MEDICAL MUTUAL®

2019 Quality Program Evaluation Commercial and Marketplace

Executive Summary
Measurement Year 2018

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I.   Introduction

The purpose of this report is to evaluate quality improvement activities conducted in 2018 and the overall effectiveness of the Company's Quality Improvement (QI) Program. The foundation of Medical Mutual's Quality Improvement program is the Triple Aim: improving our population's health, enhancing our members' experience with care and services, and reducing costs.

The Clinical Quality Improvement (CQI) department annually evaluates CQI activities, initiatives and results. The measurement period is January to December 2018. Clinical interventions were largely in response to Healthcare Effectiveness Data Information Set (HEDIS) Measurement Year 2017 which was reported in 2018. The following Medical Mutual health plans are included: Medical Mutual of Ohio (MMO) and Medical Health Insuring Corporation of Ohio (MHICO). In 2018, these licensed entities offered Commercial and Marketplace plans with HMO, POS and/or PPO products. The demographics and population characteristics are similar across MMO and MHICO plans, quality initiatives are similar, however, in certain circumstances data and analytics will be used to meet certain population targets.

This document does not contain any data for the Medicare population due to having a separate evaluation for that population.

Included within this QI Program Evaluation are the following:

- HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), and survey data with clinical quality measures compared to prior year's performance, and Quality Compass percentiles
- Performance compared to established goals as stated within the Work Plan and individual Action Plans
- Barriers to improvement and root cause analysis
- Evaluation of the structure of the quality program and ability to meet areas of responsibilities
- Evaluation of the adequacy of appropriate resources dedicated and available to the quality program

II. 2018 Clinical Quality Highlights and Accomplishments

A. Clinical Quality Improvement Program, Health/ Wellness and Disease Management Program

Disease Management as delegated to Optum Health Care Solutions, LLC (Optum) was offered to all eligible members based upon an assessment of the needs of the various populations. The following condition management programs were available in 2018:
  - Asthma (Commercial)
  - Chronic Obstructive Pulmonary Disease (COPD) (Commercial)
  - Coronary Heart Disease (Commercial)
  - Diabetes (Commercial and Marketplace)
  - Heart Failure (Commercial)
- Other Health management programs as delegated to Optum
  - Maternity
  - 24/7 NurseLine
  - QuitLine, tobacco cessation program
  - Wellness Portal, coaching programs available
  - Lifestyle Coaching, for eligible members of employer groups
- Weight Watchers® at a discounted rate continued to be offered to all members whose goal was weight loss. Weight Watchers for Diabetes at a discounted rate continued in 2018 for those diagnosed with diabetes.
- To facilitate accurate targeting and reporting of childhood immunizations, Medical Mutual continued to supplement claims data by accessing the Ohio Department of Health immunization registry called the Impact Statewide Immunization Information System (ImpactSIIS). Providers are encouraged to utilize ImpactSIIS.
- To encourage immunizations recommended by the Advisory Council on Immunization Practices (ACIP), Medical Mutual in partnership with WEST Interactive Services, formerly known as Televox utilized postal mail and telephonic messaging to remind parents/guardians that their child missed an immunization dose. An education reminder is sent to schedule a 12-month check-up.

B. Member and Provider Campaigns

- In response to evidence that health outcomes are improved when members have strong relationships with PCPs, Medical Mutual conducted an outreach campaign to members to identify their PCP.
- Care Alerts are routinely mailed throughout the year by Optum and are communicated during health coaching calls.
- Medical Mutual identified care gaps through its HEDIS data system. Medical Mutual conducted campaigns to members and providers on care gaps for colorectal cancer screening, breast cancer screening and comprehensive diabetic care testing

- Medical Mutual offered Commercial members a mammogram through a contracted provider with a mobile mammogram van in conjunction with Discount Drug Mart.

C. **Continued Quality Improvement Activities**

- Medical Mutual continued to acknowledge network clinicians in the provider directory who achieved recognition status in the NCQA Provider Recognition Programs for high level performance in providing patient care in:
  - Diabetes Physician Recognition Program (DPRP), or
  - Patient Centered Medical Home (PCMH)
- Annual network provider notifications, clinical updates, corporate medical policy updates and/or other educational items were published as required in Medical Mutual's quarterly Mutual News provider newsletter.
- Because of the prevalence of diabetes and hypertension among our membership, Medical Mutual mailed members diagnosed with diabetes or hypertension a comprehensive educational booklet stressing the importance of regular blood sugar testing, regular blood pressure testing, medication management and provider check-ups.
- Post-discharge calls to all hospitalized members continued in 2018. Opportunities for compliance with follow-up appointments, medication fulfillment and improved care coordination were identified. Members are offered the ability to speak with a nurse.
- Members with asthma who incurred a visit to the emergency department (ED) or were admitted to the hospital received post-discharge letters regarding the importance of follow-up care with their provider within 7 days. Providers also received a letter notifying them of their patient's ED visit or admission.
- To improve early identification of members with pre-diabetes for diabetes prevention education, Medical Mutual's Health Information Management and Analytics (HIMA) department developed an algorithm in Impact Pro that will more accurately target pre-diabetic members at emerging risk.

D. **Provider Network**

Recognizing the importance of value-based payment for quality care, Medical Mutual revised its provider contracts with additional quality metrics. These new contracts will continue to expand in 2019 in support of the Triple Aim to lower costs and improve quality.
Medical Mutual enhanced the role of provider relations department by adding a specialist who acts as a liaison between physician offices and MMO fostering provider education and quality programming.

E. Quality-Safety Reviews (QSRs)

The process by which QSRs are conducted was modified to a smaller, dedicated nursing team. The nursing team reviews at length any issues/complaints to enable improved and consistent clinical review, tracking and monitoring of case inventory. Cases are reviewed by the Chief Medical Officer, when in-depth analysis is needed and then advises on corrective action plans.

III. Completed and Ongoing QI Activities that Address Quality of Service and Member Experience

A. Quality of Clinical Care

The work plan for the quality of clinical care measures addressed three main categories for improvement which were: Prevention and Screening, Disease Management and Continuity and Coordination of Care.

1. Prevention and Screening-

In the Prevention and Screening category various activities revolved around a member. This approach included mailing educational material through our Healthy Outlooks newsletter or by direct member mailing. The measurement of this category is through HEDIS and CAHPS measures.

Table 1. Prevention and Screening Category:

Preventive Measure	HEDIS 2017 Result	HEDIS 2018 Result	Goal
Adult Body Mass Index	81.35%	73.08%	83.59%
Breast Cancer Screening	71.17%	71.43%	72.8%
Cervical Cancer Screening	73.91%	71.04%	75.39%
Colorectal Cancer Screening	59.07%	63.07%	62.03%
Flu Vaccination for Adults	44.63%	42.55%	Commercial 46.09%
			Marketplace 38.09%
Chlamydia Screening in Women	39.79%	40.59%	Commercial 41.26%
			Marketplace 53.39%

Summary:

Five measures in Table 1 are based on member seeking screening/ or an immunization meaning. The member had to seek out services to be compliant. The Basal Metabolic Index (BMI) measure is based on providers capturing the members

height and weight on an office visit and documenting the results in the medical record. Of the six measures listed above all six pertain to the female population and three pertain to the male population.

Of the six measures listed in Table 1 the Colorectal Cancer Screening met goal for the year and reached the 50th percentile. The remaining five measures were at the 25th percentile based on regional benchmarks. Regional benchmarks are results on an average rate across the county.

Recognizing the importance of value-based payment for quality care, Medical Mutual worked with the providers to align and focus on quality of activities to support optimal health for members. Goals were set to help improve and maintain high level care for members. Partnership with Value Based Contracts (VBC) will provide opportunities to evaluate quality improvement goals as meaningful data and will be supported going forward.

We will plan to continue to engage our members for education of preventive health activities.

2. Disease Management-

In the disease management category certain aspects of the disease process are evaluated. For members who have Hypertension, frequent blood pressure checks are needed to monitor for control, one blood pressure out of range does not determine Hypertension. This value over time is monitored by a provider to evaluate the members diagnosis. For members with Diabetes, frequent blood and urine specimens help to evaluate over time how a member is in control with their blood sugar levels. This diagnosis is monitored over time.
The measurement of this category is through HEDIS measures.

Table 2. Disease Management Category:

Disease Management Measure	HEDIS 2017 Result	HEDIS 2018 Result	Goal
Controlling Blood Pressure	45.91%	45.74%	46.09%
Diabetes Care			
HBa1c testing	90.44%	88.69%	91.8%
Eye exams	54.87%	54.56%	59.36%
Nephropathy	89.93%	85.04%	89.96%
Prenatal/Postnatal Care	87.29%/72.51%	82.99%/75.82%	89.78%
Asthma Medication Ratio	79.84%	79.37%	80.22%

Summary:
A member approach was used for all four measures in which the member might have received a call or letter or an informational brochure. For one of the measures a

vendor (OPTUM) handled the pre/postnatal care information by calling members directly. Of the six disease management measures listed above no measures met goal.

Recognizing the importance of value-based payment for quality care, Medical Mutual worked with the providers to align and focus on quality of activities to support optimal health for members. Goals were set to help improve and maintain high level care for members. Partnership with VBC will provide opportunities to evaluate quality improvement goals as meaningful data will be supported in longitudinal review.

Care Coordination is an integral part of value-based contracting. Care coordination fees help pay for disease management programs designed to improve patient outcomes.

Strategies take time with support from family and health professionals. This will continue to be a worked on collaboratively with members.

3. Continuity and Coordination of Care (COC)-

In the Continuity and Coordination of Care category, MMO annually performs quality improvements to ensure members get the care they need at the appropriate time. The continuity portion looks at continuation of care a member receives with different providers. The coordination portion ensures that the members condition is managed throughout their health continuum.

Two measures were identified in the work plan for Continuity and Coordination of Care:

a. Follow up care after an Emergency Room visit (ER) for Asthma

Members who experienced an asthma attack and were treated in an ED or urgent care for a primary diagnosis of asthma between January 1st, 2018 and November 30th, 2018 were identified for outreach. The identified members received an educational letter regarding the importance of completing a follow-up office visit with their primary asthma care provider. The effectiveness of this action was measured by identifying the members with any asthma-related office visit within 30 days of the initial visit. Rates for both commercial members and marketplace were calculated.

Objective: Members having office visit within a specified time frame
Goal: 90% of members will complete a visit within 30 days.
Goal: **Not Met**
Activity: Ongoing

Summary:
Commercial members treated for asthma in an ED, urgent care or convenience clinic had a 37.1% outpatient follow-up rate with a provider. The performance goal of 60% was not met.
Marketplace members treated for asthma in an ED, urgent care or convenience clinic had a 46.0% outpatient follow-up rate with a provider. The performance goal of 60% was not met.

The findings for 2018 are similar for the two preceding years suggesting consistency and stability for these measures.

At the time of this evaluation, we were only able to evaluate the follow-up rate for eleven months of 2018, as data for January 2019 (needed for a 30-day follow-up from December 31st, 2018) is not complete.

b. Changing from a Pediatric Provider to Adult Primary Care Provider

The purpose of this initiative is to educate providers about this guideline and encourage them to transition their patients as appropriate from pediatric care to adult care.

Goal: 30% of members who were still being seen by pediatricians have transitioned to an adult PCPA visit with a PCP within 6 months will serve as a proxy for transitioning of care.
Goal: **Not Met**
Activity: Completed

Commercial Summary:
There were 767 distinct Commercial members whose pediatrician received a letter encouraging transition of their adult patients to a PCP. After 6 months, data showed that out of these 767 members, 125 are attributed to a PCP after 12/1/17 (after letter to pediatrician provider was sent)

Marketplace Summary:
There were 25 distinct Marketplace members whose pediatrician received a letter encouraging transition of adult patients to a PCP. Of these 25 members, 2 attributed to a PCP after 12/1/17 (after letter to pediatrician provider was sent).

The Marketplace sample size is small to make any strong recommendations.

B. Completed and Ongoing QI Activities that Address Quality and Safety of Clinical Care

Medical Mutual's goals for patient safety is prevention and early detection of medical errors, avoidance of potential harm and prompt corrective action in the event of an actual occurrence.

1. Quality Case Event Tracking-

Listed below are the processes by which the committee analyzes the data and reviews it for safety issues.

Table 3. Tracking levels and the description (Data from Patient Safety Report)

Quality Level	Description
Quality of Service 0.5 point	Member complaint about the quality of service.
Quality of Care Level 1 1 point	Treatment/practice determined to be within established practice standards. Other providers would have managed care in a similar manner. Practice pattern unlikely to warrant future focused review. No harm or minimal harm to member.
Quality of Care Level 2 2 points	Questionable treatment/practice not clearly within established practice standards. Variance did not affect member outcome (no harm).
Quality of Care Level 3 3 points	Treatment/practice not within established practice standards. Other providers likely to have managed the care differently; minimal harm to the member. Minimal harm is defined as an event that negatively affects the member, such as requiring an extended length of stay or additional treatment, but without permanent injury or disability.
Quality of Care Level 4 6 points	Treatment/practice not within established practice standards. High harm with negative outcome to the member. High harm is defined as an event resulting in death, permanent disability, and permanent loss of function or permanent change in quality of life.

Objective: To identify practices by tracking and trending reported quality cases related to safety events such as; unexpected deaths, hospital acquired conditions, serious reportable events, falls and complaints against provider and facilities.

a. Unexpected Deaths-
MMO investigates any quality of care issues are related to an unexpected death, as well as all deaths classified as a Serious Reportable Event, discovered during utilization/case management review are routed to the QSR department.

b. Hospital Acquired Conditions (HAC) and Serious Reportable Events (SRE)-
These conditions are unplanned events that occur in a hospital or extended care facility. HACs and SREs are presented below. The QSR department annually reviews. Activity includes ongoing tracking and trending for reporting.

c. Falls-
The QSR nursing department investigates falls that occur in an acute care, rehabilitation, skilled nursing or behavioral health facility. Activity includes ongoing tracking and trending for reporting.

2. Medication Safety- For Members

To promote medication safety through improved shared decision making through CAHPS survey results.

Current Rate: 90.59%
CAHPS Goal: 94.30%
Goal: **Met**
Activity: Ongoing

Summary:
There was a 4.45% increase in satisfaction from 2017 to 2018 regarding Question #10 "Doctor discussed reasons to take my medicine" for Commercial members. The goal was exceeded and met for Commercial 2018. No goal was selected for Marketplace.

The Commercial survey was the same for 2 years in a row. The Marketplace survey changed and therefore, no comparison can be made from 2017 to 2018. There also was no goal set for the plan on this measure.

3. Medication Safety-Pharmacy Management

To promote medication safety through monitoring for nonadherence (members not taking medication as prescribed) of prescribed medication (hypertension, diabetes and cholesterol) through communication to members.
Goal: Increase in percentage of >80% medication possession rate by 1%
Goal: **Not Met**
Activity: Ongoing

Summary:
The medication ratio captures the prescriptions being filled. This correlation assumes the members are taking the medication as prescribed. MMO uses a vendor to outreach to members to assess medication adherence by sending an alert to the

member when a medication is due for refill. MMO pharmacy also sends alerts to providers to alert them the member has not filled their prescription.

4. Follow-up Care After Nurse Line Referrals to the Emergency Department
>Objective: To assure follow-up care with the member's physician following a Nurse Line referral to Emergency.
>Goal: 90% follow up within 10 days following an ED visit.
>Goal: Not Met
>Activity: Ongoing
>
>Summary:
>The volume of Nurseline referrals to the Emergency Room (ER) increased significantly each year. After the first year, the rates were stable for both the Commercial and Marketplace populations. The performance goal was not met during any measurement period.
>
>The NurseLine calls can only be associated in time with ER visits, the data available does not discern the reason for the NurseLine encounter. Ten-day PCP follow-up from an ER visit associated with a NurseLine call should be compared with PCP follow-up from an ER visit for all members.

5. Plan All Cause Re-admission (PCR)
>Objective: This measure was developed to determine the number of re-admissions that occur after a member was discharged that could have been avoided. The goal is to prevent hospital readmission through early identification of needs and coordination of care at transitions from hospital to home.
>Goal: ≤.61 observed to expected ratio)

Table 4. Observed to Expected Ratio

Observed-to-Expected Ratio (Observed Readmission/Expected Readmissions)	HEDIS 2017	HEDIS 2018	Goal
Commercial	0.6765	0.6781	≤ 0.61
Marketplace	N/A	0.5300	≤ 0.61

6. Continuity and Coordination of Care- Behavioral Health

>For measures related to Continuity and Coordination of Care many moving parts are related to make sure members get the care they need at the appropriate time. Appropriate use of psychotropic medications such as though related to Attention Deficit Hyperactivity Disorder (ADHD) looks at the medications that help with handling emotions and behaviors- HEDIS measure

Objective: To monitor and improve appropriate use of psychotropic medications
Goal: 35%
Goal: Not Met
Activity: Not completed

Summary:
Medical Mutual performed educational outreach in quarter 3 to parents and guardians regarding the need for follow-up appointments with the prescribing provider. There were 4,059 letters sent in 2017.
The objective to ensure proper ADHD medication follow-up care was partially met, but significant opportunity for improvement exists. In 2018 we will continue educational outreach to parents and guardians and evaluate methods to more effectively outreach to providers.

C. Completed and Ongoing Activities that Address Improving Quality of Service.

The next section deals with complaints and appeals. Complaints and Appeals are categorized as: *a.* Quality of Care, *b.* Access, *c.* Attitude/Service, *d.* Billing/Financial, *e.* Quality of Practitioner Office Site.

1. Complaints for Non-Behavioral Healthcare Members both Commercial and Marketplace

This section evaluates non-behavioral complaints of dissatisfaction or concern against the health plan and its networks that are received from the member or reported on behalf of the member from an authorized representative.
Complaints are responded to and resolved upon initial contact or within 30 calendar days. If an extension is needed due to requesting additional information, the member will be notified with an estimated time frame of completion, but no longer than 30 additional calendar days. Complaints are managed in the same manner across both legal entities and their products.

Table 5: Complaints for Non-BH 2017 and 2018

Complaint Categories	Commercial		Marketplace	
	Non BH 2017 Goal	Non BH 2018 Goal	Non BH 2017 Goal	Non BH 2018 Goal
Quality of Care	Met	Met	Met	Met
Access	Met	Met	Not Met	Met
Attitude of Service	Not Met	Not Met	Not Met	Not Met
Billing	Met	Not Met	Not Met	Not Met
Quality of Practitioner Site	N/A	Met	Met	Met

Summary:
The categories of Quality of Care, Access and Quality of Practitioner Office Site complaints met the goal for both Commercial and Marketplace. Attitude and Service and Billing and Financial complaints fell short of their individual goals for both Commercial and Marketplace and both areas will work on improving performance going forward.

2. Appeals for Non-Behavioral Health (BH) Members both Commercial and Marketplace

Members are afforded the right to appeal pre-service, post service and urgent or expedited decisions regarding utilizations of medical services. The member appeals department process appeals according to applicable state and federal regulations, member certificates or benefit books and NCQA standards, as possible.

Table 6: Appeals for Non-BH 2017 and 2018

Appeals Categories	Commercial		Marketplace	
	Non BH 2017 Goal	Non BH 2018 Goal	Non BH 2017 Goal	Non BH 2018 Goal
Quality of Care	N/A	Met	Met	Met
Access	Met	Not Met	Not Met	Not Met
Attitude of Service	N/A	Met	Met	Met
Billing	Not Met	Not Met	Not Met	Not Met
Quality of Practitioner Site	N/A	Met	N/A	Met

Summary:
The most frequent Non-BH concern was Access which related to issues with member's lack of knowledge regarding network limitations when using out-of-network providers for both Commercial and Marketplace
There is a plan in place to improve this area.

The most frequent Non-BH Access appeals related to member's lack of knowledge regarding network limitations in using in network providers to receive maximum benefit coverage, and members utilizing the Emergency Room for non-emergent issues for both Commercial and Marketplace. Work is being done in education to members to improve this process.

3. Complaints for Behavioral Health Members both Commercial and Marketplace

Complaints are categorized as: *a.* Quality of Care, *b.* Access, *c.* Attitude/Service *d.* Billing/Financial, *e.* Quality of Practitioner Office Site

The Customer Care department investigates and works to resolve non-clinical complaints regarding the categories above.

Table 7. Complaints BH 2017 and 2018

BH Complaints Categories	Commercial		Marketplace	
	BH 2017 Goal	BH 2018 Goal	BH 2017 Goal	BH 2018 Goal
Quality of Care	Not Met	Met	Met	Met
Access	Met	Met	Not Met	Met
Attitude of Service	Not Met	Met	Not Met	Met
Billing	Not Met	Met	Not Met	Met
Quality of Practitioner Site	Met	Met	Met	Met

Summary:
All 5 categories for Commercial and Marketplace Met their 2018 goals

4. Appeals for Behavioral Health Members both Commercial and Marketplace

Please note: the reporting populations and methodologies described for Non-BH services are applicable to BH services.

Table 8. Appeals BH 2017 and 2018

BH Appeals Categories	Commercial		Marketplace	
	BH 2017 Goal	BH 2018 Goal	BH 2017 Goal	BH 2018 Goal
Quality of Care	Met	Met	Met	Met
Access	Met	Met	Met	Met
Attitude of Service	Not Met	Met	Met	Met
Billing	Not Met	Met	Met	Not Met
Quality of Practitioner Site	Met	Met	Met	Met

Summary:
For the 5 categories listed above all goals were met except for the billing category. Upon analysis, the common themes were cases denied due to medical necessity or length of inpatient stay was not necessary. Due to the low number of complaints, there are no interventions identified.

5. Satisfaction with the Health Plan

Increase the rate of member satisfied with the health plan by evaluating the top scores to questions 8, 9, and 10 in the CAHPS survey.

Surveys/Satisfaction= Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Annually, Medical Mutual collects feedback from its members on their experiences with the health plan's performance and the care delivered by its providers.   In March

of 2018, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) conducted a survey on behalf of Medical Mutual. This report evaluates the results for the commercial product line.

Survey results to increase ratings
Goal: 62.54%
Goal: **Met**
Activity: Ongoing

<u>Summary:</u>
Results were very strong for Commercial in 2018. Goals were met, and increases were seen for 9 of the 10 areas/domains.

Actions taken to address the access issues identified in the 2017 CAHPS survey had a positive result and were effective in achieving the set goals. The Company prioritized its contracting efforts which ultimately resulted in many new physician practices, hospitals and other facilities being added and available to its members. The additions of both the University of Pittsburgh Medical Center (UPMC) and the University Hospital (UH) expansion were key additions to the health plan's commercial network.

Table 9. Qualified Health Plan (QHP) (Data from enrollee Experience Survey Results)

QHP Composite and Domains	2017		2018	
	Results	Goal 2016 Nat'l Avg.	Results	Goal
Rating of Health Plan	62.50%	65.80%	47.10%	65.80%
Rating of Health Care	85.71%	84.02%	85.07%	86.00%
Rating of Personal Doctor	90.16%	91.75%	94.58%	91.75%
Rating of Specialist	87.50%	89.17%	94.50%	89.17%
Getting Care Quickly	77.35%	80.58%	80.75%	80.58%
Getting Needed Care	87.50%	83.67%	85.15%	88.00%
Access to Information	65.51%	54.80%	57.61%	66.00%
Getting Information in a Needed Language or Format	85.00%	68.10%	65.56%	86.00%
How Well Doctors Coordinate Care and	85.34%	87.04%	90.83%	87.04%

QHP Composite and Domains	2017		2018	
	Results	Goal 2016 Nat'l Avg.	Results	Goal
Keep Patients Informed				
Health Plan Customer Service	81.94%	80.05%	82.21%	82.00%
Enrollee Experience with Cost	81.51%	83.56%	77.61%	83.56%
How Well Doctors Communicate	95.16%	94.19%	96.87%	96.00%

Summary:
The overall ratings of Health Plan and Health Care did drop (and goals were missed), while the overall Ratings of Personal Doctor and Specialist increased (and goals were met). Within the composite measures, Getting Care Quickly, How Well Doctors Coordinate Care and Keep Patients Informed, Health Plan Customer Service and How Well Doctors Communicate all improved and met their 2018 goal, while Getting Needed Care, Access to Information, Getting Information in a Needed Language or Format and Enrollee Experience with Cost all decreased and did not meet their 2018 goal.

Overall, results were mixed in 2018 when compared to the 2018 goals. The overall Ratings of Health Plan and Health Care did drop (and goals were missed), while the overall Ratings of Personal Doctor and Specialist increased (and goals were met).

D. Completed and Ongoing Activities that Address Improving Member Experience

1. Availability of Behavioral Practitioners and Facilities
To improve the availability of in-network behavioral health practitioners and facilities to assure access to needed care

Goal: 87% Commercial and 92% Marketplace surveyed can get care in 30 days of call
Goal: **Met** for Commercial
      Met/Not Met for Marketplace

Table 10. Behavioral Health Member Experience Survey Results

Getting Treatment Quickly			
COMMERCIAL			
Question	**2017 Results**	**2018 Goal**	**2018 Results**
Q2. How frequently were you able to get an appointment for behavioral/mental health counseling or treatment within 30 days of calling your provider.	83%	85%	91% Goal Met
Q3. How many times did you go to an emergency room to get help for a behavioral/mental health problem because an appointment was not available?	96%	96%	96% Goal Met
MARKETPLACE			
Q2. How frequently were you able to get an appointment for behavioral/mental health counseling or treatment within 30 days of calling your provider?	88%	90%	90% Goal Met
Q3. How many times did you go to an emergency room to get help for a behavioral/mental health problem because an appointment was not available?	98%	98%	94% Goal Not Met

Summary:
The Behavioral Health (BH) Member Experience survey was sent to larger sample sizes in 2018 and response rates increased markedly.

More members found it necessary to go to the emergency room to get help in 2018 than in 2017 because an appointment was not available. The larger sample size may have affected rates.
The number of Behavioral Health Providers in our network may not be adequate to address our members' conditions. We know that there is a general lack of Behavioral Health providers in certain geographical areas in our book of business, like rural areas and Southern Ohio.

2. Accuracy of Provider Directory
Assure that accurate physician practice information is provided to our members.
Goal: 40% deficiency rate
Goal: **Not Met**
Activity: Ongoing

Measurement: An internal audit was conducted by the Medicare Advantage (MA) Compliance team from MMO on the provider directory. The audit was conducted in quarters for the year and a comparison was made from 2017 to 2018.

Table11. Final Weighted Deficiency Scores by quarter 2017 and 2018

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Goal Met /Not Met
2017	62.20%	64.80%	62.10%	66.70%	Not Met
2018	41.80%	51.90%	42.60%	**40.40%**	

The end of the quarter for 2018 resulted in MMO having a 40.40% deficiency rate below the CMS benchmark of 44.97%. MMO's internal goal was 40%. In comparing 2017 to 2018's 4th quarter data, there has been a 25 % reduction in deficiency's from year 2017 to year 2018.

Continued Efforts:
Several work flow processes were put into place to correct deficiencies in a more timely fashion as of November 2018. Going forward there are plans to have eVIP's (provider information systems) fully implemented by the end of 2019.

IV.   Trending of Measures to Assess Performance in Quality of Safety Service and Member Experience

A summary of key trends is listed below based on the top measures and how the measures performed.

Medical Mutual –Commercial HEDIS reporting year 2018

Table 12. MMO Commercial with a positive increase

Measure	HEDIS 2017	HEDIS 2018	Percent Increase / Q/C Percentile	Goal	Goal Met/Not Met
Colorectal Cancer screening (P)	59.07%	63.07%	+4.0 50th percentile	62.03%	Met
Prenatal/Postpartum care (DM)	72.51%	75.82%	+ 3.31 25th percentile	89.87%	Not Met
Chlamydia screening (P)	39.79%	40.59%	+.80 25th percentile	41.26%	Not Met

Table 13. MMO Commercial HEDIS Measures with the lowest scores

Measure	HEDIS 2017	HEDIS 2018	Percent Decrease /Percentile	Goal	Goal Met/Not Met
ABA /BMI (P)	81.35%	73.08%	-8.27%	83.59%	Not Met
Nephropathy testing (DM)	89.93%	85.04%	- 4.89%	89.96%	Not Met
Cervical Cancer screening (P)	73.91%	71.04%	-2.87%	75.39%	Not Met
Flu shots (P)	44.63%	42.55%	-2.08%	46.09%	Not Met
CDC HbA1c testing (DM)	90.44%	88.69%	- 1.75%	91.48%	Not Met

Table 14. MMO Commercial HEDIS Measures with no significant change in scores

Measure	HEDIS 2017	HEDIS 2018	Percent Change	Goal	Goal Met/Not Met
Breast cancer (P)	71.17%	71.43%	- .26%	72.80%	Not Met
CBP Controlling High B/P (DM)	45.91%	45.74%	- .17%	46.09%	Not Met
CDC Eye (DM)	54.87%	54.56%	- .31%	59.36%	Not Met
Asthma Medication ratio (DM)	79.84%	79.37 %	- .47%	80.22%	Not Met

(P) Preventive
(DM) Disease Management

V. Serving a Diverse Membership Cultural Diversity Summary

Medical Mutual's goal is to maintain sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network to meet the needs and preferences of our membership in Ohio in relationship to culture, ethnicity, race and language. Data was collected from multiple internal and external sources and evaluated for any unmet member needs. Results of this report are used to adjust the availability of network practitioners if necessary.

Medical Mutual's 2018 objectives for serving a diverse membership was to:
- Meet identified cultural and linguistic needs in materials and communication
- Assure network practitioners are available to meet the needs of our members
- Identify healthcare disparities related to culture, language or race during quality care reviews
- Identify and reduce healthcare disparities through reporting of geographic variances
- Reinforce identification of issues through staff training

For the 2018 report (2017 measurement year) data was collected from the US Census Bureau on counties, Transperfect, AT&T, CAHPS/Quality Health Plan (QHP), Optum HA, member complaints and MMO provider data.

Sources that were reviewed:

A review of the language needs of potential members was conducted using the 2017 American Community Survey (ACS) Five Year Population Assessment data for language spoken at home published by the United States Census Bureau (U.S. Census Bureau). Each Ohio county was evaluated by population and preferred language spoken.

- Data on race was obtained from the U.S. Census Bureau (2010)
- Data from internal sources

RESULTS/ANALYSIS- Population Profile

<u>Language</u>

Speaking a language other than English is an indicator of potential health care disparity due to the inability to understand information relevant to care needed or in progress. (Source: US Census Bureau)

- Predominant language spoken was English followed by Spanish, then German.
- For any county in Ohio with a population greater than 10% who speak another language other than English, AND, where >10% of members reside in that county, then, then an evaluation was performed to determine if there are sufficient number of providers who speak that language.
- Five counties had >10% non-English speaking, but only one county (Geauga) had both >10% non-English plus >10% of members comprising the county population. Almost 10% of the members in Geauga county were part of the Marketplace.
- Spanish noted to be the top language requested for written translation and verbal interpretation.

<u>Race</u>

- Counties identified as highest prevalence of minorities include in order: Cuyahoga, Franklin, Hamilton, and Lucas all of which also contain the largest cities in the Ohio
- Analysis of CAHPS results regarding race showed predominance of respondents were White followed by Black/African American then Hispanic/Latino for both product lines.

- No data collected on provider's race or the provider's ability to address other cultural needs or preferences, therefore unable to display in the provider directory

Evaluation of MMO Activities

Credentialing Department maintains log of network providers who speak a language in addition to English. This information is made available to members on "Find a Provider" are on web site.

- Documents are provided for members printed in other languages
- Provider network meets needs of the population by maintaining a Spanish translated version of Member FAQ on member website
- ATT Language line for interpreter services
- Complaints recorded annually to identify member complaints regarding the availability of network providers who spoke a requested language, or any other issue related to cultural preference.
- Latino is not currently an option for members to select on the Optum Health Assessment which has been brought to the attention of Optum. Due to the CAHPS survey showing almost 2 percent of members were Hispanic/Latino it is important to recognize this group.
- Analysis of over 26,000 member assessments on preferred language conducted by Optum during interactive coaching sessions showed the majority prefer English followed by Spanish, then German.

CONCLUSION

Goal #1: Adjust the availability of providers within the network as appropriate
Medical Mutual meets this threshold and no further action is necessary to adjust the network.
Goal #2: Meet the needs of members with expressed preferences
There have been no complaints about insufficient providers who speak a preferred language or any other cultural need or preference.
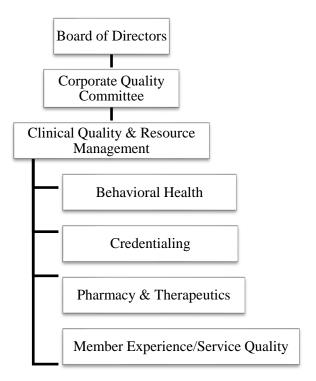
Summary:
Based on the information pooled from different resources and the analysis of the data, MMO is meeting the needs of its diverse culture and is able to adjust to the demands if needed.

VI. Analysis and Evaluation of the Overall Effectiveness of the QI Program

A. Quality Committee Structure

In 2018, the quality committees have been evolving to their new structure and membership as described below. These changes have made a significant impact on the Company's Quality Improvement Program and have enhanced our ability to meet our responsibilities to improve the quality and safety of care provided to our members as well as the service they receive and overall experience.

The 2019 quality committee structure as illustrated below reflects a commitment of the Company to advancing quality.

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                    ┌──────────────────┐
                    │ Board of Directors│
                    └──────────────────┘
                             │
                    ┌──────────────────┐
                    │ Corporate Quality │
                    │    Committee      │
                    └──────────────────┘
                             │
              ┌──────────────────────────┐
              │ Clinical Quality & Resource│
              │       Management          │
              └──────────────────────────┘
               │
               │      ┌──────────────────┐
               ├──────│ Behavioral Health │
               │      └──────────────────┘
               │
               │      ┌──────────────────┐
               ├──────│   Credentialing   │
               │      └──────────────────┘
               │
               │      ┌──────────────────────┐
               ├──────│ Pharmacy & Therapeutics│
               │      └──────────────────────┘
               │
               │      ┌──────────────────────────────┐
               └──────│ Member Experience/Service Quality│
                      └──────────────────────────────┘
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B. Resources

Significant enhancements to QI program resources occurred in 2018 and to current as explained below.

- The Member Experience department continues to provide analytical support for service related initiatives and CAHPS survey analysis. This department has expanded its use of Speech Analytics which helps us better understand the voice of the customer.

- Medical Mutual expanded its support for the certification of the CQI department nurses for obtaining their designation of Certified Professional in Healthcare Quality.

Together with our leadership, the new quality committee structure, and new and ongoing resources described above Medical Mutual is well-positioned to improve the effectiveness of our quality program and influence safe clinical practices across our network.

C. Implemented goals in 2018

The 2018 QI Work Plan was developed for Commercial and Marketplace members. Separate project plans are the responsibility of a project lead and are developed and updated periodically throughout the year as progress is achieved and/or barriers are identified

Medical Mutual's overarching goals for quality improvement in 2018 are listed below.

Specific objectives are included within the Action Plan.

Move to a continuum of care model that aims to improve the quality and safety of clinical care our members receive

- Achieve stated percentile goals on for measures specific to improving clinical care.
- Strengthen internal processes that provide for our members' safe transitions across healthcare settings as measured by reduction in readmission rates and facilitation of follow-up care after Emergency Department visits.
- Promote patient safety by early identification and corrective action of unsafe practices from providers. Measurements related to improvement of medication safety and reduction of quality concern events including falls will denote improved safety.
- Continue integration of clinical activities towards population health management
- Refine outreach process to members with emerging risk and multiple chronic illnesses.

Improve the quality of service to our members
- Pursue opportunities to streamline a member's burden in obtaining appropriate care. Success to be measured by a decrease in the number of member appeals, implementation of more efficient workflows that impact members, and identification of tactics to improve satisfaction with the health plan.

Improve our member's experience through improved payer and provider relationships
- Increase data sharing with enhanced reporting that will enable providers to improve the delivery of healthcare services.

- Establish new workflows between Medical Mutual and providers to improve the collection of practice information used in creating network directories used by members.

Improve the overall value of healthcare by more rigorous adherence to evidence-based medicine
- Evaluate frequency of selected procedure was not implemented

VII. Conclusion

If you would like a full copy of this evaluation, please call the Clinical Quality department at 800-586-4523.

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