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Quality Assessment Performance Improvement

Program Description
01/01/2026-12/31/2026



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I. Program Overview

HAP CareSource¹ Quality Assessment and Performance Improvement (QAPI) program applies the principles of continuous quality improvement (CQI) to all aspects of the delivery system, including all aspects delegated to First Tier, Downstream and Related Entities (FDR) through ongoing data collection, performance monitoring, analysis and infrastructure evaluations that inform systematic and meaningful enhancements across all operations of the plan. HAP CareSource develops, implements and provides oversight to the plan's QAPI program in accordance with the standards and requirements and in compliance with the 42 CFR §438.330, Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and MDHHS Quality Strategy, National Committee for Quality Assurance (NCQA) and in alignment with the plan's Model of Care (MOC).

The purpose of the HAP CareSource's QAPI Program is to ensure that the plan has the necessary infrastructure (people, processes, and systems) to:

- Improve health outcomes for the HAP CareSource Michigan Medicaid and HIDE SNP Members.
- Coordinate care using evidence-based tools.
- Promote quality care and services.
- Ensure performance and efficiency on an ongoing basis.
- Provide for a systemic data collection of performance and Member outcomes.
- Improve timely access to primary, behavioral and specialty care, safety, and equity of clinical care and Long Term Services & Supports (LTSS).
- Improve patient safety and quality of clinical care and services.
- Identify and address health opportunity needs to reduce disparities.
- Advance health equity.
- Promote CQI across functional areas to drive process and performance improvement.

The QAPI Program encompasses both clinical and non-clinical activities and services and is reviewed and revised as needed to, but annually at a minimum, to remain responsive to:

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

¹ All subsequent references in this document to HAP CareSource may be listed as: "the plan" or health plan.



PROGRAM SCOPE

HAP CareSource QAPI program's scope is comprehensive and considers clinical and non-clinical aspects of care, services, and experience needs. Scope includes, but is not limited to, the following activities and abilities:

- Meet the federal, state, regional, local and accreditation Quality Program requirements.
- Monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care and services delivered to members.
- Incorporate an internal system for monitoring services, including:
 - Data collection and management for clinical studies.
 - Data collection capabilities to collect and report data on race, ethnicity, sex, primary language and disability status for the member and the member's parents or legal guardians, as applicable.
 - Internal quality management activities.
 - Assessment of the quality and appropriateness of care furnished to members with special health care needs inclusive of care furnished to members using LTSS.
 - Assessment of the quality and appropriateness of care furnished to all members, including availability of services, second opinions, timely access, and cultural considerations.
 - Other quality management activities requested by MDHHS or CMS including ad-hoc reporting to appropriate committees and subcommittees.
- Disseminate performance and health outcome metrics of the QAPI program to our providers, members, and regulators.
- Ensure access to and availability of high-quality care and services.
- Participate appropriately in clinical and non-clinical studies and Performance Improvement Projects (PIPs).
- Cooperate fully with external evaluations and assessments conducted by state contracted External Quality Review Organization (EQRO).
- Use Healthcare Effectiveness Data and Information Set (HEDIS®), CMS Core Sets, and data from other sources to regularly assess the quality and appropriateness of care provided to plan members.
- Assess the quality and appropriateness of care provided to Michigan Medicaid members under twenty-one (21) years of age in accordance with the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) periodicity and program requirements.
- Collect measurement indicator data for areas of clinical priority and quality of care as outlined by MDHHS.
- Develop, review, adopt, and disseminate evidence based Clinical Practice



Guidelines (CPGs).

- Collaborate with MDHHS to develop specialized CPGs for providers, as requested or contractually required.
- Provide quality oversight of all clinical services.
- Evaluate member and provider satisfaction.
- Monitor over/underutilization.
- Maintain written policies and procedures that govern quality assurance and performance improvement activities.
- Develop organizational competency in quality methodologies, including the use of the Plan Do Study Act (PDSA) rapid cycle improvement model.
- Ensure efforts to monitor and improve behavioral healthcare (BH), including care for mental health and substance use disorders.
- Ensure effective and equitable care for members with varying levels of health, safety, or welfare needs, including complex health issues.
- Establish framework to provide data required for participation in performance and quality improvement projects, clinical studies, and External Quality Reviews.
- Assess population profile needs, including health-related social needs/social determinants of health (HRSN/SDoH).
- Assess the geographic availability and accessibility of primary, specialty care and BH providers.
- Collaborate, develop, and implement Alternate Payment Models (APMs), including but not limited to Value-Based Payment (VBP) models.
- Develop member incentive programs to encourage member responsibility for their healthcare and outcomes that promote self-management.
- Participate in clinical studies, as appropriate.
- Maintain procedures for collecting and ensuring accuracy, validity, and reliability of performance measures consistent with regulatory protocols.
- Perform an annual QAPI evaluation.

Goals and Objectives

HAP CareSource supports compliance with the MDHHS and CMS Quality Strategy to improve the health outcomes of the Medicaid and HIDE SNP members, advance health equity, ensure Member health, safety, and welfare. Performance goals are determined and aligned with the MDHHS and CMS goals and national benchmarks where applicable.

The clinical aspects of the QAPI program are derived from evidence based medical research and nationally recognized best practices and standards of care. The QAPI program is designed to ensure quality and appropriate health care and services including those with limited English proficiency, diverse cultural and ethnic backgrounds, and considers the influence of SDOH outcomes while pursuing



advancement in health equity.

Key to improving health outcomes is understanding the populations the plan serves, encompassing an array of demographics, such as age, race/ethnicity, geographical disparity, gender identity, sexual orientation, cultural health beliefs, and disease states, which may place members at risk for negative health outcomes. Systematic and standardized data collection and analysis are paramount to continuous quality improvement (CQI). QAPI processes are significant to monitoring, evaluating, and actively pursuing opportunities for improvement.

HAP CareSource's overarching goals of the QAPI program are aligned with the Institute for Healthcare Improvement's (IHI) quintuple aim: (1) improving the health of the population; (2) enhancing the care experience; (3) reducing per capita cost of care; (4) Improving provider experience; and (5) advancing health equity.²

HAP CareSource strives to achieve the following primary goals:

- Implement the 2026 QAPI program that effectively promotes and builds quality into the organization landscape through appropriate structure and processes.
- Improve Members' health outcomes.
- Improve Member and provider experience with healthcare services.
- Ensure network adequacy, access and availability of care and services.
- Support ongoing CQI processes for the assessment of member care and services, including LTSS.
- Ensure programs of care and services meet the culturally and linguistically diverse needs of the HIDE SNP members.
- Develop, implement, and continually improve programs and services to meet the complex health needs of the HIDE SNP members and population as a whole.
- Implement a robust population health strategy.
- Pursue Health Equity Accreditation with NCQA for HIDE and obtain for Medicaid in 2026.
- Promote enrollees' health, safety, and welfare.
- Implement a robust EPSDT program for the Michigan Medicaid 0-21 years of age members.

² Institute for Healthcare Improvement, 2024. "The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity." <https://www.ihi.org/resources/publications/quintuple-aim-health-care-improvement-new-imperative-advance-health-equity>



- Implement required and population-needs based clinical and non-clinical PIPs for the Michigan Medicaid membership.
- Improve member and provider experience.
- Maintain compliance with state, federal, regional, local and accreditation requirements.

II. Program Framework

Quality Improvement (QI) activities that support the goals and objectives of the QAPI program that foster QAPI processes are coordinated on an annual basis and ongoing monitoring. HAP CareSource's QAPI program cycle is based on the State of Michigan requirements. The following components form the framework to meet the health plan's goals and objectives:

- QAPI Program Description
- QAPI Program Work Plan
- QAPI Program Evaluation
- Policies and Procedures

These critical components of the QAPI program framework are developed, reviewed, and approved annually, or more often with any substantial program changes through the QAPI program governance structure.

QAPI PROGRAM DESCRIPTION

This QAPI program description is comprehensive and outlines the plan's strategies and goals designed to meet or exceed the MDHHS and CMS quality strategy and other requirements of the health plan's contract. The QAPI program design includes:

- QAPI program governance.
- Program scope.
- Program goals and measurable objectives.
- QAPI program structure.
- Description of HAP CareSource's resources dedicated to the successful implementation of the QAPI program (people, processes, and systems), inclusive of analytics support.
- Involvement of designated physicians and BH practitioners in the structure of QAPI design.
- QAPI components and performance measurement.
- Work plan detailing ongoing QI activities.
- Reporting relationships of the QAPI program committees.



- Description of collaborative QI activities.
- QI methodologies.

QAPI PROGRAM WORK PLAN

QAPI program activities are not mutually exclusive. Integration is essential to successful implementation and management of QI efforts across all functional areas. The QI work plan is an activity-tracking tool used to facilitate achievements of the QAPI program's goals and objectives each year.

The QI work plan is a dynamic document which provides timelines, schedules and description of deliverables and includes all QI activities, resources, designated staff and/or department responsibilities, monitoring of previously identified issues and progress towards completion. At the minimum, the QI Work Plan includes:

- A written description of QAPI program governance.
- Timetable for the coming year with identified target dates for implementation and completion of phases of all QAPI efforts and activities, consistent with specific targets, benchmarks and goals set forth by MDHHS and CMS.
- Composition of the Quality Improvement Committee (QIC) including both physical and behavioral health providers.
- Procedures for remedial action when deficiencies are identified.
- Specific types of problems requiring corrective action(s).
- Provisions for monitoring and evaluating corrective action(s).
- Procedures for provider review and feedback.
- The annual QAPI Program Evaluation.

HAP CareSource utilizes the QI Work Plan to monitor ongoing progress of plan-wide QI activities and objectives for improving quality and safety of clinical care, quality of services, and Member and provider experience throughout the year.

The QI Work Plan approval is obtained through the review by the health plan's QIC and the plan's Board of Directors (BoD).

QAPI PROGRAM EVALUATION

Measuring the effectiveness of the QAPI program and the QI Work Plan takes place annually through the evaluation and application of realistic, program and population applicable performance measures, which are incorporated into the QI initiatives to establish baseline data, guide, and monitor improvement efforts, and demonstrate the success of change strategies. The annual QAPI Program Evaluation reflects an assessment of completed and ongoing activities as outlined in the QI Work Plan and described in the QAPI Program Description.

The evaluation is comprehensive, providing quantitative and qualitative analyses followed by recommendations for the following year. It includes the following:



- Performance on required reportable measures.
- Outcomes of trended results of each PIP, including documentation of successful and unsuccessful interventions.
- A description of how HAP CareSource met the requirements for the development and dissemination of CPGs.
- A description of HAP CareSource's efforts to prevent, detect, and remediate Critical Incidents.
- Summary of the QAPI program's quality committee structure and activities associated with each committee, including, at a minimum, the QIC that monitors the quality strategy and QI Work Plan.
- An assessment of the quality and appropriateness of care furnished to members with special health care needs, inclusive of LTSS, describing the methodology of aggregate data collection of members identified and methods used to evaluate the need for direct access to specialists.
- A demonstration of improvement in an area of poor performance in care coordination for members with special health care needs, inclusive of LTSS, and behavioral health conditions.
- A description of mechanisms HAP CareSource uses to monitor and enforce consumer rights and protections that ensure consistent responses to complaints of violations of these rights and protections.
- Description of the overall effectiveness of the QAPI and how HAP CareSource will incorporate the results from previous measurement year into the future QAPI design.

HAP CareSource reviews the annual QAPI program evaluation and uses the findings to establish QAPI and performance improvement goals for the upcoming year. Opportunities for improvement identified in the evaluation or articulated by MDHHS or other key stakeholders, inform the identification and selection of the goals and objectives. HAP CareSource submits the QAPI Program Evaluation to the State annually, as per reporting requirements.

The health plan's Quality department is responsible for preparing the annual QAPI Program Evaluation and submitting it for review and approval to the QIC and the BoD.

QUALITY IMPROVEMENT METHODOLOGY

For standardization and efficiency, the health plan has adopted the IHI model as a tool for implementing quality improvement activities. 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 leading to positive outcomes. Adoption of the IHI QI methodology promotes the development of practices to institutionalize and implement best practices to ensure long term



success of quality efforts. This process ensures sustainability and diffusion.

Using the IHI Model for Improvement, the plan leverages the following benefits:

- Rapid cycle testing and learning.
- Well-informed hypothesis of the test of change results and sustainability in improvement.
- Results that support sustainability and ongoing improvement
- Collaboration and prioritization of proposed changes that will lead to the desired improvement.
- Analytical quantification of the estimated potential for improvement resulting from a change.
- Systematic and standardized diffusion of success.
- Evaluation of costs, impact, and side effects from proposed changes.
- Alignment and ongoing support of QAPI program's CQI principles.

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 in an effort to improve organizational performance.



III. ORGANIZATIONAL STRUCTURE AND ADMINISTRATION

HAP CARESOURCE BOARD OF DIRECTORS

HAP CareSource Board of Directors (BoD) has ultimate authority and accountability of the QAPI program and related processes, activities, and systems.



This includes responsibility to establish, maintain and support the health plan's QAPI program and all related QI activities.

The HAP CareSource' BoD delegated its authority to the Joint Operations Committee (JOC) which is responsible for the structural program elements and Delegation Vendor Oversight of its delegated entities. The QAPI Program Description, QI Work Plan and the QAPI Program Evaluation and any subsequent revisions are submitted to the BoD by JOC for review and approval. After reviewing the information, the BoD will approve or provide directions and recommendations for enhancements to the QAPI program and the QI Work Plan, if applicable. Subsequent revisions based on the BoD's recommendations are re-submitted for review and approval.

QAPI PROGRAM OVERSIGHT BODIES

Formal committees and subcommittees advise and guide the QAPI program processes. The committee members foster collaborative partnership and integrate multi-variate functions into the ongoing monitoring of the effectiveness of the QAPI program. The plan's QI department provides administrative support for the coordination of committee meetings, meeting preparations, and follow-up activities. The JOC provides oversight of quality activities and their integration across the plan through its receipt and review of reports and minutes from the respective committees.

HAP CARESOURCE QUALITY OVERSIGHT COMMITTEES

HAP CareSource QAPI Program Committees include:

Market level:

- HAP CareSource Joint Operations Committee (JOC)
- Quality Improvement Committee (QIC)
- Provider Advisory Committee (PAC)
- Consumer Advisory Council (CAC) - Medicaid, Enrollee Advisory Council (EAC) - HIDE SNP
 - LTSS Member Advisory Council
 - Rural Health Advisory Council
 - Stakeholder Advisory Council
- Michigan Health Opportunity Committee (MHOC)
- Market Utilization Management/Care Management Committee (UMCMC)

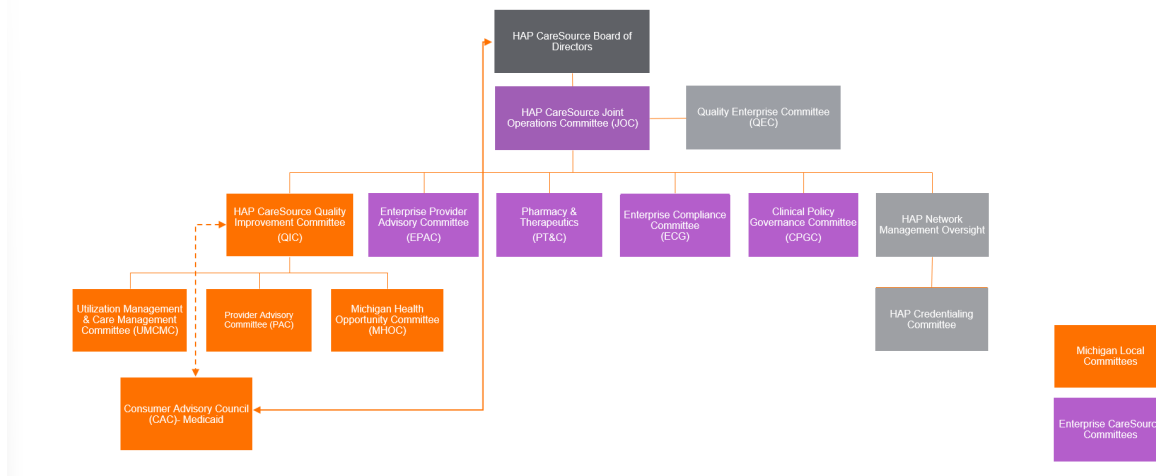
Enterprise level:

- Quality Enterprise Committee (QEC)
- Enterprise Provider Advisory Committee (EPAC)



- Pharmacy and Therapeutics Committee (P&TC)
- Enterprise Compliance Committee (ECC)
- Enterprise Utilization Management/Care Management Committee (UMCMC)
- Clinical Policy Governance Committee (CPGC)

HAP CareSource Michigan Committee Structure



Procedures:

Quorum – HAP CareSource committees convene at regularly scheduled meetings, or more often as the chairperson deems necessary. A quorum consisting of 50% plus one (1) of the voting membership must be present for any HAP CareSource committee to conduct business. A simple majority vote of the quorum will constitute committee approval. Committee voting cannot take place unless a quorum is present.

Committee Membership Responsibilities:

Voting members of the committees are expected to be present and/or have a representative proxy in the meetings to ensure that a quorum is present to conduct business.

Meeting attendance:

Committee attendance in person, via telephone or video conference is acceptable.

Confidentiality and Conflict of Interest:

HAP CareSource maintains a process to ensure rules of confidentiality are followed



in quality improvement discussions as well as avoidance of conflicts of interest on the part of the committee members.

Agenda:

Each committee chairperson in collaboration with committee facilitator is responsible for organizing the agenda for each meeting to ensure that the committee uses its time and resources to adequately manage the activities for each of its functional areas according to the established goals and objectives.

Minutes:

An assigned staff member records committee minutes for each committee meeting. Minutes include the name of the committee, date and list of members present along with a list of meeting guests, if applicable. The minutes reflect discussions, decisions and recommendations put forth by committee members. Committee members review and approve all minutes which are then signed by the committee chairperson or designee. Signed and approved minutes are maintained as per HAP CareSource's document retention policy.

HAP CareSource Joint Operations Committee (JOC)

Authority:

The primary purpose of the JOC, on behalf of the BoD, is to provide oversight of quality activities and their integration across the administration, health plan, communities and participating providers which includes review and approval of the QAPI Program Description, QI Work Plan, QAPI program evaluation and ongoing monitoring of QI activities, inclusive of Delegation Vendor Oversight and monitoring of delegated entities.

Reports to: HAP CareSource BoD

Frequency of Meetings: Quarterly, or more frequently if necessary.

Scope of Committee:

- Annual review and approval of the QAPI program description, QI Work Plan and QAPI Program Evaluation.
- Ongoing monitoring of Value Based Payment Arrangements.
- Ongoing monitoring and oversight of the HAP CareSource's Population Health Management Strategy and related activities.
- Ongoing monitoring and oversight of the plan's Network Management activities.
- Ongoing monitoring and oversight of the plan's Utilization Management activities.
- Ongoing monitoring and oversight of the plan's Credentialing activities.



- Ongoing monitoring and oversight of the plan's Member Experience NCQA standard requirements and activities.
- Delegation Vendor Oversight activities.

Voting Membership:

- Joint Venture Governance Lead – Chairperson
- Chief Medical Officer
- Market President
- Senior Director of Quality and Population Health
- Director of Provider Contracting
- Director of Grievances and Appeals
- Director of Utilization Management
- Director, Care Management
- Director, Member Services
- Director, Credentialing

Quality Enterprise Committee (QEC)

Authority:

The QIC has a dotted line to the Quality Enterprise Committee (QEC). 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 HAP CareSource members consistently meet 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.

Frequency of meetings: Quarterly or more frequently if necessary

Scope of Committee:

- Oversight of QI programs.
- Oversight of QI Work Plans.
- Oversight of health, safety, and welfare programs.
- Oversight of Enterprise Provider Advisory Committee (EPAC) activities.
- Provision of guidance on quality management priorities and projects.
- Oversight of market quality/performance improvement projects.
- Approval of evidence-based clinical practice guidelines, nationally recognized standards of care and preventive health guidelines.



- Oversight of enterprise NCQA readiness.

Quality Improvement Committee (QIC)

Authority:

The QIC is chaired by the HAP CareSource Market Medical Director. The committee provides leadership, oversight, and evaluation of the QAPI program, QI Workplan, and all quality related activities to ensure adherence to state, federal and accreditation requirements. The primary responsibility of the committee is to provide strategic direction, development and continuous monitoring of the annual program activities and quality/performance improvement projects.

Reports to: JOC

Frequency of Meetings: Quarterly, or more frequently if necessary.

Scope of Committee:

- Oversee the QAPI program and QI function.
- Review the QAPI program, its results and activities and recommend changes on an ongoing basis.
- Review and annually approve the QAPI Program Description, QI Work Plan, and the QAPI Program Evaluation.
- Oversee the development, execution, and evaluation of all PIPs.
- Review and provide recommendations on QI policies and procedures.
- Review and monitor key performance indicators.
- Review and monitor Model of Care performance metrics.
- Identify, develop, implement, and monitor corrective action plans for quality improvement purposes.
- Provide guidance and feedback to staff on quality management priorities, projects, and issues.
- Approve and monitor progress towards goals of the quality improvement projects and clinical studies, if applicable.
- Adopt clinical practice and preventive health guidelines, where appropriate, and assess performance.
- Maintains an active role in the overall QAPI program structure.
- Annual review of reports on the following committee and team activities:
 - Utilization management
 - P&T activities
 - HEDIS updates
 - CM and UM updates
 - Grievance & Appeals
- Ongoing evaluation of the over and underutilization of services.
- Monitor the impact of member health, safety and welfare interventions and



- outcomes. Identify opportunities to promote member safety and welfare.
- Monitoring of HEDIS, MLTSS, MCAHPS, CAHPS®, and other member and provider experience survey results, identify opportunities, and advise on improvement strategies.
 - Receive reports on opportunities for improvement from the Provider Advisory Committee.
 - Evaluate the effectiveness of implemented quality improvement activities and recommend interventions as necessary to improve member experience.
 - Monitor and promote continuity and coordination of care.
 - Monitor and promote availability and accessibility of network providers.
 - Oversight of the EPSDT services for Michigan Medicaid Members.
 - Ensure alignment with the HAP CareSource Michigan PHM Strategy.
 - Monitor NCQA accreditation readiness.
 - Identify health opportunity initiatives and recommend process improvement to advance health opportunities among the served Medicaid and HIDE SNP members.

Provider Advisory Committee (PAC)

Authority:

The PAC provides a forum for external providers with the opportunity to participate and inform the HAP CareSource QAPI program, discuss policy needs, program recommendations, and quality initiatives. The committee is comprised of market specific providers who are HAP CareSource participating providers and represent primary care and other HIDE SNP clinical specialties. The committee fosters discussion among practicing healthcare providers to discuss, review and make recommendations related to HAP CareSource new and revised medical policies, clinical practice guidelines, and clinical operational decisions. Through the PAC, the plan solicits input and expertise regarding new program development and changes to existing programs to ensure clinical operations remain relevant to practicing providers. The PAC also serves as a market level peer review council allowing for recommendations to ensure Member health, safety, and welfare through the review of critical incidents and adverse events that occur on a regular basis. The market Chief Medical Officer chairs the committee. Committee membership includes medical (physical health) and behavioral health directors and community providers.

Reports to: QIC

Frequency of Meetings: Quarterly, or more frequently if necessary.

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.
- Reviews critical incidents and adverse events as they occur on a regular basis and summary reports on at least quarterly basis. Monitors, recommends, and issues corrective action plans and protocols for remediable actions that provide guidance to providers in preventing or delivering appropriate responses to commonly experienced events or identified trends requiring opportunities for Member health, safety, and welfare improvement.

Michigan Health Opportunity Committee (MHOC)

Authority:

The MHOC operates under the Quality Management infrastructure, is chaired by the Population Health Director, and is accountable to the QIC. It provides oversight, strategy, and guidance for the population health management (PHM) program strategy across HAP CareSource to support prevention, wellness, and improved health outcomes.

Reports to: QIC

Frequency of meetings: Quarterly

Scope of Committee:

- Evaluate and analyze population profile needs and inform PHM program design based on population needs.
- Identify, implement, and monitor measures of effectiveness associated with PHM programs.
- Ensure program resource allocations and processes which include, but are not limited to data analytics, health disparities, community partnership, health education, health promotion, risk screenings, assessments, risk stratification, care management program design, interventions, addressing health literacy needs, advancing health equity.

Consumer Advisory Council (CAC)- Medicaid, Enrollee Advisory Council (EAC)-HIDE SNP

Authority:

The CAC and EAC offers HAP CareSource members a forum and a direct line of input to the health plan and is facilitated by the Consumer Experience and Community Outreach teams. The CAC and EAC provides summary reports to the HAP CareSource Board of Directors (BOD) and makes recommendations on the plan's improvement strategies to the Quality Improvement Committee. HAP CareSource encourages and ensures adequate member participation in the



quarterly CAC & EAC, at a minimum, accommodating virtual participation, providing meeting materials to attendees, providing meeting materials at a literacy level appropriate for participants, arranging transportation when appropriate, and providing childcare when appropriate.

Reports to: BoD, QIC

Frequency of meetings: Quarterly

Scope of Council:

- Focus on the health and well-being of HAP CareSource members by soliciting feedback and recommendations specific to quality of care and services, access to and availability of care, and member experience.
- Review member education materials and benefits, as needed.

Utilization Management/Care Management Committee (UMCMC)

Authority:

The UMCMC is co-chaired by the market Vice president of Clinical Operations and market Chief Medical Officer. Committee is comprised of cross-functional leadership and integrates UM, CM and QI, reporting its findings and activities to the QEC. The UMCMC reviews and approves UM, CM and LTSS program descriptions, workplans, and program evaluations.

Reports to: QEC & dotted line to Enterprise UMCMC

Frequency of meetings: Quarterly or more frequently if needed.

Committee Scope:

- Oversight of the UM, CM and LTSS programs.
- Ensure compliance with state, federal and accreditation standard requirements in the UM and CM program designs.
- Ensure that the integrated UM, CM and LTSS programs and program processes are developed to guarantee the quality of care provided to our members is consistent with standards of care, provided timely and consistently.
- Monitor and report utilization metrics, including any trends related to the over/underutilization of service, outcomes related to the utilization management and care management processes and initiatives.
- Discuss identified trends detected within the UM program data.
- Measure and monitor outcomes related to program designs, initiatives, and activities against set targets.
- Provide recommendations regarding programmatic enhancements,



- process improvement, and prior authorization requirements.
- Review reports and identify trends and opportunities for improvement specific to: UM, CM, LTSS, Transitions of Care, Clinical Call Center, Clinical Delegate activity and NCQA readiness.

Enterprise Provider Advisory Committee (EPAC)

Authority:

The purpose of the EPAC is to provide Chief Medical Officers, Clinical Quality, Policy & Appeals, Enterprise Medical directors, Behavioral Health Medical Directors, market medical directors and representatives from Clinical Operations, Pharmacy, Program Integrity, Quality, Utilization Management, and other stakeholders a forum for discussions and determinations related to:

- Standards of Care/ Evidence Based CareSource
- Clinical Practice Guidelines and Preventive Guidelines
- Standardization of the Potential Quality of Care (PQoC) concern case severity leveling system and review processes
- Review PQoC grievances and other critical incidents re: health, safety and welfare of the Medicaid and HIDE SNP members' data and trends previously reviewed and addressed by the PAC.
- Policy and procedure review specific to PQoC.
- 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 PQoC, sentinel events and health, safety, and welfare concerns.

Reports to: QEC with a dotted line to market QIC

Frequency of meetings: Quarterly or more frequently if needed.

Committee Scope:

- Review trends in quality of care, sentinel events, and member safety. Provide recommendations based on this review to the appropriate committees.
- Review and provide final approval of the Clinical Practice/Preventive health Guidelines.
- Establish criteria for leveling of PQoCs, inclusive of sentinel events and critical incidents. Ensure follow-up processes are established and followed.

Pharmacy & Therapeutics Committee (P&TC)

Authority:



The P&TC provides HAP CareSource administration of formulary management, inclusive of specialty drugs. The P&TC, which includes provider review panel, determines 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.

Reports to: QEC

Frequency of meetings: Quarterly or more frequently if needed.

Committee Scope:

- Develop and maintain formularies to ensure the pharmaceuticals covered are effective and safe and review annually at a minimum.
- Review new drugs and chemical entities, drug classes, new clinical indications, therapeutic advantages, and new safety information within six (60 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.
- Complete final review of the VAC formulary placement determinations.

Enterprise Utilization Management/Care Management Committee (UMCMC)

Authority:

The UMCMC is co-chaired by the market Vice president of Clinical Operations and market Chief Medical Officer. Committee is comprised of cross-functional leadership and integrates UM, CM and QI, reporting its findings and activities to the QEC. The UMCMC reviews and approves UM, CM and LTSS program descriptions, workplans, and program evaluations.

Reports to: QEC & dotted line to Market UMCMC

Frequency of meetings: Quarterly or more frequently if needed.

Committee Scope:

- Oversight of the UM, CM and LTSS programs.
- Ensure compliance with state, federal and accreditation standard requirements in the UM and CM program designs.
- Ensure that the integrated UM, CM and LTSS programs and program processes are developed to guarantee the quality of care provided to our members is consistent with standards of care, provided timely and consistently.



- Monitor and report utilization metrics, including any trends related to the over/underutilization of service, outcomes related to the utilization management and care management processes and initiatives.
- Discuss identified trends detected within the UM program data.
- Measure and monitor outcomes related to program designs, initiatives, and activities against set targets.
- Provide recommendations regarding programmatic enhancements, process improvement, and prior authorization requirements.
- Review reports and identify trends and opportunities for improvement specific to: UM, CM, LTSS, Transitions of Care, Clinical Call Center, Clinical Delegate activity and NCQA readiness.

Enterprise Compliance Committee (ECC)

Authority:

The ECC provides oversight of HAP CareSource's Ethics and Compliance program.

Reports to: QEC

Frequency of meetings: Quarterly or more frequently if needed.

Committee Scope:

- Review and evaluate the enterprise compliance program including 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 and Compliance, Fraud Waste and Abuse (FWA) training to ensure effectiveness and completion.
- Ensure a system for staff and First Tier, Downstream and Related Entities (FDRs) for inquiries and reporting of potential program non-compliance.
- Review the effectiveness of Program Integrity Plan.
- Review, assess and guide appropriate actions regarding reports from both internal and external compliance audits.
- Review and evaluate key compliance indicators of compliance performance of significant risks.
- Provide support and advisement to the Enterprise Compliance Officer to ensure appropriate resources, actions, information, and personnel are engaged to support an effective program.
- Review and address results of reports of monitoring and auditing 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.



Clinical Policy Governance Committee (CPGC)

Authority:

The CPGC is the official governing body charged with the approval of new or revised clinical policies that relate to medical necessity determinations and is chaired by the Enterprise Medical Director – Clinical Operations. The CPGC is responsible for determining whether the proposed clinical policy is clearly defined, is clinically evidence-based, assures a high level of members' safety and quality of care, and articulates business value. In addition, the New Medical Technology Subcommittee, as part of the CPGC, evaluates new or emerging technologies. The Subcommittee conducts quality & safety assessments of the proposed technology. Recommendations from this group follow the current workflow of CPGC.

Reports to: QEC

Frequency of meetings: Quarterly or more frequently if necessary

Scope of Committee:

- Develop and maintain Medical Policy Statements which 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 case management functions of HAP CareSource.
- Coordinate peer review of Medical Policy Statements by appropriate providers.

Provide clinical policy recommendations and solicit input from Medical and Behavioral Health Directors.

Credentialing Committee (CC)

Authority:

The CC 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 make decisions based on the information presented through thoughtful and meaningful discussion. Discussion and decisions are documented in the meeting minutes.

Reports to: HAP Clinical Quality Management Committee (CQMC)

Frequency of meetings: At least 12 times per year.

Communication between Committees

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

IV. Resources Dedicated to HAP CareSource QAPI Program

ENTERPRISE RESOURCES

Executive Vice President (EVP) – Enterprise Chief Medical Officer

The EVP and Chief Medical Officer are responsible for the overall direction of all clinical programs, including the QAPI Program, and is also a member of and provides oversight to the Executive Council, Physician Advisory, Credentialing, and Pharmacy and Therapeutics Committees. The EVP and Chief Medical Officer have the responsibility to oversee the activities of the Market dedicated Physical Health and Behavioral Health Medical Directors and is responsible for oversight and direction of all physician reviewers and those serving on peer committees. The EVP and Chief Medical Officer facilitate participation of practitioners/providers in the overall QAPI 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 oversee the operations of the Enterprise Quality Improvement Department and is responsible for the execution and coordination of QI 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 EVP and Chief Medical Officer and Executive Leadership Team.

Associate Vice President (AVP), Quality Reporting and Analytics

The AVP of Quality Reporting and Analytics leads enterprise strategy and support for the quality infrastructure needed to drive performance across health plans. This



role supports regulatory compliance, strengthens reporting and analytics capabilities, and advances execution of multi-product and multi-plan beneficiary experience initiatives across multiple data and engagement modalities.

Associate Vice President (AVP), Pharmacy

The AVP of Pharmacy oversees prescription drug benefits, cost management, and compliance with Centers for Medicare & Medicaid Services (CMS) requirements. This role manages formulary strategy, supports negotiations with Pharmacy Benefit Managers (PBMs), and advances quality performance across CMS Star-rated Part D measures. The AVP also supports Quality Improvement initiatives designed to maximize CMS Star Ratings, including efforts to improve medication adherence for diabetes, cholesterol, and hypertension.

Associate Vice President (AVP) Enterprise Quality Assurance and Accreditation

The AVP Enterprise Quality Assurance and Accreditation oversees Enterprise systems and resources that support market-based Quality Programs, organizational goals, accreditation compliance, excellence, and alignment of industry innovations with organizational needs. This role manages Enterprise Quality Advisors who support performance and process improvement through IHI projects and training, facilitates the Quality Enterprise Committee and New Medical Technology Committee, provides enterprise guidance, partners with markets to scale improvement strategies, and manages the Quality Innovation team's vendor relationships to close member gaps in care.

Associate Vice President (AVP), Grievance and Appeals

The AVP of Grievance and Appeals oversees the plan's formal dispute and complaint processes. This role ensures compliance with Medicare requirements by managing coverage denials, quality-of-care complaints, and required reporting to the Centers for Medicare & Medicaid Services (CMS). The AVP also monitors complaint trends to identify operational or network issues, ensures cases are resolved within required regulatory timeframes, and maintains the documentation needed to support compliant case handling.

Associate Vice President (AVP), Integrated Care & Clinical Operations

The AVP of Integrated Care & Clinical Operations provides clinical expertise and oversight into Case Management activities, inclusive of LTSS management. Evaluate caseloads, ensure compliance with all regulatory compliance. Works collaboratively with quality partners in advancing health equity and drives performance improvement through Case Management activities. Has oversight of the Model of Care framework across the clinical operations department.



Associate Vice President (AVP), Customer Care

The AVP of Customer Care oversees call center operations, manages member inquiries, and supports the resolution of benefit and claims-related issues. This role ensures compliance with Centers for Medicare & Medicaid Services (CMS) guidelines, improves operational workflows, and uses call analytics to identify member pain points. The AVP also monitors key performance metrics, including Average Speed of Answer (ASA), and partners with clinical, pharmacy, and billing teams to resolve escalated issues, reduce barriers to care, and improve access to prescription drugs.

Associate Vice President (AVP), Quality Reporting and Analytics

The AVP of Quality Reporting and Analytics leads enterprise strategy and support for the quality infrastructure needed to drive performance across health plans. This role supports regulatory compliance, strengthens reporting and analytics capabilities, and advances execution of multi-product and multi-plan beneficiary experience initiatives across multiple data and engagement modalities.

Senior Director, Quality Enterprise Strategy

The Senior Director, Quality Enterprise Strategy, is responsible for ensuring effective execution of Enterprise Quality Programs, Activities, Work Plans and Compliance with CMS and market-specific guidelines to achieve Enterprise Quality Improvement goals. It is the Director, Enterprise Quality Improvement Programs' responsibility to influence quality outcomes through assisting in the development, implementation, and monitoring of strategies to improve HEDIS, NCQA, and Health Plan rating program results. The Director, Enterprise Quality Improvement Programs collaborates with Market QI Directors and Senior QI Directors to support activities for STARS Measures Performance Improvement Programs and Provider Engagement strategies to close 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.

Senior Director, Consumer Experience

The Senior Director of Consumer Experience is responsible for executing the enterprise-wide Consumer Experience (CX) strategy and roadmap to achieve unparalleled consumer experience. They lead the creation of baseline measures, insights-driven recommendations, and Return on Investments (ROI) estimates against programs and initiatives that drive positive consumer experience. Lead the CX team that focuses on gathering consumer research/insights, consumer analytics, and performance measures; leverage digital business strategy to enable growth, quality, beneficiary retention, and consumer loyalty for the enterprise. Lead stakeholder teams to drive innovation and overall improvements for consumers and health partners.

Regional Vice President (RVP), of Care Management

The RVP of Care Management provides clinical expertise and oversight into Care Management activities. Evaluate caseloads, ensure compliance with all regulatory compliance. Works collaboratively with quality partners in advancing health equity and drives performance improvement through Case Management activities.

Enterprise 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.

Director, Quality Enterprise Strategy

The Director, Quality Enterprise Strategy, is responsible for aligning and executing organization-wide quality initiatives to meet regulatory standards set by the Centers for Medicare & Medicaid Services and market-specific requirements. The role drives performance improvement across key measurement frameworks, including HEDIS, National Committee for Quality Assurance programs, and Medicare Advantage Star Ratings. In close collaboration with market quality leaders, the Director Quality Enterprise Strategy provides strategic oversight for performance improvement initiatives, including Stars measure optimization and provider engagement efforts. Focused on closing gaps in care, improving clinical outcomes, and ensuring a consistent, enterprise-wide approach to quality improvement.



MARKET RESOURCES

President, Market

Market President holds an executive position within HAP CareSource and is authorized and empowered to represent HAP CareSource regarding all matters pertaining to the health plan.

Market Medical Director

Market Medical Director is a physician with an active medical license in the state of Michigan and is responsible for the coordination and implementation of the QAPI Program and all aspects of health services utilization and clinical strategies. The Market Medical Director chairs the quarterly QIC, PAC, MHOC, UMCMC, and is an active participant in various enterprise-wide subcommittees (IMSC, CPC, etc.). The Market Medical Director 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 conduct 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.

Population Health Director

The Population Health Program Director designs, implements, evaluates, and provides oversight to the Population Health Strategy through the integration of quality improvement science methodologies ensuring that the strategy aligns with the State Quality Strategy and population needs.

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 SYSTEMS³

The HAP CareSource Health Information Systems (HIS), in accordance with 42 CFR §§ 438.242(a) and (b), is used to collect, analyze, and integrate data that informs the HAP CareSource QAPI Program on areas of opportunity to pursue. The plan's HIS also supports all aspects of the Medicaid & SNP MOC. 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 data (vendor)
- Provider Credentialing database
- Encounter data submissions to regulatory entities, including State and Federal as requested or required.
- Analytic data view
- Encounter data view
- Enterprise Data Warehouse
- Clinical authorization and Care Coordination data

³ MDHHS State Medicaid Agency Contract Section 7.4



- Bi-directional data sharing such as Admissions-Transfers-Discharges (ADT) feeds, Health Information Exchange (HIE)
- Supplemental data feeds such as lab data, ancillary vendor, or provider data.
- State and regional demographic 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 QI activities, focused studies, QIPs, PIPs, CCIPs, incentive programs, value-based reimbursements (VBR), and other QI -related activities and initiatives.
- Interface with state of Michigan HIE to share data and information and maximize data integration or provider electronic health record (EHR) systems.
- Integration of state of Michigan HIE and immunization registries to obtain file extracts to supplement clinical data.
- Provider portal platform which allows bi-directional data and information sharing.
- Member portal platform which hallows bi-directional data and information sharing.

V. QAPI Program Systems and Program Components

CLINICAL PRACTICE GUIDELINES⁴

The evidence-based Clinical Practice Guidelines (CPG) and Preventive Service Guidelines (PSG), which include physical health (PH), behavioral health (BH), oral health, and the delivery of LTSS, stem from recognized organizations or are developed with the involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of services and are relevant to the served Medicaid and HIDE SNP populations. The plan's CPGs and PSGs do not contradict existing state of Michigan promulgated statues, policies or requirements published by the Departments of Community Health, Human Services, Licensing and Regulatory Authority, Insurance and Financial Services or other State agencies.

⁴ MDHHS State Medicaid Agency Contract Section 7.13



Prior to being recommended for use, CPGs and PSGs are reviewed by the plan's Medical Director(s), practitioners, and network providers. CPGs and PSGs are reviewed, revised, as appropriate at least every two (2) years. CPGs and PSGs may be reviewed, revised, and presented for adoption and approval more frequently based on changes in national guidelines, changes in valid and reliable clinical evidence or consensus of health care professionals and providers. Adoption of CPGs and PSGs is approved by applicable medical committees. HAP CareSource notifies network providers of the availability and location of the guidelines and upon any changes or revisions. Approved CPGs and PSGs are disseminated to HAP CareSource's provider network, inclusive of new network providers, and are made available on the plan's website. The health plan submits a listing and description of CPGs and PSGs (if applicable) adopted, endorsed, disseminated, and utilized upon request.

SPECIAL NEEDS PLAN MODEL OF CARE⁵

HAP CareSource develops, implements, maintains, and monitors the Special Needs Plan (SNP) Model of Care (MOC) in accordance with 42 CFR §422.101(f) and §422.152(g) and Section 1856(f)(7) of the Patient Protection and Affordable Care Act. The SNP MOC serves as an operational infrastructure for care management processes and systems that enable HAP CareSource to provide coordinated care for special needs Members. HAP CareSource submits the SNP MOC to CMS for NCQA evaluation as required but not less than every three (3) years or more often if substantive changes to the plan's MOC infrastructure occur. HAP CareSource's SNP MOC focuses on:

- Description of the target SNP population's general population profile.
- Infrastructure to determine, verify and track eligibility.
- Identification of the most vulnerable Members.
- Establishing community partnerships to address the needs of the most vulnerable Members.
- Roles, responsibilities, and qualifications of clinical and administrative staff that work with the HAP CareSource Members.
- Care Management processes; Health Risk (re)assessments, completion of an individualized care plan, face to face encounters as per 42 CFR §422.101(f)(1)(iv), involvement of an interdisciplinary care team in the care of the HAP CareSource Members, care transitions protocols.
- HIDE-SNP specialized expertise in the plan's provider network.
- Use of Clinical Practice Guidelines and Care Transition Protocols by network providers and practitioners.

⁵ CMS (2025), Medicare Managed Care Manual. Chapter 5 – *Quality Assessment*.



- Development, implementation, and oversight of initial and annual completion of the SNP MOC education internally and across in and out-of-network providers and practitioners.
- Quality Measurement and Performance Improvement through the development of a Quality Performance Improvement Plan, identification and tracking of measurable goals and health outcomes for the HIDE SNP Members, measuring Member experience and continuous quality improvement evaluation.

HAP CareSource's SNP MOC emphasizes health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on Health-Related Social Needs (HRSN) and the Social Determinants of Health (SDoH) which drives advancements in Health Equity and support in building resilient communities.

EXTERNAL QUALITY REVIEWS⁶

In accordance with 42 CFR §438.358, 42 CFR Part 476 and Section 1152 of the Social Security Act HAP CareSource fully cooperates and supports any external evaluations and assessments of its performance conducted by the MDHHS's contracted External Quality Review Organization (EQRO) and CMS designated Quality Improvement Organization (QIO) and/or other MDHHS approved activities deemed necessary. On at least tri-annual basis, HAP CareSource will comply with the comprehensive EQR compliance with standards set forth in 42 CFR §438 subpart D, the disenrollment requirements and limitations described in 42 CFR §438.56, the Member rights requirements described in 42 CFR §438.100, the emergency and post-stabilization services requirements described in 42 CFR §438.114 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. HAP CareSource addresses any external quality review (EQR) findings through the QAPI program process through the development and implementation of performance improvement goals, objectives, and activities.

QUALITY IMPROVEMENT PROJECTS⁷

HAP CareSource conducts quality improvement projects (QIP) that focus on clinical and non-clinical areas including any performance improvement projects (PIP) and, in accordance with 42 CFR §422.152(a)(2) and (c), chronic conditions improvement programs (CCIP)⁸ required by CMS, MDHHS and in alignment with the plan's Medicaid and SNP MOC and relevant to our Medicaid and HIDE SNP populations.

⁶ MDHHS State Medicaid Agency Contract Section 7.10

⁷ Ibid Section 7.9

⁸ CMS (2025), Medicare Managed Care Manual. *Chapter 5 – Quality Assessment.*



Health plan's QIPs, PIPs and CCIPs meet all relevant CMS and MDHHS requirements that are intended to achieve significant improvement, sustained over time in health outcomes and Member satisfaction. HAP CareSource works collaboratively with EQRO, MDHHS, CMS and QIO to satisfy the QIP, PIP and CCIP requirements while reducing administrative burden.

Performance Improvement Projects

HAP CareSource collaborates with MDHHS and other Medicaid and HIDE SNP impacting stakeholders to determine priority areas for statewide PIPs and, when required, redirects PIPs to address priority shift per State requirements or directives. Each PIP will include:

- Measurement of performance using objective quality indicators.
- Implementation of culturally competent interventions to achieve improvement in the access to and quality of care.
- In accordance with 42 CFR collect information and data.
- Evaluation of the effectiveness of the interventions based on the performance measures required by MDHHS and reported to EQRO in accordance with 42 CFR §438.330(d).
- Planning and initiation of activities for increasing or sustaining improvement.

HAP CareSource reports on the status and the results of each Medicaid and HIDE SNP PIP to MDHHS as requested, but not less than annually. The health plan's Medical Director reviews trends of PIP performance and forwards to the QIC for review and recommendations. HAP CareSource providers receive results of the PIPs to encourage input for CQI strategies.

Chronic Conditions Improvement Program

HAP CareSource complies with program requirements outlined in the Medicare Managed Care Manual Chapter 5 and in accordance with CFR §422.152(a)(2) and (c) specific to the design and implementation of a relevant CCIP. Objective of CCIP is to promote effective chronic condition/disease management and to improve the care and health outcomes of the HIDE SNP population. Understanding the vulnerability of the HIDE SNP Members, population relevant CCIP allows for the diffusion and sustainment of effective management of chronic conditions which can lead to positive outcomes such as slowing disease progression, reducing condition-related complications, morbidity, and/or mortality, reducing preventable emergency room utilization, inpatient admissions, and unplanned readmissions. The purpose of the CCIP relevant to the HIDE SNP is to optimize quality of life and reduce unnecessary cost of care.

The plan complies with the two (2) parted CCIP activities: (1) The Plan Section which allows the plan to describe the criteria for the CCIP, describe methodology



used for identifying participating members, mechanisms for monitoring Members and performance assessments; and (2) The Annual Update which requires HIDE SNP plan to report to CMS through HPMS reporting using CMS prescribed reporting template on the progress of implementing the three (3) year recommended CCIP. The health plan conducts activities in the CCIP design implementation and uses CMS recommended PDSA QI methodology for implementation and monitoring of the program.

SERVING MEMBERS WITH COMPLEX HEALTH NEEDS

HAP CareSource addresses the complex healthcare needs of the most vulnerable Members which includes members with LTSS, BH, substance use disorders (SUD) and intellectual/developmental disabilities (I/DD). The plan identifies the most vulnerable population and tailors services accordingly and in alignment with the Medicaid and SNP MOC requirements. The plan employs ongoing assessment of the Medicaid and HIDE SNP population profile and needs through annual population profile assessment which incorporates member claims data and internal analytics support. Data extrapolated specific to the Medicaid and HIDE SNP populations is derived from the plan's risk stratification process which identifies and quantifies vulnerability within the served population.

Additional information considered in the identification of members with complex health needs expands on the demographic data identifying vulnerability of members at highest risk for negative impact of HRSN and SDoH on their health outcomes. Predictive modeling risk stratification is superseded by stratification based on completed health risk assessments. HAP CareSource has systems in place to assess the quality and appropriateness of care provided to LTSS members, including, but not limited to assessment of care between care settings; comparison of services and supports received with those set forth in member's service plan.

MEMBER SAFETY AND WELFARE^{9,10}

Member safety is paramount to the QAPI Program design. HAP CareSource maintains processes and systems to ensure member health, safety and welfare that is integrated across the plan. The plan's Critical Incident Management processes consist of policies and procedures that identify, report, review, and manage Critical Incidents and Adverse Events. The plan also participates in efforts by the State to prevent, detect, and remediate Critical Incidents that are based, at a minimum, on the requirements of for the home and community based (HCBS) waiver programs per 42 CFR §441.302(h).

⁹ MDHHS State Medicaid Contract Section 16

¹⁰ 42 CFR §§ 441.302 and 441.730 (a), 42 CFR § 441.302(h)

¹¹ MDHHS State Medicaid Contract Section 7.3



HAP CareSource strives to ensure that all network providers, Medicaid and HIDE SNP members and their families (if applicable) receive proper education and training on topics, issues, and procedures for identifying, preventing, and reporting Critical Incidents including how to identify and reporting events when they occur.

The health plan designates a Critical Incident manager responsible for the administering, management, and oversight of the Critical Incident management system. The plan designates a multi-disciplinary committee under the leadership of the Chief Medical Officer to review Critical Incidents and Adverse Events that implements and monitors needed corrective actions if action is remediable.

POPULATION HEALTH MANAGEMENT

On an annual basis, the health plan completes a comprehensive population profile assessment to evaluate appropriateness and availability of internal and external resources and programs against assessed population characteristics and subsequent needs. Population assessment includes member demographic data, utilization trends (including over and underutilization), segmentation disease burden, geographic distribution, cultural assessment (race/ethnicity, preferred languages, and cultural diversity), age distribution and evaluation of HRSN and SDoH. Population assessment findings allow HAP CareSource to identify opportunities for improvement in the current program(s) structure and provisions of service. The health plan uses the assessment to identify population-based healthcare services focusing on prevention and wellness, mitigation of emerging health needs, member safety and outcomes across settings and management of chronic conditions.

The health plan evaluates the assessed data and identifies programs and initiatives to benefit the Medicaid and HIDE SNP populations as a whole as well as tailored services for the most vulnerable enrollees. Subsequently, the plan incorporates selected programs into the Population Health Management Strategy (PHMS). HAP CareSource's PHMS is comprehensive and meets the care needs of all Members across the continuum of care with a strong focus on advancing health equity¹¹. It includes programs and initiatives that are directed towards members, providers, and communities. PHMS programs may be member interactive or non-interactive with ultimate goal of assisting members in achieving their personal health goals. Non-direct member programs focus on collaboration with providers and communities to improve utilization of preventive service, improve morbidity and mortality and lower cost of care through more efficient and effective utilization management practices and member management.

EARLY & PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT PLAN (EPSDT)

The health plan complies with section 1902(a)(43); 1905(a)(4)(b) and 1905(r) of the social security act and 42 C.F.R. Part 411 subpart b of the federal regulations which



describe the plan's obligation to include necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions for the Michigan Medicaid members 0-21 years of age. HAP CareSource, under the early and periodic screenings, diagnostics and treatment (EPSDT) program, offers, without limitations, periodic health screenings as recommended by American Academy of Pediatrics (AAP) and appropriate and up-to-date immunizations using Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule.

HAP CareSource strives to optimize EPSDT service utilization for the eligible Michigan Medicaid members through a robust governing EPSDT program process which includes member/parent/guardian engagement strategies, provider of EPSDT service utilization as per periodicity schedule. HAP CareSource collects data and submits the CMS-416 report annually.

PREVENTION AND WELLNESS¹²

HAP CareSource works to improve member health status through a culturally diverse and competent approach to prevention and wellness informed by member life experiences, personal preferences, and desires. Prevention and wellness initiatives and activities are based on the plan's PHMS and strategic imperatives. Activities integrate telephonic and mailing outreach efforts along with educational programs for all members. HAP CareSource collaborates with communities, providers, and schools. Prevention and wellness activities are integrated with the HAP CareSource's PHM Strategy.

ACCREDITATION¹³

HAP CareSource is a Medicaid Health Plan Accredited plan inclusive of the Medicaid Module and holds the LTSS Distinction issued by the National Committee for Quality Assurance (NCQA). The health plan will also pursue and maintain the Health Equity Accreditation through NCQA as per MDHHS' s contractual requirements but no later than the end of the second full calendar year of operations (2027). HAP CareSource will maintain all required accreditations throughout the life of the contract with MDHHS. The health plan's Medical Director and the QI director are responsible for monitoring accreditation activities and presenting findings, as needed, to the HAP CareSource QIC.

The Quality department is responsible for ongoing auditing and monitoring of policies, procedures, and processes for compliance with the most current

¹² MDHHS State Medicaid Contract Section 6.10

¹³ Ibid Section 7.11



accreditation standards and requirements published by CMS, State and/or Federal regulators and the Affordable Care Act (ACA), if applicable.

The Quality department actively works across the business areas to identify and correct deficiencies, and/or process shifts. The HAP CareSource Michigan Medical Director and Michigan Quality Improvement Senior Director are responsible for monitoring these activities and presenting findings, as needed, to the QIC.

HAP CareSource authorizes NCQA to provide the State with all information specified in 42 CFR §438.332(b) and 42 CFR §457.1240(c).

ADDRESSING CULTURALLY & LINGUISTICALLY DIVERSE POPULATIONS

HAP CareSource serves a diverse and vulnerable population. The plan takes immense pride in being able to acknowledge and provide services to its members from various cultural backgrounds. The plan's QAPI program is fully integrated with the plan's Health Opportunity and Cultural Competency program. HAP CareSource operates under the National Standards for Culturally and Linguistically Appropriate Services in health and health care (the National CLAS standards).

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

The plan works diligently to ensure cultural competency across our Provider Network. On an annual basis the plan formally assesses the cultural, ethnic, racial, and linguistic needs of Medicaid and HIDE SNP members and adjusts the availability of providers within its network, as applicable, to align to the diversity of the served population.

¹⁴ Ibid, Section 9.8(B)(a)(i)(ii)(iii)(iv) and (b)



The health plan complies with the following requirements specific to linguistic competency:¹⁴

- The provision of care, including twenty-four (24- hour telephone access and scheduling appointments, by providers who are fluent in both English and the language spoken by the member, or through translation services performance by individuals who are trained to translate in a medical setting; are fluent in English; and are fluent in the member's language.
- Linguistically appropriate pharmacy, specialty, behavioral health, and LTSS providers.

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

- Quarterly Member Advisory Boards.
- Adoption of the HAP CareSource HSW Program.
- Availability of member materials in prevalent languages other than English as per contractual requirements.
- Interpreters available for Limited English Proficiency and Special Needs populations.
- 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 Provider Network.
- Americans with Disabilities Act.
- Work Connect.
- Medical Assistance Fund.
- Non-emergent Medical Transportation.

CARE COORDINATION PROGRAM^{15,16}

HAP CareSource's integrated Care Coordination program ensures effective integration and coordination between providers of medical services and supplies, BH, SUD and/or I/DD, pharmacy, and LTSS. The plan's program provides full spectrum of integrated care, including coordinating care along the continuum of health and well-being. Principles of the program are to maintain or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum.

¹⁵ Ibid Section 6

¹⁶ CMS, (2025). Medicare Managed Care Manual. *Chapter 5 – Quality Assessment*.



HAP CareSource's Care Coordination program is aligned with the requirements of the plan's Medicaid and SNP MOCs in accordance with 42 CFR §422.101(f) and MDHHS which includes prescriptive guidance on Care Coordination program requirements such as, but not limited to:

- Timely and complete completion of initial Health Risk Assessment.
- Timely and complete completion of an annual and/or change in health status appropriate Health Risk Re-assessment.
- Annual and/or change in health status or transition between setting Medication Review and Reconciliation.
- Development and implementation of an Individualized Care Plan focused on opportunities for members to choose arrangements that support self-determination.
- Identification of key stakeholders and implementation of an Interdisciplinary Care Team (ICT).
- Providing face-to-face encounters for the delivery of health care and care coordination services on at least an annual basis and within the first 12 months of enrollment.
- Coordination of the delivery of care through care transitions protocols.
- Collaborating with Prepaid Inpatient Health Plans (PIHP) to address at a minimum, processes for member referrals, access to and coordination of care to ensure continuity of care for Members served by the plan and the PIHPs.

The integrated Care Coordination program uses innovative care delivery models and provides a range of community-based services in an effort to promote independent living and alternatives to high-cost institutionally based services.

HAP CareSource will exhaust the use of community-based services before utilizing institutional settings for LTSS.

HAP CareSource recognizes and has built a program to address access, care coordination, and Care Management throughout contracted Michigan regions. HAP CareSource empowers members by allowing them to take charge of their own care with the support of effective care management. This includes access to a diverse provider network and a system of CBOs tailored to a member's unique needs. Through on-demand tools, members can learn about their health conditions, connect with local services and resources, and receive streamlined support through care management.

A key aspect of the HAP CareSource ICM Program is addressing health care and health equity disparities. This program identifies and addresses barriers that may prevent members from accessing care and treatment due to factors like race,



ethnicity, gender, sexual orientation, age, disability, socioeconomic status, geographic region, as well as HRSN/SDoH such as food insecurity, access to stable housing, and employment status. HAP CareSource provides CLAS to ensure members receive care that aligns to their cultural and linguistic needs.

Additionally, CM mitigates disparities in HRSN/SDoH by providing assistance and referrals to available supportive services including those provided by Community and Faith based organizations.

The CM Program includes outreach to conduct a Health Needs/Risk Assessment (HNA/HRA) for all members within specified timeframes to identify their needs and determine eligibility for CM services. The program is committed to using predictive modeling tools to stratify members by risk and identify those who may require additional support. Furthermore, the program ensures continuity of care and effective communication with all stakeholders involved in a member's care, including discharge planning and coordination of services between settings.

Proactive outreach and engagement with members are essential components of the program, utilizing various methods to ensure members are connected to the care they need.

DELEGATION VENDOR OVERSIGHT

CareSource may delegate to designated contractors' responsibilities for specific function(s) such as, but not limited to credentialing, recredentialing, care management, call center operations, coordination of benefits, claims administration, member functions/experience, provider functions and utilization management. To ensure consistent delivery of high-quality, compliant care across all contracted entities, CareSource maintains a robust Delegation Vendor Oversight Program that aligns with applicable regulatory, contractual, and accreditation requirements. This oversight program ensures that any delegated activities are executed in accordance with state and federal standards, contractual obligations, accreditation requirements, and evidence-based practices.

CareSource ensures that the delegated functions a subcontractor performs are monitored and audited. Delegation Vendor Oversight requirements include the following:

- Delegation determination
- Predelegation Assessments
- Ongoing monitoring to include:
 - Scorecard monitoring of contractual and regulatory SLAs
 - Deficiency process, which will include vendor to supply root cause analysis and remediation planning



- Enforcement of applicable penalties
- Annual Audit

CareSource's policies and procedures governing delegation require all delegation arrangements to be supported by a written delegation agreement, which outlines the responsibilities of the parties, defines their relationships and scope of responsibilities, specifies how the delegate's performance will be monitored and sets forth remedies if either party is not meeting contractual obligations in accordance with State Requirements, CMS requirements, and NCQA requirements.

BEHAVIORAL HEALTH

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. Behavioral Health Pop Stream Meetings meet regularly to review and evaluate results. Initiatives and interventions are modified as required to ensure member behavioral health needs are met.

CUSTOMER CARE¹⁷

The Member Services department provides telephonic, chat, application, and web support to the HAP CareSource members (current and potential), authorized representatives, and providers. The plan's member services teams recognize that each Medicaid and HIDE SNP member has a unique need and deserves to be treated with dignity, kindness, and care. HAP CareSource's member services training plan, Interactions with Heart, is designed to support the team members in building personal relationships that empower members to manage their health and build trust in the plan. The Member Services department adheres to contractually required performance metrics such as, but not limited to:

- Total call volume.
- Average call length.

¹⁷ MDHHS State Medicaid Agency Contract Section 10.2



- Average hold time.
- Abandonment rate.
- Average response time (average speed of answer [ASA]).

Monitoring of member services performance metrics occurs daily through departmental leadership oversight. Formal performance trends are presented and evaluated against set targets on at least quarterly basis through the QI Committee Structure.

NETWORK MANAGEMENT¹⁸

Network Management is pivotal to ensuring access to care sufficient to provide all Medicaid and HIDE SNP members full range of Covered Services, including the appropriate range of preventive, primary care, and specialty services, BH services and other specialty services and services in accordance with 42 CFR §§422.112, 423.120 and 438.206, Medicaid Provider Manual and HIDE SNP 1915 (b) and (c) waiver applications. Through our network management operations, we ensure geographic distance, time travelled, provider to member ratios, and appointment availability standards prescribed by MDHHS, CMS or accreditation entity standards, whichever is the most stringent, are met. Industry standard software is used to compare provider networks against set standards and report any adequacy gaps to the regulatory bodies, as applicable. The plan monitors appointment availability across provider types on an ongoing basis. Monitoring activities may include provider surveys, provider direct calls, on-site visits, evaluation of member satisfaction surveys, evaluation of concerns/complaints/grievances and/or appears reports, evaluation of provider to member ratios and monitoring of closed primary care provider panels.

HAP CareSource works diligently to ensure cultural competency across our provider network to meet the culturally and linguistically diverse needs of the Medicaid and HIDE SNP members. Network management works cross-functionally towards minimizing the administrative burden for network provider administrative burden, inclusive of LTSS providers, in the areas of payment, prior authorization and coordination of care.

Monitoring and outreach include the following:

- Monthly Geo Analysis of provider networks using industry standard software.
- Reporting of network adequacy gaps to the appropriate market to trigger recruitment efforts.
- After hours and secret shopper calls conducted by outside vendor to monitor member access to care.

¹⁸ MDHHS State Medicaid Agency Contract Section 4



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

The health plan also monitors Provider Network through a medical record review process to ensure compliance with policies and procedures, specifications, and appropriateness of care consistent with the utilization control requirements outlined in 42 CFR Part 456. Medical record review process is proportionate to utilization by service type, including LTSS. HAP CareSource submits the medical record review process and the results to MDHHS annually.¹⁹

Provider Contracting and (Re)Credentialing^{20,21}

HAP CareSource's policies and procedures describe provider contracting practices and requirements in alignment with MDHHS, CMS and accreditation standard requirements for the provision of services for the Medicaid and HIDE SNP membership. Contracts with providers and organizational providers (e.g., hospitals, home health agencies, skilled nursing facilities, and other ancillary providers) are mutually acceptable and require cooperation with the plan's QI activities. Additionally, the plan's contracted providers and organizations allow HAP CareSource to use provider performance data for QI activities. The health plan contracts with high quality providers and organizations for the provision of care and service delivery. HAP CareSource ensures (re)credentialing activities and Delegation Vendor Oversight of FDR entities responsible for such activities is aligned with MDHHS, CMS and accreditation standard requirements. The health plan reviews, approves, and audits the credentialing process on an ongoing basis.

UTILIZATION MANAGEMENT²²

HAP CareSource maintains a well-structured Utilization Management (UM) program that is integrated with the QAPI program that supports the application of fair, impartial and consistent UM determinations. QI activities for the UM program align with State, CMS, and NCQA accreditation standards, and, at a minimum:

- Has industry standards compliant with written policies with review decision criteria.
- Incorporates the Utilization Review Committee into the HAP CareSource QI committee structure.
- Has sufficient infrastructure (people, systems, and processes) to review the

• ¹⁹ Ibid Section 7.2(C)(d)(iv)

• ²⁰ NCQA HP Standards, 2025. QI2A (1-2); QI2B (1-2)

• ²¹ MDHHS State Medicaid Agency Contract Appendix J

• ²² MDHHS State Medicaid Agency Contract Section 7.12



effectiveness of the utilization review process and apply changes as needed.

- Complete and annual review and reporting of utilization activities and outcomes and interventions resultant from the review.
- Has mechanisms to detect over and underutilization of services.
- Has a process to measure clinical reviewer consistency in applying clinical criteria to UM activities using inter-rater reliability.
- UM Delegation Vendor Oversight and program integrity.
- Is supported by policies and procedures for prior authorization approval, medical necessity criteria reviews, required health care professional qualifications in the UM decision making processes.

Medical Necessity Criteria

HAP CareSource formally adopts clinical criteria through a formal adoption process that is based on sound clinical evidence that allows the plan to determine the medical necessity and clinical appropriateness of services requiring approval. The plan's development (if applicable), review, and adoption of the medical necessity criteria involve appropriate providers with clinical expertise in the area being reviewed. The plan reviews and updates criteria against current clinical and medical evidence on at least annual basis and is no more restrictive than Medicaid and Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS and community mental health and SUD services. HAP CareSource makes the criteria available to providers on the plan's website, provider newsletters notifications and other provider communication modalities.

HAP CareSource Policies and Procedures

HAP CareSource policies and procedures are reviewed no less than annually and revised as necessary to ensure compliance with MDHHS, CMS, NCQA and other State and Federal requirements. Review and approval are completed by the functional business owner and further presented to the Policy Committee for review and approval.

VI. Clinical Measurement Activities: Process and Outcomes

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)²³

HEDIS is a set of standardized performance measures designed to evaluate and improve quality of care. The performance measures are related to many significant public health issues such as diabetes, cancer, and heart disease. HAP CareSource

²³ MDHHS State Medicaid Agency Contract Section 7.6(B)(D); Section 18.2(d)(e); Section 18.3(A)(a)(i)



cooperates with the Division's designated EQRO to validate the HEDIS reporting on required performance measures. HEDIS® is managed by NCQA. HEDIS audited summary level and patient-level data (PLD) is reported to NCQA and CMS, respectively.

Annually, HAP CareSource participates in the HEDIS® reporting by collecting, analyzing, and reporting all required performance measures to ensure that members have adequate access to care and are able to address all healthcare needs accordingly. Data is collected, evaluated, and compared to regional and national benchmarks. Based on the results and comparison data, HAP CareSource, through the QAPI program process(es) and in alignment with CQI principles, identifies and acts on opportunities for improvement. The plan complies with HEDIS® reporting specifications provided annually in the Michigan Medicaid contract and HIDE SNP Reporting Requirements Technical Specifications and annual Reporting Requirements. Health plan contracts with NCQA certified HEDIS audit firm on an annual basis to conduct the certified audit of HEDIS reporting compliance and submit the Final Audit Report (FAR) and calculated rates to MDHHS at time of submission to NCQA and CMS.

LONG TERM SUPPORTS AND SERVICES (LTSS)^{24,25}

HAP CareSource collects, monitors, and reports on measures related to LTSS provision. The LTSS performance dataset follows the NCQA required LTSS dataset collection and reporting specifications. The MLTSS measures are specifically designed to ensure that all relevant processes improve or maintain the health for the HIDE SNP LTSS Members. HIDE SNP specific MLTSS measures, in accordance with reporting requirements, focus on Falls Prevention and Rebalancing

LTSS. The plan also collects additional LTSS measures specific to Care Coordination activities and in alignment with the HAP CareSource's SNP MOC reporting requirements. HAP CareSource also assesses the quality and appropriateness of care furnished to Members using LTSS which includes an assessment of care between settings and comparative analysis of services and supports received against the ICP.

CMS CORE SETS^{26,27}

HAP CareSource collects, reports, and submits to NCQA and MDHHS Core Set of Adult Health Care Quality Measures for Medicaid annually. The plan contributes

²⁴ MDHHS State Medicaid Agency Contract Section 18.2

²⁵ Ibid Section 7.2 (C)(d)(x)

²⁶ Ibid Section 7.2 (C)(d)(i)

²⁷ Ibid Section 7.6 (F)



and supports state-level data reporting by MDHHS to CMS. HAP CareSource utilizes the required CMS Core Set of Adult Health Care Quality Measures for Medicaid to continually improve all aspects of healthcare delivery for the served membership as part of the QAPI program's CQI.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (MCAHPS®)^{28,29,30}

Medicare (M)CAHPS is a member satisfaction survey and a component of the HEDIS® scores. The MCAHPS® survey is a measurement tool used to report and evaluate Member experience with health care in the areas of service, access to care, claims processing and provider interactions. The survey includes health plan ratings and health plan composite groupings (Getting Needed Care, Getting Care Quickly, Care Coordination, Customer Service, etc). HAP CareSource uses the results of the MCAHPS survey as a tool to drive CQI. The survey is administered annually by an NCQA certified vendor. Health plan submits MCAHPS data and calculated rates directly to MDHHS at the time of submission to CMS via specifications identified by CMS and established by NCQA. The health plan includes additional supplemental questions as determined by MDHHS to the MCAHPS annual survey administration.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)³¹

CAHPS® is a member satisfaction survey and a component of HEDIS® scores. The CAHPS® survey is a measurement tool used to report and evaluate members' experience with health care in the areas of service, access to care, claims processing, and provider interactions. The survey includes health plan ratings and health plan composite groupings (Getting Needed Care, Getting Care Quickly, Care Coordination, Customer Service, etc.). HAP CareSource uses the results of the CAHPS® survey as a tool to drive CQI. The survey is administered by an NCQA certified vendor. HAP CareSource administers a child and adults CAHPS survey. HAP CareSource submits results from the CAHPS Child Medicaid Survey on access to specialized care and coordination of care from other health care Providers as per the Division's reporting requirements.

EPSDT CMS-416

HAP CareSource collects EPSDT program utilization to evaluate program effectiveness and to comply with all federal and state program requirements for the Medicaid program. On an annual basis, HAP CareSource submits the CMS-416 Annual EPSDT Participation Report.

²⁸ Ibid Section 7.2 (C)(d)(i)

²⁹ Ibid Section 7.6 (B)(D)

³⁰ Ibid Section 7.7 (A)

³¹ Ibid, Section 16.3.1



HEALTH OUTCOMES SURVEY (HOS)^{32,33} * HIDE Only

Health Outcomes Survey is 2-year cohort survey that collects information from Members and assesses plan's ability to maintain or improve Members' physical and mental health over time. The HOS is administered and managed by CMS. On an annual basis, HAP CareSource administers through the observance of reporting specifications through a CMS approved vendor, baseline HOS survey and a follow-up cohort survey to previously surveyed eligible Members. The plan uses the results to evaluate QAPI program effectiveness in the management of Member health status. HAP CareSource submits the baseline and follow-up cohort survey data reports to MDHHS annually.

PROVIDER EXPERIENCE SURVEY³⁴

As part of the QAPI program's framework of the IHI Quintuple Aim, HAP CareSource strives to enhance provider experience and reduce provider burden. HAP CareSource administers an annual Provider Experience Survey to its provider network to assess their experience with the plan specific, but not limited to:

- Overall satisfaction with the health plan
- Ease of billing/promptness of payment
- Prior authorization process
- Referral process
- Satisfaction with the plan's Provider Relations Department
- Satisfaction with the plan's Member Services
- Involvement in the plan's Care Coordination processes, including participation in the Interdisciplinary Care Team (ICT) and collaboration in developing and implementing Individualized Care Plans (ICP).

HAP CareSource administers the Provider Experience survey to all types of Network Providers, including BH and LTSS. The plan administers the survey through a third-party vendor, analyzes survey results annually and identifies and acts on opportunities for improvement.

MEMBER EXPERIENCE SURVEYS³⁵

HAP CareSource contributes to the statewide administration of Member experience surveys for Members utilizing LTSS, including, but not limited to CAHPS for Home and Community Based Services (HCBS) Survey.

³² MDHHS State Medicaid Agency Contract Section 7.2 (C)(d)(i)

³³ Ibid Section 18.2

³⁴ Ibid Section 7.8

³⁵ MDHHS State Medicaid Agency Contract Section 7.7 (A)



The health plan conducts a quality-of-life survey targeting adapted for general HIDE SNP membership and submits results to MDHHS upon request. HAP CareSource also utilizes additional Member experience surveys to inform CQI processes such as the:

- New Member Experience Survey
 - The New Member Experience Survey ensures members a clear understanding of their health plan benefits, including how to access services, use their health insurance, and reach member services.
 - Findings from the survey inform ongoing improvements in member onboarding and communications.
- Care Coordination Experience Survey
 - The CM Experience Survey evaluates members' satisfaction with CM services.
 - Feedback from this survey is used to measure the quality and effectiveness of CM services, identify quality improvement opportunities, and support the plan's quality and compliance goals along with the PHM strategy.
- Behavioral Health Experience Survey

The BH Experience Survey evaluates member experiences with network providers (prescribers and non-prescribers), as well as the plan's behavioral health benefits and services, including mental health and substance use disorder treatments.

- The survey results inform quality improvement opportunities and ensure member satisfaction of network providers and health plan benefits and services are effective and member centric.

The plan uses the experience survey in alignment with the NCQA approved Medicaid and SNP MOCs.

DISENROLLMENT SURVEY

HAP CareSource administers the Disenrollment survey to Members via phone and/or text within five (5) days of the Member disenrolling from the health plan. The health plan analyzes the quantitative and qualitative data, presents findings in its QI committee structure, and identifies opportunities for improvement to enhance member experience.

OTHER PROCESS/OUTCOME MEASURES³⁶

Understanding the multifaceted nature of quality and Member needs, HAP CareSource collects, monitors, reports and/or evaluates data from additional

³⁶ Ibid Section Appendix F



sources to continuously evaluate the quality of care and services of the Medicaid and HIDE SNP members such as:

- CMS Medicare Part C and Part D Reporting Requirements
- Member and Provider Grievance and Appeals data
- Encounter data timeliness and completeness
- Utilization trends
- Pharmacy utilization trends
- Member Service telephone statistics
- Nurse Line reports
- Feedback from external regulators and accrediting agencies
- Lifetime Hepatitis C Screening
- Hepatitis C Treatment
- Quality of Care concerns.
- Critical Incident reporting
- Appointment Availability survey results.
- Other Member experience surveys.

VII. Confidentiality and Conflict of Interest

All QI 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 persons are to participate in the review process of QI 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 participants sign a statement of this understanding.



VIII. Approvals

Brittnee S. Berry, MSN, RN

HAP CareSource of Michigan Quality
Improvement and Population Health, Senior
Director

Date: 03/19/2026

Lori Billis, M.D.

HAP CareSource of Michigan Medical Director

Date: 03/19/2026

HAP CareSource QIC Approval

Date: 03/19/2026



IX. Definitions

Acronym	Definition
AAP	American Academy of Pediatrics
ACA	Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
ADT	Admissions-Transfers-Discharge
ALOS	Average Length of Stay
AI/AN	American Indian/Alaska Native
APM	Alternate Payment Models
ASA	Average Speed of Answer
AVP	Associate Vice President
BH	Behavioral Health
BoD	Board of Directors
CAC	Consumer Advisory Council (CAC)
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBO	Community Based Organization
CC	Credentialing Committee
CCC	Children with Chronic Conditions
CFR	Code of Federal Regulations
CLAS	Culturally and Linguistically Appropriate Services
CM	Care Management
CMO	Chief Medical Officer
CMS	Center for Medicare and Medicaid Services



CPG	Clinical Practice Guidelines
CPGC	Clinical Practice Guideline Committee
CQI	Continuous Quality Improvement
CVO	Credentialing Verification Organization
CY	Calendar Year
EAC	Enrollee Advisory Council
ECC	Enterprise Compliance Committee
ECDS	Electronic Clinical Data Systems
EPAC	Enterprise Provider Advisory Committee
EPSDT	Early and Periodic, Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
EVP	Executive Vice President
FAR	Final Audit Report
FDA	Food and Drug Administration
FDR	First Tier, Downstream, and Related Entities
FWA	Fraud, Waste, and Abuse
HEDIS®	Healthcare Effectiveness Data and information Set
HIE	Health Information Exchange
HIPAA	Health Information Portability and Accountability Act
HLA	Health Literacy Advisor
HNA	Health Needs Assessment
HRSN	Health-Related Social Needs
HSW	Health, Safety, Welfare
ICM	Integrated Care Management



ICSS	Intensive Crisis Stabilization Services
IHI	Institute for Healthcare Improvement
IQAP	Internal Quality Assurance Program
IT	Information Technology
LTSS	Long Term Services and Supports
OB/GYN	Obstetrics and Gynecology
NCQA	National Committee for Quality Assurance
PAC	Provider Advisory Council
PCP	Primary Care Provider
PDSA	Plan-Do-Study-Act
PHC	Population Health Committee
PHM	Population Health Management
PIP	Performance Improvement Project
PQoC	Potential Quality of Care
P&TC	Pharmacy and Therapeutics Committee
QI	Quality Improvement
QEC	Quality Enterprise Committee
QMC	Quality Management Committee
QoC	Quality of Care
RN	Registered Nurse
RVP	Regional Vice President
SUD	Substance Use Disorder
<The Division>	<Callout State Division or Department>
UM	Utilization Management



UMCMC	Utilization Management and Care Management Committee
VAC	Value Assessment Committee
VBP	Value Based Purchasing
VP	Vice President





HAP CareSource™