has continued to utilize their extensive clinical and administrative managed care experience to improve the health plan. As a result, throughout 2014, MHP has continued to build its Quality Performance Improvement Program (QPIP) to deliver high quality health care.

In order to evaluate the overall effectiveness of the QPIP, MHP completed an assessment of the quality operations, including utilization practices of MHP's 2014 operations. While the ultimate goal of providing meaningful improvement will not always be demonstrated, this assessment provides for the identification of opportunities for improvement. Based on these identified opportunities, MHP's initiatives for 2015 will result in significant improvement in the health care delivery to MHP's membership.

The evaluation of the 2014 QPIP is included in detail in the following document. However, this executive summary provides interested persons a condensed format of the evaluation.

MILESTONES REVIEW

In order to evaluate the accomplishments of MHP in 2014 MHP reflects on the impact of major milestones. These significant milestones have resulted in a long-term positive effect on MHP.

THE ADMINISTRATIVE INFRASTRUCTURE

MHP has continually met the rigorous standards of our external compliance auditor, HealthcareData Company LLC. MHP has again in 2014 maintained an audit designation of Full Report for all measures based on the conformity with the Healthcare Effectiveness Data and Information Set (HEDIS)®* for all subsequent years.

MEETING STATE PERFORMANCE MONITORING FOR MEDICAID

In October 2001, the Michigan Department of Community Health (MDCH) contract was amended to include Performance Targets. Performance Targets are key areas of quality, access, customer service and reporting. Eleven performance measures were identified for the 2013-2014 contract year, including six clinical targets and member complaint data. Monthly updates of the health plan's performance are delivered by the state.

The purpose of the performance monitoring is to establish an explicit process for the ongoing monitoring of all health plans' performance. The process is dynamic and reflects statewide indicators that may change year to year. The indicators range from childhood immunization rates to claims processing timeframes. The indicator performance is compared to each plan over time, to other health plans, and to industry standards if they exist.

In addition to exceeding all of performance standards, in 2014 MHP has successfully completed MDCH and the Department of Insurance and Financial Services (DIFS) requirements as demonstrated by successful onsite audits with both entities.

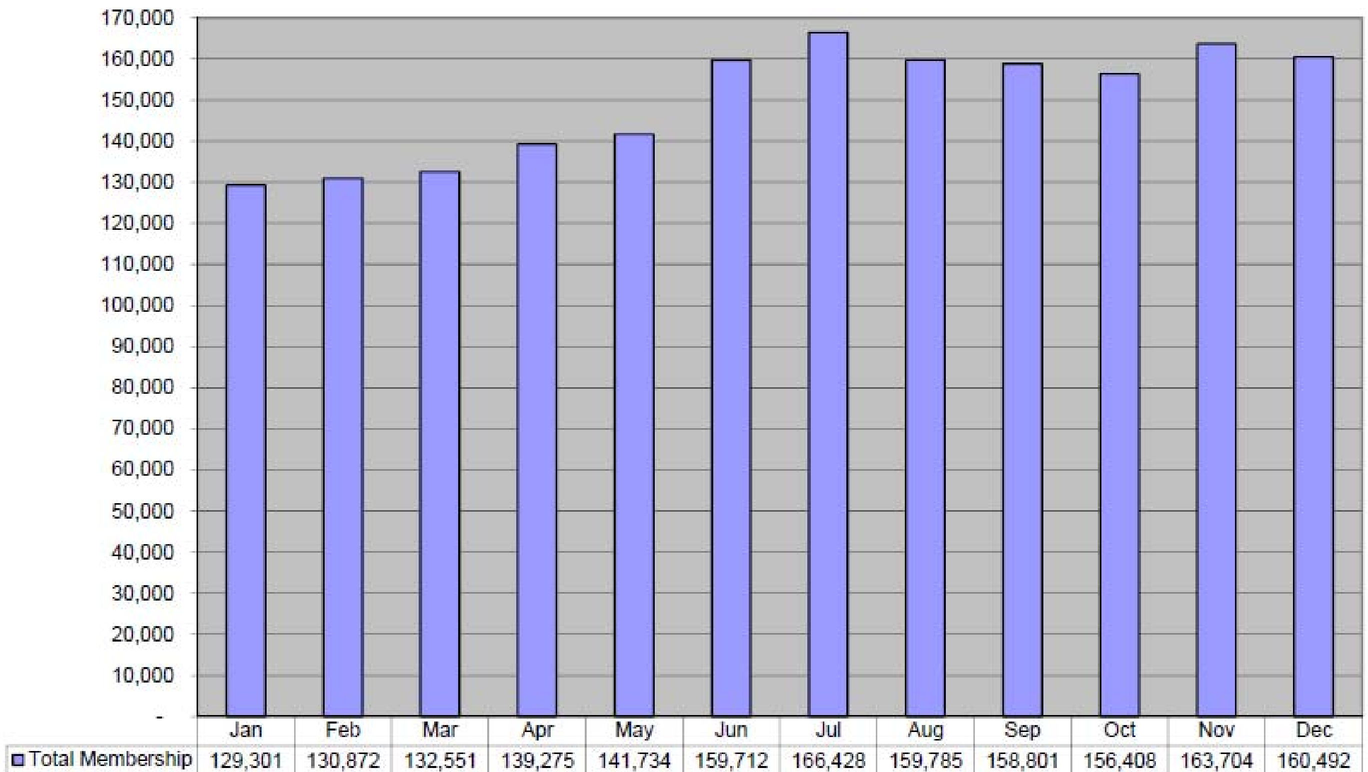
*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

MAINTAINING CONTINUED MEMBERSHIP GROWTH

Medicaid participation is evaluated monthly. This allows for a significant shifting of members in and out of the plans. With this movement, MHP has maintained the ability to be a plan of choice for many Medicaid members. In 2014, Medicaid expanded eligibility requirements which resulted in significant membership growth. The program was added as Healthy Michigan. There was an aggressive movement on the part of the State of Michigan to include these members. In addition to Medicaid benefits, there are a variety of differences from regular Medicaid, for example an HRA requirement, member and provider incentives and member's premium requirement.

McLaren Health Plan experienced a slow but positive growth in 2012, and acquired CareSource of Michigan Medicaid health plan in August 2012. This increased our Medicaid membership by over 35,000 members and allowed expansion into 25 additional counties. Growth continued throughout 2013 by almost 9,000 members. In 2014, the increase in membership has continued, driven by the Healthy Michigan program.

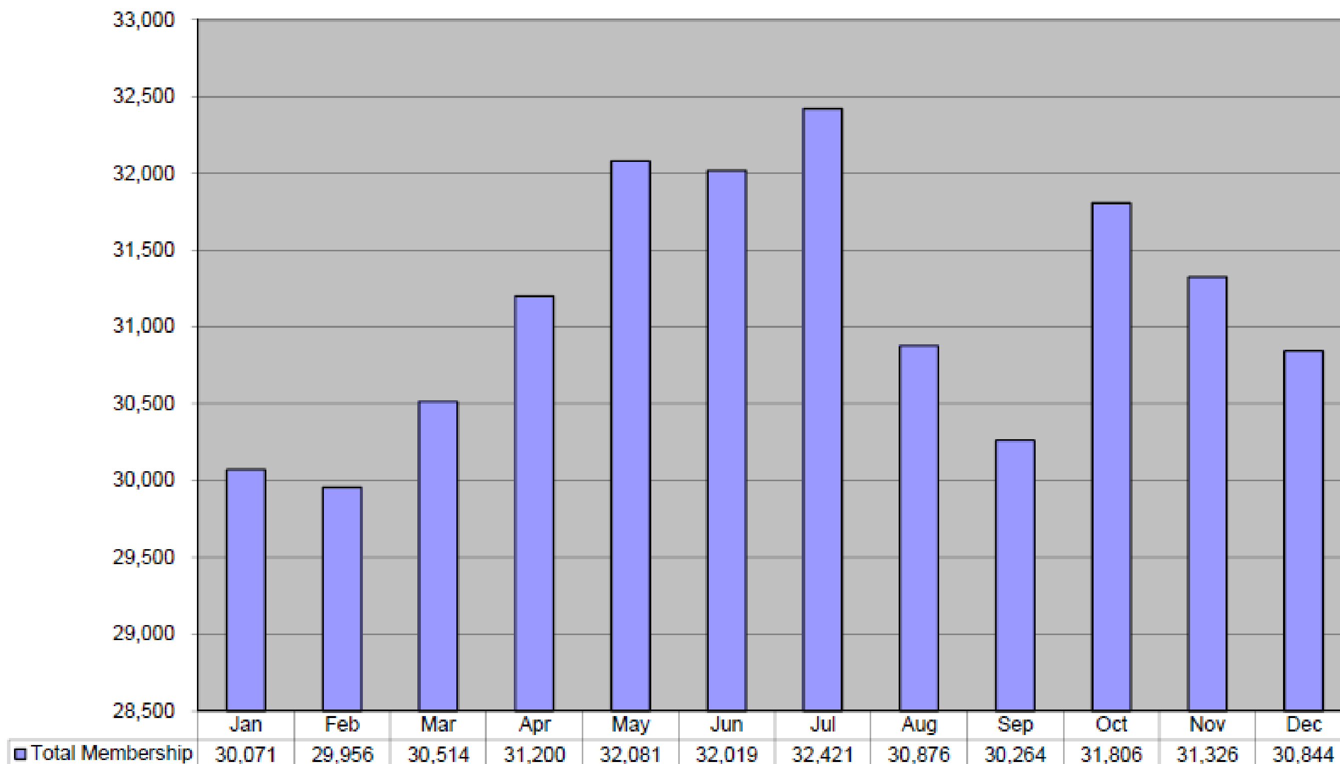
Medicaid Membership
CY 2014



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Membership	129,301	130,872	132,551	139,275	141,734	159,712	166,428	159,785	158,801	156,408	163,704	160,492

A seamless transition from an all Medicaid plan to including a commercial product line occurred in 2006. The first members were effective April 1, 2006. As of December 2014, there are over 30,000 members, and the groups enrolled have increased from 1,000 to almost 1,200 during 2014.

A barrier to continued significant growth is the state of financial affairs in Michigan. Employment rates are high and inside growth for current groups is limited. MHP also decided to remove offering the commercial small group product off the exchange. This has resulted in a stagnant growth pattern in the commercial membership.



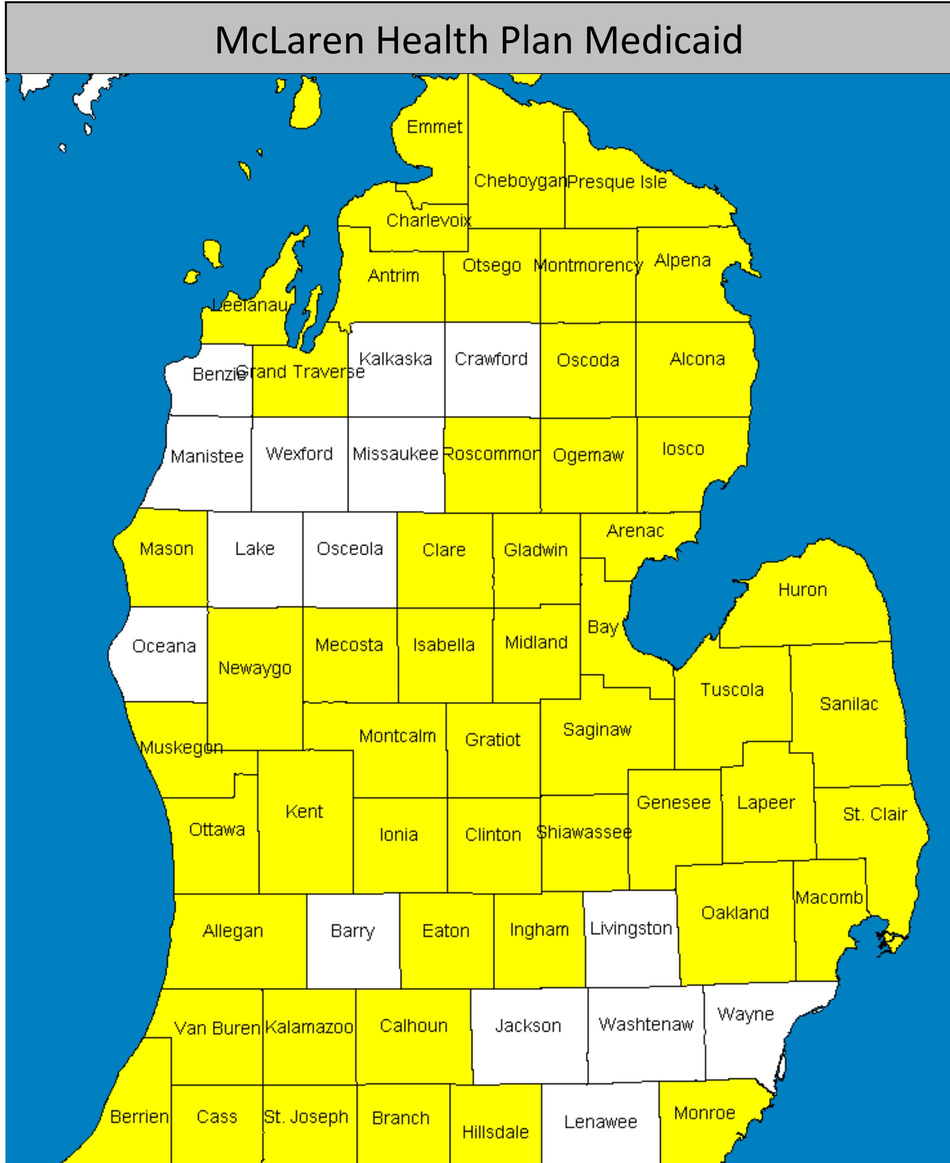
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Membership	30,071	29,956	30,514	31,200	32,081	32,019	32,421	30,876	30,264	31,806	31,326	30,844

Operationally, both the Commercial and the Medicaid product are governed in compliance with the same HMO licensure. In certain circumstances, the State of Michigan contract requires additional services and/or directives. Currently all operations of both HMO products are compliant with the appropriate NCQA standards, and the commercial product was brought forward for accreditation in 2013. In addition, for the commercial product the membership via the Marketplace is managed and subject to all the same policies, procedures and programs as the commercial membership off the marketplace.

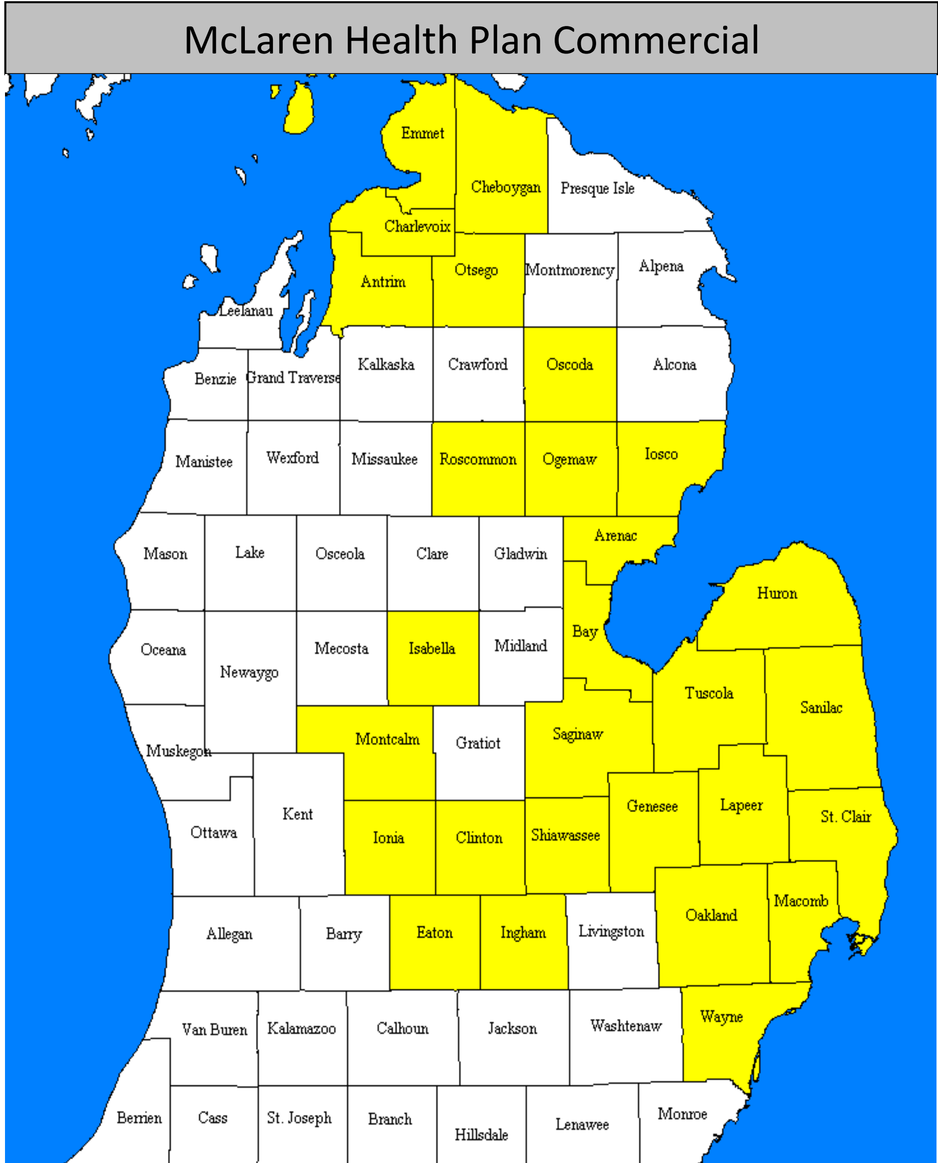
See following map for contracted counties by product:

McLaren Health Plan – Medicaid and Commercial
December 2014
Approved Counties

McLaren Health Plan Medicaid



McLaren Health Plan Commercial



MAINTAINING NCQA MANAGED CARE ORGANIZATION (MCO) ACCREDITATION

MHP completed the National Committee for Quality Assurance (NCQA) accreditation process for a MCO in August 2003 with an onsite review of the quality operations for the Medicaid product. MHP's score resulted in an Excellent Accreditation status. Annually, our Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Healthcare Effectiveness Data and Information Set (HEDIS) results have been adjusted. The 2011 standards score is unchanged; the standards score received in the 2009 full accreditation year remains with the plan for three years. For 2012, an onsite visit occurred with CAHPS and HEDIS scores re-evaluated. Our status for Medicaid did fall to Commendable as the HEDIS and CAHPS scores value increased and regional increases were eliminated. The accreditation score will be updated annually. MHP had received the following final 2014 scores for Medicaid:

Accreditation Category	2014	2013	2012	2011	2010	2009
HEDIS*	19.67	20.1	26.6	19.27	20.2	20.8
CAHPS	7.28	9.36	11.5	11.5	9.1	11.6
STANDARDS*	53.25	53.25	53.25	60.7	60.7	60.7
TOTAL POINTS	80.21	82.78	91.35 Prior to annual review	91.47	90.1	93.1

*The HEDIS score percentage value has generally increased over the measurement years with a decrease in standards percentage score value.

MHP has received the following final 2014 scores for Commercial:

Accreditation Category	2014	2013
HEDIS*	17.79	NA
CAHPS	6.91	NA
STANDARDS*	53.25	53.25
TOTAL POINTS	77.96	79.59

*The HEDIS score percentage value has generally increased over the measurement years with a decrease in standards percentage score value.

This significant milestone provides an outstanding framework as MHP continues to provide quality care and expand its service in Michigan. However, the decrease in accreditation score has been moved to a work group to analyze what areas need the greatest work. Since 2006, NCQA is moving the accreditation scores to be more focused on HEDIS and CAHPS rates verses the standard scores. This focus applies more pressure on MHP to improve both HEDIS and CAHPS rates. The decline in both HEDIS and CAHPS scores is addressed in detail in this evaluation. Our commercial product in 2013 received the highest accreditation possible, Commendable, as CAHPS and HEDIS were not submitted due to low membership. For 2014 a score of 79.59 was

achieved and moved us to accredited. Both HEDIS and CAHPS results are discussed in detail in this evaluation.

OPERATIONAL EXCHANGE COMMERCIAL PRODUCT

Per the specifications in the Affordable Care Act, MHP is participating on the Health Care Market Place (Exchange.) In addition, MHP did seek and receive NCQA award of accreditation for our HMO/POS combined product. All processes and policies utilized for the management of our members currently enrolled in our accredited HMO's remain in effect for this product. It is only how the member enrolled that differentiates this population. All management is the same as per our current processes.

LAUCH OF NEW SOFTWARE PROGRAM

In June 2014, MHP began, for our Medicaid population, the conversion from the FACTS claim and benefit administration system to an innovative platform called Health Edge. All other products will convert to Health Edge on a scheduled basis. The new system is transitioning MHP to an integrated administrative system that boasts the highest technology currently available for claims and benefit administration. In addition, this technology will provide an unsurpassed ability to manage members care and monitor for quality improvement.

The new system will further differentiate MHP in the health care marketplace, increase business transparency, allow more flexibility in benefit designs, and increase our customer satisfaction. The capability this new system brings to MHP is revolutionary. This new technology was operational in June 2014 and is a next-generation solution that enables MHP to quickly offer the innovative products the market demands, while simultaneously reducing administrative costs and increasing operational efficiencies. It is currently the only system in the nation that is configured as rules based and runs using English-like healthcare language. There are many advantages to this system, to name a few:

- Promotes "green", environmentally friendly and ecologically responsible communication with reducing paper distribution
- Increases the ability to accurately auto-adjudicate claims by mastering the many variables that affect claims payment, i.e., provider type, location, and network status.
- Allows issuing of member health statements that will provide monthly EOB statements rather than service by service statements, better communicate plan benefits at the individual level, notify members of deductible and other out-of-pocket balances, etc.
- Unsurpassed platform for regulatory compliance such as ICD-10 and HIPAA 5010
- Offers Benefit Predictor: aids in assisting customer service response time and directs the content for consistent responses.
- Is wrapped with comprehensive web services including interactive member and provider portals
- Provides available partnerships that enhance processes for core business activity such as enrollment, Click 4 Care (care management), Predictive modeling, etc.

These milestones are significant to MHP as an organization: MHP is financially sound, is established as a premier health plan in the nation, complies with all regulatory bodies, and is retaining members while growing at a significant rate. To continue the process of identifying opportunities for 2015 the accomplishments of 2014 are noted.

2014 ACCOMPLISHMENTS

2014 has been a significant year for MHP demonstrating many accomplishments and identifying several opportunities for improvement. As a result of the following successes in 2013, MHP has continued to build on its reputation of being a premier HMO who provides access to quality care:

- A smooth transition of the Healthy Michigan membership into our current Medicaid program, with a clear focus on the multiple special initiatives to improve the health of this population

- The successful launch of a Member Outreach team that supports our commitment to improving the care provided to our membership, with a focus on HEDIS scores, PCP relationships, and member satisfaction

- MHP maintained the number of members identified in disease management programs at 7% of our membership. In the Asthma and Diabetes programs over 2% of the diabetic enrolled members were also in case management and 1.2% of the asthma members were in case management. Many initiatives were continued including the diabetic blitz program in the 2nd quarter, which entailed contacting members regarding core measures much earlier in the year so that members were able to obtain services.

- The McLaren MOMS (Early Care Healthy Families) program enrolled over 4824 pregnant members with 4200 deliveries, and 63% being contacted before delivery. The HEDIS measures for the Medicaid prenatal and postpartum care remain the highest in the State.

- For Medicaid, MDCH identified 27 Key Measures from HEDIS. MHP Medicaid results included 27% of the measures increased and 47% of measures decreased. The goal of the NCQA 75th percentile was achieved in 25% of the measures, with 12% at the 90th percentile. Efforts will remain to move all measures above the 75th percentile benchmark.

- In 2014, MHP continued to support, Patient Information Exchange (PIE) as a means to exchange health information with PCPs to support the medical home concept. In addition, a provider portal was launched in 2014 and continued enhancements are being developed.

- Lead screening remains a key indicator of performance for MDCH. The goal is 80% of 2 year olds having had a blood lead screening. MHP is currently at 83% of 2 year olds. Ongoing initiatives remain effective.

- Revision of the referral processes which allowed for less referral requirements and the ability to submit referrals electronically. Improved the eFAX that was implemented in 2013 to ensure that referrals are received and processed electronically, eliminating concerns for non-receipt of paper based faxes. This new process is invisible to the provider, so that they may continue to use paper based FAX machines to send and receive their requests for authorization. In 2014, 90% of referrals were electronic.

- Ongoing efforts to connect with the at-risk membership remained a priority in 2014. The disabled population continues to be targeted with the “Let’s Connect” program. Over 7,000 members were contacted with the goal of encouraging access to their PCP within 60 days of enrollment. 72% had a PCP visit within 60 days.

- The promotion of patient safety increased in 2014. The standardization of care was introduced into the case management programs with the emphasis on Clinical Practice Guidelines as the basis for all treatment.

- Pharmaceutical management focused on monitoring capabilities that can be communicated to both the member and the providers regarding appropriateness of treatment. MHP continued the Drug Utilization Programs and formulary management during 2014. There are over 500 members being monitored by the pharmacist for utilization patterns based on drug class and cost, and for quality edits. In addition, these members were reviewed for case management referral. MHP’s clinical pharmacist works collaboratively with our PBM to administer a high quality, cost effective benefit.

- MHP had membership bolus activity again in 2014. MHP added 35,000 Medicaid members effective 10/2012. An additional 30,000 were added in 2014. The members were transitioned smoothly through a special outreach program, including welcome calls, through customer service throughout 2014.

- MHP continued with two new health management programs, a weight management program, *Taking It Off* and a blood pressure support program, *Down With Hypertension.* All MHP members who qualify are eligible for these programs. The focus on these programs is the promotion of life style changes. Both were fully operational throughout 2014, along with an additional partnership with a weight management pilot program with a PCP group. This pilot program, entitled “WOW” has assisted over 100 children in Shiawassee County with dietician visits and healthy lifestyle promotion.

- Gap analysis was an ongoing activity throughout 2014 for all services areas. This review of the provider network resulted in over 4000 newly contracted providers.

- Network Development continued to service and visit the network in record numbers. Reporting supported 100% of PCP with at least one visit and many with 2 or more. Provider forums were developed in 2014 and 15 were held. Specialty physicians and Hospitals remain a target for 2015 with significant outreach goals.

- The Emergency Room Program (ERP) became operational in 2005. In 2014, MHP remained focused on frequent utilizers. The foundation of the program is member education coupled with PCP awareness of the members' utilization patterns. Over 4,700 Medicaid members were contacted in 2014 and 218 commercial members were contacted.

- MHP participates with Epocrates and E-prescribing to enhance formulary communication to our network. The activity is tracked monthly by product and currently MHP is reporting an average of over 48% of prescriptions for MHP (all products) are E-prescribed. This increased 13% during 2013.

- During 2013, MHP remained aligned with a concept of a Health Services department. This department now holds responsibility for Customer Service, Medical Management, and Provider Contracting and Servicing. Meetings occurred twice in 2014. Staff motivation and education are the main goals of these meetings.

- Operational in 2013 is a commercial customer service team that focuses on issues by product line, allowing for expertise in the claims arena for our commercial members. In 2013, the teams were further separated by member and provider. In 2014, continual evaluation occurred with call management as the bolus membership activity affected all call teams.

- Expansion of the established 2013 TEAM PODS, a new concept in the delivery of case management services for all members with simple and complex needs. Additionally in 2014 the movement of the utilization activity to a TEAM POD which allows for more consistency and improved case management

- MHP delivered physician specific HEDIS reports and continues to research and institute internal processes to expand the tracking of provider data submission rates. This increased profiling capability will allow MHP to partner with providers to improve care delivery. In 2014, interim HEDIS reports were available which allows for real time data feeds.

- Through the increase in HEDIS interim reporting, a new focus on gaps in care was delivered to PCPs and office assistance of patient scheduling occurred by the Member Outreach team.

- In 2014, MHP expanded the partnership with Health Delivery Inc (HDI), an eight office federally qualified health center to several other PCP sites. The goal is to increase the number of well visits for its assigned MHP membership.

- MHP partnered with McLaren Medical Group (MMG) with incentives to increase well child visits and diabetic screenings. Each MMG office was provided a list of pediatric and adolescent members assigned to their office that had not had a well visit in 2014. The offices were given lists of diabetic members assigned to their practice that had not had their diabetic core measures completed in 2014, (i.e., HbA1c testing, LDL screening,

eye exams). There are practitioner incentives tied to completing these required visits and testing if performed by the end of 2014. Additional member incentives were also added to the program.

- MHP continued to focus on the management of behavioral health issues for all product lines with a focus on coordination with medical issues. Through frequent promotion of the depression guideline with follow up of members needing additional benefits, MHP continues to support our members. In addition, for the commercial product, Eyes Wide Open is a depression support program, and a behavioral health satisfaction survey was sent to commercial members in late 2014.

- Behavioral health coordination expanded to include PIHP, CMH and the health plan to allow for communication between all treating providers. Several different counties across Michigan were added to our outreach. In late 2014, a new focus on the promotion of PCP embedded in Community Mental Health facilities was identified as an initiative.

- MHP has over 24 outreach programs focusing on preventive care. Collaboratively, Customer Service and Medical Management have championed this area and the increase in HEDIS and State Performance rates validate these programs. Quarterly review of these programs is completed by the senior team work group.

- The fully insured commercial product (including those through the Marketplace) remains strong with an increase in membership to over 30,000 members. All operations are compliant with the appropriate NCQA standards and management strategies that promote high quality, cost effective utilization. This product was successfully presented for NCQA accreditation in 2013. In 2014, an increase in FTE was in response to membership growth and the marketplace membership.

2014 OPPORTUNITIES FOR IMPROVEMENT

The 2012 NCQA onsite evaluation team documented MHP strengths to be:

- Through the annual evaluation, demonstrated both success and barriers with planned interventions
- A comprehensive evaluation of the CAHPS for member satisfaction
- Excellent well organized complex case management processes with good use of interventions
- Strong quality committee who engages in active discussion of quality and practitioner issues
- Strong working relationship with rigorous oversight of delegated credentialing entities
- Excellent website

In 2014, MHP has continued to build on these strengths and in addition the following interventions will target opportunities for improvement, identified through the evaluation of 2014. Many of these interventions have been a focus since MHP began. The ongoing interventions for 2015 are:

- Identifying reasons and barriers for member dissatisfaction and developing strong solutions with focus on PCP relationships
- Further development of the promotion of all healthy behaviors with a focus on better outcomes
- Remain focused on the Healthy Michigan Population with attention to the MDCH Performance Monitoring Program
- Focus on HEDIS data for the commercial product (in addition to Medicaid)
- "Employee-Centered" approach, engaging members in their health management through health information and education
- Every new member is provided a brief, confidential health screening, allowing our RNs to provide individualized medical management interventions
- Removing barriers for members access to preventive care, with specific attention to well child, lead screening, and adult access to annual exams
- Focus on disparities of the membership in relationship to access to care, and health outcomes with relationship to health literacy and racial barriers
- Engaging the contracted provider network through aggressive case management of individual office sites by the nurse case manager
- Research the need for additional disease states requiring interventions
- Expanding the provider network to meet the access needs of the membership through ongoing gap analysis and servicing of current contracted providers to maintain relationships
- Developing useful physician profiles for the contracted network to improve quality of care
- Implementation of the Beneficiary Monitoring Program for Medicaid which is designed to identify members who may be potentially over-utilizing or misusing services and benefits
- Further integration of complex case management processes that focus on pre-assessment, documented care plans, and demonstrate cost effectiveness
- Increasing the use of data analysis to drive efforts and outcomes, with specific attention to overall utilization patterns, under and over utilization issues, and the Early Care Healthy Family program with regards to birth outcomes
- Focus on CAHPS results as a catalyst for customer service education, physician awareness and re-evaluation of current outreach programs
- Intensifying customer service education to enhance communication skills and promote optimal member contacts with a focus on claims processes
- Review to ensure that efforts in pharmacy management are focusing on new and innovative techniques to hold costs, while ensuring high quality benefits
- Continue to research industry best practices regarding authorization requirements with specific attention to the streamlining of MHP's authorization process
- Continually strive to identify member and provider fraud and abuse by investigating aberrant patterns, and report findings
- Distributing the collected information on provider and practitioner actions that improve patient safety, focusing on safe clinical practices for the membership

- Promote continuity of care between all providers and practitioners through development of useful internal communication processes and tools
- Remain committed to the Primary Care Medical Home as the model for delivery of care
- Continue efforts to advance provider adoption of health information technology to improve care coordination
- Continue to monitor data for the most prevalent and costly ailments of our populations
- Further development of member and provider portals
- Expansion of the Member Outreach Team with attention to coordination with all departments
- A focus on the education of the Marketplace population through our programs and processes
- Implement a Predictive Modeling Population Health Management program that provides data analytics to identify, assess, and design specific care interventions for the targeted population
- Initiate a Delivery Payment Transformation Pilot to pay for quality and appropriate utilization for the Fee for Service Medicaid population
- Think innovatively as we proceed into 2015 with new ideas to aid in meeting the Triple Aim

With the opportunities resulting in:

- Improved members' overall health status
- Demonstration of improved outcomes for members with significant health issues
- Increased members' access to services including PCP and specialist care
- Improvement of member and provider satisfaction
- Improvement of targeted HEDIS scores
- Improvement of targeted CAHPS scores
- Improvement of state performance measures

MHP will remain focused on these areas targeted for improvement. The Quality Work Plan will track the progress. Additionally, throughout 2015 if other areas are identified, the work plan will be updated.