Quality Program Description Executive Summary

2017
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Introduction

Medical Mutual of Ohio’s (MMO) mission is to provide Ohioans access to quality, high-value healthcare coverage. MMO employees strive to attain high levels of satisfaction and quality to support our customers who include members, practitioners and providers, group benefit managers, brokers and other stakeholders. Collaborative efforts across functional areas throughout the Company are vital to attaining our goals.

The foundation of MMO’s Quality Improvement (QI) program is the Triple Aim: improving our population’s health, enhancing our members’ experience with care and services, and reducing costs.

MMO’s QI Program applies to all Commercial, Marketplace and Medicare Advantage members--fully-insured and ASO (administrative services only)--within our three legal entities, Medical Mutual of Ohio, Consumers Life Insurance Company (CLIC) and Medical Health Insuring Corporation of Ohio (MHICO). Our Commercial and Marketplace products are accredited by the National Committee for Quality Assurance (NCQA), and hold the Status of Accredited as a Single Site Multiple Entity through December 20, 2019.
I. Program Structure

QI Program Functional Areas of Responsibility

Executive direction of MMO’s quality structure and activities are led primarily by the Chief Medical Officer, the Chief Health Officer and the Chief Experience Officer with final approval by the Chief Executive Officer.

The Vice President of Quality & Population Health is responsible for design and execution of the QI program. Reporting to the Vice President are the following groups and respective responsibilities.

- **Clinical Quality Improvement (CQI):** Registered Nurses (RNs) execute evidence-based, data driven initiatives to advance quality across all populations; monitor patient safety; investigate complaints and quality of care concerns; maintain clinical practice guidelines; coordinate the annual HEDIS hybrid submission; and support quality committees.

- **Clinical Compliance/Accreditation:** Sr. Clinical Compliance Specialists facilitate and assure MMO maintains all quality-related requirements for NCQA; educate employees on accreditation standards; assure adherence to and compliance with oversight requirements for delegated entities; and support quality committees.

- **Wellness/Health Promotion/Disease and Maternity Management:** Program Managers design solutions for employers, members and MMO employees to take responsibility for their health; collaborate with CQI on health screenings and prevention activities. An RN facilitates operations and oversight of our delegated Disease and Maternity Management (DM) programs to Optum Healthcare Solutions.

- **Provider Quality:** Provider Quality supports Provider Contracting in recommending and monitoring value-based quality measures, as well as assuring maintenance of a high value quality network for our members.

- **Medical Policy Development:** Medical Policy Development is attentive to quality in analyzing how corporate medical policies impact the member experience from rejected services.

- **Risk Adjustment:** Risk Adjustment conducts activities to be in compliance with government programs and regulations for Marketplace (ACA) and Medicare Advantage. The compliance requirements include but are not limited to claims file submissions and diagnosis coding abstraction and auditing on medical charts. These activities and the analytics of our vendor Altegra identify Medicare and Marketplace members who are high risk, and offer at-home assessments and testing and facilitation of health plan services.

- **Medicare Stars:** The focus of Medicare Stars department is to design and implement programs to support Medicare quality Star measures. The programs are diverse and address all three aspects of the Triple Aim: improve health outcomes, improve member experience with care, and provide cost-effective access to benefits and services. The department includes a group of Care Navigators, primarily Social Workers, who conduct outreach with members to support essential connections between the member and the delivery system.
The Chief Medical Officer (CMO) is responsible for providing the medical direction for MMO’s corporate quality strategy and oversight of all physician activities. The CMO also provides oversight of clinical care management, clinical quality improvement, disease management, wellness and health promotion. Reporting to the CMO are two Senior Medical Directors who are responsible for oversight of the medical and behavioral health utilization management and quality programs, as well as participation in the Pharmacy Quality Management, Credentialing and Clinical Quality Resource Management committees.

The Vice President of Clinical Care Management is responsible for all activities related to utilization management, medical review and complex case management. Quality is embedded in all areas including: satisfaction with utilization and case management; timeliness of reviews and appeals; and overall utilization of care such as admissions, emergency department visits, imaging and office visits. Clinical Care Management (CCM) promotes efficient and effective transitions of care with post-discharge calls, attention to members at high risk and preventing readmissions. The roles and responsibilities of Clinical Care Management are further described in their respective program description.

The Vice President of Pharmacy Management is responsible for quality initiatives for improving medication adherence, encouraging members to follow-up visits for proper dosing and intervening on immunization gaps in care. Clinical Pharmacists collaborate with RN’s and Social Workers in CCM on potential safety issues or barriers to drug access including high cost of certain drugs. Clinical Pharmacists also assist CQI nurses in evaluating quality cases involving prescription drug safety or utilization. Pharmacy and Accreditation work together on delegated oversight of our PBM, Express Scripts, and Care Continuum who performs medical review for managed specialty drugs.

The Vice President of Customer Care oversees all Customer Care representatives who communicate with customers about benefits and claims payment. They are often the first line of critical touch points that impact members’ experience with the quality and timeliness of telephone and email responsiveness.

The Vice President of Member Experience plays a key role in deciding strategies on how to best drive a positive member experience. Speech analytics, post-call surveys and quality audits are some of the tools the team uses to evaluate experience. Also, this area arranges for all member surveys, e.g. CAHPS, Health Outcomes Survey (HOS), and others.

The Member Appeals department handles member appeals and external reviews, and regularly evaluates data to reduce volume and high over-turn rates.

Provider Engagement monitors the adequacy of our provider networks to assure networks meet geographic and timeliness standards, and include practitioners who meet our members’ cultural needs. This area is also responsible for the accuracy of our provider directory. As stated above, Provider Engagement works in collaboration with the quality department in assuring that our provider contracts
support improved health outcomes for our members, positive member experience and access to cost-effective services.

**Resources and Analytical Support**

Marketing Communication provides journalistic expertise on the design and delivery of written and electronic communications. Member materials are aimed to help members make informed decisions, learn self-care behaviors, problem-solve and be an active collaborator with their healthcare team.

Health Informatics is the primary source for providing data and analytics on costs, quality and utilization. This department manages the HEDIS, Stars and QRS submissions, and offers advanced analysis on healthcare related studies. Data Scientists utilize software such as SAS and Tableau to provide advance statistical computation.

MMO has dedicated substantial resources to the adoption and implementation of Optum’s advanced analytic tools to support high quality service to our members. Applications use membership and claims data to group claims by episode for risk scores, for predictive modeling, for case management targeting and for disease management stratification.

Informational resources when considering clinical studies, monitoring progress and for measurement strategies include but are not limited to:

- The Centers for Disease Control and Prevention (CDC)
- U.S. Preventive Services Task Force (USPSTF or Task Force)
- Agency for Healthcare Research and Quality (AHRQ)
- Quality Compass®
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Medicare Health Outcomes Survey (HOS)
- Healthcare Effectiveness Data and Information Set (HEDIS®) measures
II. Behavioral Healthcare

MMO has implemented programs designed to improve the quality of clinical care and service provided to members who demonstrate behavioral health conditions. The behavioral healthcare program is led by a Senior Medical Director who is a board certified Psychiatrist in Addiction Medicine. This physician leads a multi-disciplinary committee of physicians, nurses, data scientists and management who are committed to improving the quality and access of care to our members having behavioral healthcare needs. Specialists in marketing and electronic communications collaborate on member and provider communications. Aspects to monitor and improve behavioral healthcare include but are not limited to:

1. Quality of care cases where treatment or practice was not within acceptable clinical practice guidelines and member harm to a varying degree was evident.
2. Review and approve practice guidelines and management of major depression
3. Review regulatory guidelines pertinent to behavioral healthcare such as mental health parity
4. Review data analytics on availability of behavioral healthcare providers
5. Review results of access to behavioral healthcare practitioners and facilities
6. Review survey results applicable to behavioral healthcare including CAHPS and HOS
7. Evaluate HEDIS/Stars measures related to behavioral healthcare such as BH follow-up visits after hospitalization, diabetes screening for members with schizophrenia and alcohol screening in office setting
8. Review, approve and monitor effectiveness of quality interventions such as coordination of care between PCPs and BH providers
9. Review reporting on BH such as the population health assessment with data on serious and persistent mental health conditions, substance abuse and adolescent conditions
10. Review and approve materials and communications to members and providers and their impact
11. Over- or under-utilization of services such as lab testing and opioids use
   o Accessibility to Behavioral Health Specialists
   o Monitoring the Effectiveness of Behavioral Health Clinical Care Management Initiatives
III. Patient Safety

MMO is committed to comprehensive patient safety initiatives to afford our members a provider network that consistently demonstrates safe healthcare practices. All activities are designed to reduce medical errors and hazardous conditions before they occur and in response to actual occurrences. Our initiatives employ a team approach to identify, trend and address quality and safety issues.

The Clinical Quality Resource Management Committee (CQRMC) lead by the CMO, oversees all patient safety initiatives. The Committee is made up of practicing physicians from various specialties and is responsible for the review of breaches of quality or safety that occur during medical care. Components of the CQI Program specifically directed toward safety include:

- Ensuring that network providers possess appropriate credentials and are monitored for disciplinary actions that might incur the loss of network participation
- Recommending use of Centers of Excellence programs based on quality criteria
- Clinical Care Management activities, including concurrent review, that monitors potential safety issues and potential over and or underutilization situations
- Routine safety assessments for members in Case Management
- Continuity and Coordination of Care activities at transitions of care to prevent complications or readmissions
- Focused studies of quality clinical care and service
- Hospital-acquired conditions and adverse or serious reportable event tracking and monitoring
- Inpatient mortality analysis, monitoring and reporting
- Investigation of member and provider complaints and quality case reporting
- Member and provider communications regarding safety education
- Review of provider office safety, where indicated
- Prescription medication monitoring for overuse

Safety is maintained through the CQI departmental activities:

- Encouraging recognition and immediate referral of potential or actual risks to member safety, as well as, suspected or actual medical error review by CQI nurse and escalation, if warranted, to physician reviewers and the CQRMC.
- Monitoring actions to reduce these risks and/or errors.
- Reporting routinely on quality cases. Educating staff and delegated vendors to ensure safety practices are being followed.
- Communicate pertinent safety topics to both members and providers through multi-channel options.
IV. Involvement of Designated Physicians:

MMO’s full-time, employed physician leaders are integral to our foundation of quality. They lead and/or participate in all quality committee and provide guidance on all quality initiatives.

- The CMO is board certified in Internal Medicine and Geriatrics and reports directly to MMO’s Chairman, President and CEO. She is the co-chair of the Corporate Quality Committee, chair of the CQRMC, provides general medical direction to the quality foundation of the company and is responsible for all physician activities. She also provides medical oversight of clinical care management, clinical quality improvement, disease management, wellness and health promotion.
- Two Senior Medical Directors:
  1. A behavioral health practitioner who is board certified in Addiction Medicine and oversees the behavioral health aspects of the quality program. He also participates in the Pharmacy Quality Management, Credentialing and Clinical Quality Resource Management committees.
  2. An internal medicine physician who is board certified in Internal Medicine and is responsible for physician oversight of utilization management. She participates in the Clinical Quality Resource Management committee.

Additional physician guidance is provided by employed and contracted community-based physician consultants who specialize in pediatrics, family medicine, internal medicine and multiple other specialties. Like MMO’s physician leaders they are designated members of various committees and lend guidance to our quality initiatives as appropriate. During 2017 MMO plans to add additional physicians for broader geographic representation.

V. Involvement of Designated Behavioral Healthcare Practitioner

MMO employs a full-time Senior Medical Director who is a behavioral health specialist board certified in Addiction Medicine. He oversees the behavioral health aspects of the QI program, as well as participates in the Pharmacy Quality Management, Credentialing and Clinical Quality Resource Management committees. He directs our behavioral health quality initiatives including those focused on improving the availability of practitioners in the network.

VI. QI Committee Oversight

The Corporate Quality Committee (CQC) is the overseeing body of MMO’s corporate quality program. Reporting to the CQC are committees that monitor, direct and evaluate clinical and service initiatives while promoting the Triple Aim. Sub-committees and/or ad hoc teams are assigned on an as needed basis.
Each committee’s Charter provides a detailed description of specific responsibilities and member composition.

- **Corporate Quality Committee (CQC)** - The CQC is co-chaired by the Chief Health Officer and the Chief Medical Officer. Executive Vice Presidents and Vice Presidents are responsible for the strategic direction and governance of the Company’s overall quality improvement (QI) program. The quality improvement process strives to optimize the health, safety and experience of all members; promote collaboration with providers to drive value; and reduce healthcare costs of the population. The CQC oversees compliance with quality-related standards, guidelines and operational processes. The CQC reports to the Board of Directors.

- **Clinical Quality & Resource Management Committee (CQRMC)** – The CQRMC provides strategic direction and oversight to all committees and work groups focused on the quality and safety of clinical care. The CQRMC reports to the CQC. Reporting to CQRMC are four committees.
  - **Behavioral Health Committee (BHC)** - The BHC provides leadership and guidance on the strategic direction of the behavioral health services, policy decisions and quality activities. The BHC reports to the Clinical Quality and Resource Management committee.
  - **Credentialing Committee (CCC)** - The CRC uses a peer-review process to make final determinations regarding credentialing decisions. Practitioners participating in the health plan’s networks and who are selected for this committee provide meaningful advice and expertise when making decisions. The CC reports to the Clinical Quality & Resource Management Committee.
  - **Population Health Sub-Committee (PHC)** - The DMC is responsible for the strategic direction of programs, activities, quality improvement initiatives and vendor relationships that support population health across the continuum of healthcare; assures compliance with standards and guidelines. The DMC reports to the Clinical Quality and Resource Management Committee.
  - **Pharmacy & Therapeutics Committee (P&T)** - The mission of the P&T committee is to provide safe, high quality, pharmaceutical care that is cost-effective by providing ongoing oversight and direction to MMO’s prescription drug program and drug management initiatives. The P&T committee reports to the Clinical Quality and Resource Management committee.

- **Member Experience/Service Quality Improvement Committee (MESQC)** – The MESQC is a cross-functional committee whose objectives are to oversee and improve upon the quality of members’ experience with health plan services. The MESQC reports to the Corporate Quality Committee.

### VII. Annual QI Work Plan

The QI Work Plan is developed annually and reflects the overall goals and objectives of the QI Program. The Work Plan is updated periodically throughout the year as progress is achieved. Evaluation of the QI Program helps identify new objectives and activity planning for the coming year.

Evaluation of the QI program includes analysis of product-specific Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results. Beginning in 2016, evaluation of the QI Program for Medicare Advantage members included efforts to collaborate internally to examine MMO’s mini CAHPS
survey results. Responsibility for Medicare Advantage program evaluation rests with the Vice President, Population Health and Quality with input from various supporting committees. Additionally, when the Medicare Advantage product was implemented in January 2016, Medical Mutual included all enrollees in appropriate clinical quality improvement program activities and goals where Star ratings will be used as our framework.

2017 Goals and Objectives

The Quality Improvement Program is continuously exploring methods to identify and recognize treatment methodologies and protocols that contribute to the improvement of health outcomes. Toward these efforts, annual goals and objectives guide all quality improvement activities. The goals and objectives for 2017 include:

1. Uphold the 2017 NCQA Health Plan standards, regulatory guidelines and evidence-based protocols to ensure appropriate care for our members.
2. Promote effective relationships with providers by increasing input regarding quality initiatives.
3. Promote member, provider and client satisfaction to optimize healthcare value.
4. Meet our members’ culturally diverse and linguistic needs as identified.
5. Intervene on members with complex health needs through targeted interventions and programs.
6. Educate members on product benefit design, operational policies and health plan procedures.
7. Provide members and providers web-based information and tools to promote and enhance services and clinical care.
8. Ensure that adequate and appropriate resources are available to maintain and enrich the ongoing Quality Improvement Program.
9. Review evidence-based clinical practice guidelines from nationally recognized sources, adopt updated versions and make them available to network providers.
10. Promote the utilization of preventive health services and communicate member care gaps or missed services to members and network providers.
11. Use analysis of data collected from the Healthcare Effectiveness Data and Information Set (HEDIS), CAHPS survey results, Health Outcome Survey (HOS) results, internally developed performance measurement studies and the annual Provider Satisfaction Survey to identify opportunities for improvement. Incorporate interventions into the annual Quality Work Plan.
12. Promote the implementation of integrated wellness and disease management programs for employer groups, members and employees.
13. Monitor patient safety indicators and identify opportunities for improvement. Determine interventions including our network practitioners and providers in addressing patient safety issues.
14. Evaluate member experience and service quality indicators, identify areas of improvement and decide on interventions. Continue to improve upon the core service functions of timely and accurate adjudication of claims and response to written correspondence, email and telephone calls.
15. Identify opportunities to support lowering healthcare costs through quality initiatives.
Evaluation
An annual evaluation of the QI Program is conducted to measure actual results against goals and benchmarks, as available. Barriers are identified and opportunities for improvement are utilized to develop the Work Plan for the following year.

VIII. Serving a Diverse Membership

MMO evaluates the cultural and linguistic needs of our membership and summarizes findings in an annual Cultural Competence report. This report serves to meet the needs of both current and prospective members. MMO’s objectives are to:

- Meet identified cultural and linguistic needs in materials and verbal communications.
- Assure available network practitioners to meet the cultural needs of our members.
- Improve upon areas identified through analysis.

The process by which cultural needs are evaluated is highlighted below. Findings are discussed at the Member Experience and Clinical Quality & Resource Management committees, and are utilized by Provider Contracting in the annual review of provider network availability.

A review of the language needs of potential members as conducted annually using the most current American Community Survey (ACS) Five Year Population Assessment data for language spoken at home published by the United States Census Bureau (U.S. Census Bureau).

- The ASC is tracked by county population and preferred language spoken. The goal is to identify any county in Ohio with at least 10% of the population speaking one language other than English and speaking English less than well. Membership in those counties identified is then reviewed to determine if there is a need for improved materials and communications.

- The number of network providers who speak a language other than English is tracked, monitored and evaluated to assure availability to members.

- Supplemental data is collected to further identify trends, needs and preferences, including:
  - Reports on calls interpreted through the AT&T Language Line and documents translated by Transperfect
  - Member demographics from the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) health plan survey
  - Member demographics from Health Appraisal data
• Contacts from members with special needs recorded in the Contact On-line Reporting System (CORS) by Customer Care Specialists for translation of complaint or appeal documentation

• Support for sight and hearing impaired members through referral to Care Navigators, who arrange for large print/braille materials or American Sign Language (ASL) interpreters.

• Regulatory and accreditation are reviewed for compliance.

IX. Serving Members with Complex Health Needs

Members with one or more complex health issues are identified for specific activities to better coordinate care and services. Activities are coordinated among all Clinical Care Management departments and communication is facilitated between all the member’s healthcare providers. MMO comprehensively addresses the needs of our members with the following complex health issues:

- Developmental disabilities
- Chronic conditions
- Physical disabilities
- Severe and persistent mental health conditions

When members with one or more complex health issues are identified through our current practice processes, they are targeted for specific planning. This plan is implemented through the integration and coordination of activities of multiple departments. Current initiatives encourage and facilitate communication between primary care practitioners and specialists (medical and behavioral health), physicians and hospitals, and members and physicians by providing preprinted summary communication forms. Initiatives target fragmented care among practitioners and across care settings by facilitating the exchange of vital information and increasing member awareness of the importance of information sharing. Whenever a pattern is identified that may indicate a safety or quality issue, claims and medical records are reviewed by CQI nurses to address any issues that put members at risk of harm.

Clinical Practice Guidelines

Clinical practice guidelines are adopted for common chronic conditions and are endorsed by nationally recognized sources based on scientific evidence of effectiveness, including, but not limited to:

- Alcohol screening
- Asthma
- Attention deficit/hyperactivity disorder
- Depression
- Diabetes
- Preventive care
To better coordinate care and services for members with co-morbid medical and behavioral conditions, the MMO continues a medical/behavioral Case Management program to ensure that the same Case Manager coordinates care for both medical and behavioral conditions. Additionally, Case Managers determine if referral to a disease management program is warranted.

Health Informatics conducts an annual assessment of our population and findings are discussed at the Clinical Quality & Resource Management and Behavioral Health committees, and are utilized to help identify quality initiatives.

*Note: Information generated as a result of the Company’s CQI Program is strictly confidential and is to be accessed only by those with authority and as required by certain governmental agencies. CQI activities are conducted in a manner that protects the confidentiality of the member and provider.*