



MEDICAL MUTUAL®

INFORMATION

Quality Program Description Commercial and Marketplace Executive Summary

2018

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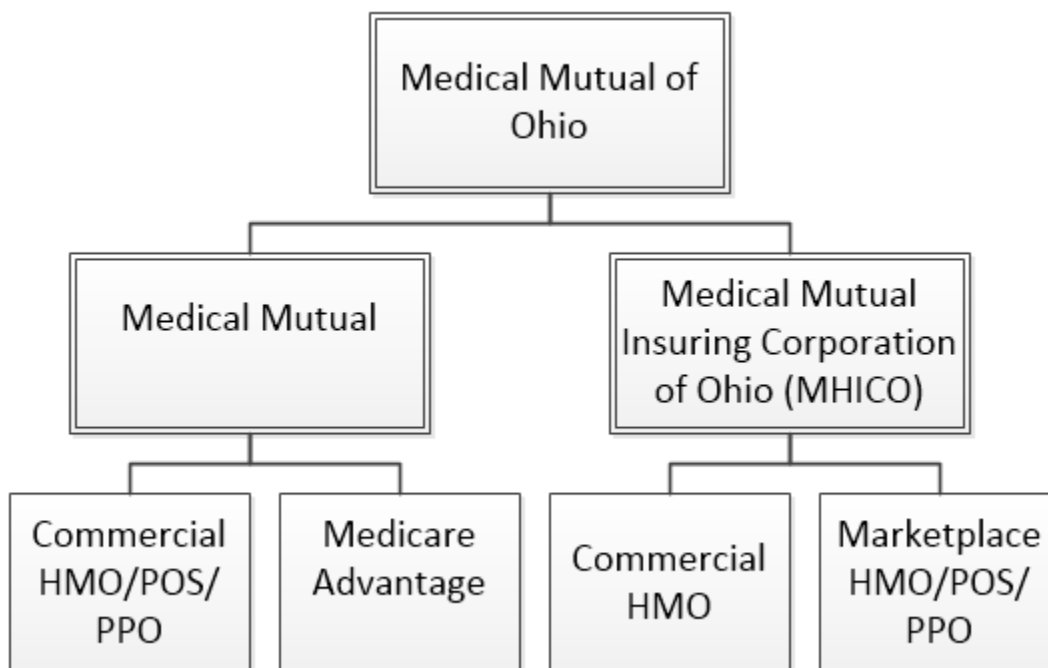
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Introduction

Medical Mutual of Ohio (Medical Mutual) is committed to improving the lives of Ohioans by offering high quality healthcare coverage. Medical Mutual employees strive to attain high levels of satisfaction and quality to support our customers who include members, practitioners and providers, group benefit managers, brokers and other stakeholders. Collaborative efforts across functional areas throughout the Company are vital to attaining our goals.

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

Medical Mutual's QI Program applies to all Commercial, Marketplace and Medicare Advantage members--fully-insured and ASO (administrative services only) within Medical Mutual of Ohio and Medical Health Insuring Corporation of Ohio (MHICO). Our Commercial and Marketplace products are accredited by the National Committee for Quality Assurance (NCQA), and hold the Status of Accredited through December 20, 2019.



I. Program Structure

QI Program Functional Areas of Responsibility

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

The Vice President of Clinical Services and Health Management is responsible for design and execution of the QI program. Reporting to the Vice President are the following groups and respective responsibilities.

- **Clinical Quality Improvement (CQI):** Registered Nurses (RNs) execute evidence-based, data driven initiatives to advance quality across all populations; develops and implements action plans for quality initiatives; monitors and investigates complaints, grievances and quality of care of safety concerns; maintains clinical practice guidelines in collaboration with the CMO; conducts delegated oversight of population health program (Disease management) vendor; and performs over-read of abstracted medical records for the annual Healthcare Effectiveness Data and Information Set (HEDIS) submission.
- **Accreditation:** Facilitates and assures Medical Mutual maintains all quality-related requirements for National Committee for Quality Assurance (NCQA) accreditation; educates employees about accreditation standards; assures adherence to and compliance with oversight requirements for delegate entities; assists in conducting oversight of vendors; and maintains policies and procedures.
- **Wellness/Health Promotion:** Designs solutions for employers, members and Medical Mutual employees to take responsibility for their health; develops programs to reinforce preventive care initiatives for keeping members healthy; conducts oversight of vendors who provide contracted health and wellness programs.
- **Medicare Stars:** Designs and implements programs to support Medicare Advantage Star Ratings clinical measures. Care Navigators conduct telephonic outreach with members to support essential connections between the member and the delivery system.
- **Physician Staff:** Medical Mutual physicians participate in the Behavioral Health, Credentialing, Clinical Quality & Resource Management, Pharmacy & Therapeutics and Population Health committees. They provide consultation on member-related issues and are responsible for utilization management reviews.
- **Clinical Care Management:** Includes Comprehensive Care, Care Authorizations, MA Clinical Services, Care Transitions and Disease Management. Promotes efficient and effective transitions of care with post-discharge calls, attention to members at high risk and preventing readmissions. Collaborates to promote high quality outcomes across the care continuum.
- **Healthcare Information Management and Analytics (HIMA):** Provide reporting and analyses of costs, quality and utilization of care. Manages the HEDIS, Medicare Stars and Quality Rating System (QRS) submissions and provides advanced analysis on effectiveness of quality

initiatives. Analysts utilize software such as SAS and Tableau for advanced statistical computation and data visualization.

The Chief Health Officer (CHO) is responsible for functions that support provider and payer relationships that contribute to the overall quality program. The following areas report to the CHO:

- **Risk Adjustment:** Conducts activities to comply with government programs. Identifies members who are high risk and communicates member needs to Medical Mutual physicians and/or nurses.
- **Pharmacy Management:** Responsible for quality initiatives to improve medication adherence, encouraging members to follow-up visits with their practitioner for proper treatment. Collaborates on potential safety issues or barriers to drug access including high cost of certain drugs and assists with evaluating quality cases involving prescription drug safety or utilization. Manages the relations with the Pharmacy Benefit Manager.
- **Provider Engagement:** Responsible for all provider and practitioner relationships and is actively transitioning contracts to value-based payment contracts. Monitors the adequacy of provider networks to assure they meet geographic and access standards, include practitioners who meet members' cultural needs and maintains and improves the accuracy of the provider directory.

The Chief Experience Officer (CXO) is responsible for all functions related to member engagement, claims and disbursements, membership services, customer care, appeals and grievances. The following areas report to the CXO:

- **Customer Care:** Communicates with customers about benefits and claims payment. This is the first line of critical touch points that impact members' experience with service quality, including telephone and email responsiveness. Participates in development and execution of care gap closure campaigns.
- **Member Experience:** Drives the development and use of personalized and connected cross-channel resources, tools and solutions that help members be informed healthcare consumers and maximize their health. Member feedback from a variety of methods, including focus groups and usability studies, online, after-call surveys, speech analytic tools, the Health Outcome Survey and CAHPS, is continually gathered, analyzed and integrated into improvement initiatives. Provides the digital experience including design of the member online Applications for My Health Plan.
- **Member Appeals and Grievances:** Responsible for investigating and resolving member appeals, grievances and external reviews.
- **Claims and Disbursements:** Assures members understand how benefits are administered in easily-understood language; responsible for processing claims in an accurate and timely manner according to state and Federal laws.

The Chief Marketing and Communications Officer is responsible for the resources to support marketing and multi-channel media for members and providers. The following areas report to the Chief Marketing and Communications Officer:

- **Communications:** Provides expertise on the design and delivery of written and electronic communications; develops member-directed materials aimed to help with making informed decision about care, teaching self-care behaviors and be an active participant in their health and healthcare decisions. Customizes and distributes written and electronic communications to network providers in support of the quality program.

II. Behavioral Healthcare

Medical Mutual's Senior Medical Officer-Clinical Operations who is board certified in Psychiatry and Addiction Medicine is responsible for the behavioral healthcare aspects of the quality program. This physician leads a multi-disciplinary Behavioral Health (BH) Committee composed of physicians, psychologists, nurses, analysts and management who are committed to improving the quality and access of care to our members having behavioral healthcare needs. Specialists in marketing and electronic communications collaborate on developing communications targeted to this population. Primary areas of responsibility include but are not limited to:

1. Determining the strategic direction of the behavioral healthcare programs.
2. Evaluating the quality of care, access to services and availability of providers.
3. Evaluating and approving clinical practice guidelines for behavioral healthcare.
4. Evaluating clinical data, survey results and effectiveness of care studies to determine opportunities for improvement.
5. Reviewing and approving communications to members and providers

Supporting the BH Committee is a Clinical Quality Improvement nurse who is primarily dedicated to behavioral aspects of the quality program. She is responsible for assuring all accreditation elements and HEDIS measures related to BH are presented to the BH Committee for review.

III. Patient Safety

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

The Clinical Quality Resource Management (CQRM) Committee lead by the CMO, oversees monitoring of patient safety and activities, including but not limited to:

1. Reviewing potential breaches of quality of care or safety that occur during medical care, known as a Quality Safety Review (QSR). Requesting Corrective Action Plans (CAPS) on cases.
2. Tracking and monitoring of serious reportable events and inpatient mortality.

3. Investigating complaints against providers that arise from members of which are published by media that may result in disciplinary action including the loss of network participation. Reviewing provider office safety, where indicated.
4. Removing providers from the network following onsite reviews where unsafe practices were identified.
5. Monitoring potential safety issues resulting from over or under utilization of services and/or prescription medications.
6. Initiating enhanced monitoring of providers' prescribing patterns of opioids.
7. Monitoring reports from the Nurse24 call line where members were directed to the Emergency Department for any safety issues or concerns.
8. Conducting routine safety assessments for members engaged in the Case Management and Disease Management programs.
9. Monitoring responses to Medicare Advantage health assessment questionnaire items regarding fall risks and ability to perform ADL's independently, then forwarding to a Care Navigator for further triage.
10. Facilitating continuity and coordination of care activities at transitions of care to prevent complications and/or readmissions including post-discharge follow-up calls and reconciliation of medications.

IV. Involvement of Designated Physicians

Medical Mutual's Chief Medical Officer (CMO) is the designated physician responsible for the development and maintenance of the corporate quality structure including committees, advising about corporate-wide quality initiatives and the provision of clinical services and health management programs for members across all lines of business. The CMO is board certified in Internal Medicine and Geriatrics and reports directly to Medical Mutual's Chairman, President and CEO. The CMO is the co-chair of the Corporate Quality Committee, chair of the Clinical Quality & Resource Management committee (CQRM) and a member of the Member Experience/Quality of Service committee.

The Designated Behavioral Healthcare Practitioner is the Senior Medical Officer-Clinical Operations who is responsible for all behavioral healthcare quality initiatives. The Senior Medical Officer is board certified in Psychiatry and Addiction Medicine and chairs the Behavioral Health (BH) Committee and Credentialing Committee. He is a member of the Pharmacy & Therapeutics Committee and the Clinical Quality & Resource Management Committee. Supporting the Chair are external physician specialists and psychologists specializing in behavioral healthcare.

The Senior Medical Officer-Clinical Operations collaborates cross-functionally on improving services for members with behavioral health needs such as improving the availability of network providers and participating on the development of medical criteria within behavioral health corporate medical policies.

V. Oversight of QI Functions

The Corporate Quality Committee (CQC) is the body which oversees Medical Mutual's corporate quality program. Reporting to the CQC are committees that monitor, direct and evaluate clinical and service initiatives while promoting the Triple Aim, which includes improving our population's health, enhancing our members' experience with care and services, and reducing costs. Sub-committees, Work Groups and/or ad hoc teams may be assigned as needed. Each committee's Charter provides a detailed description of specific responsibilities and member composition including designated physician involvement.

- **Corporate Quality Committee (CQC)** - The CQC is co-chaired by the Chief Health Officer and the Chief Medical Officer. Executive Vice Presidents and Vice Presidents are responsible for the strategic direction and governance of the Company's overall quality improvement (QI) program. The quality improvement process is intended to optimize the health, safety and experience of all members; promote collaboration with providers to drive value; and reduce healthcare costs of the population. The CQC oversees compliance with quality-related standards, guidelines and operational processes. The CQC reports to the Medical Mutual of Ohio Board of Directors.
- **Clinical Quality & Resource Management Committee (CQRM)** – The CQRM provides strategic direction and oversight to all quality committees focused on the quality and safety of clinical care. The CQRM is responsible for the reporting of delegated oversight of the utilization management vendor. The CQRM committee reports to the CQC. Reporting to CQRM committee are five supporting committees.
 - **Behavioral Health Committee (BH)** - The BHC provides leadership and guidance on the strategic direction of the behavioral health services, medical policy decisions and quality activities.
 - **Credentialing Committee** - The Credentialing committee uses a peer-review process to make final determinations regarding credentialing decisions. Practitioners participating in the health plan's networks and who are selected for this committee provide meaningful advice and expertise when making decisions. The committee is responsible for the reporting of delegated oversight of delegated credentialing entities.
 - **Population Health Sub-Committee (PH)** – Formerly the Disease Management/Wellness & Health Promotion Committee, the PH Sub-Committee is responsible for the strategic direction of programs, activities, quality improvement initiatives and vendor oversight that support population health management across the continuum of health care. This committee is responsible for the reporting of delegated oversight of the disease management and wellness vendors.
 - **Pharmacy & Therapeutics Committee (P&T)** - The mission of the P&T committee is to provide safe, high quality, pharmaceutical care that is cost-effective by providing ongoing oversight and direction to Medical Mutual's prescription drug program and drug management initiatives. This committee is responsible for the reporting of delegated oversight of the Pharmacy Benefit Manager and the utilization management vendor for drug.
 - **Member Experience/Service Quality Improvement Committee (MESQ)** – The MESQ Committee is a cross-functional committee whose objectives are to oversee and improve upon the quality of service and members' experience with health plan services.

- **Medicare Stars Steering Committee:** The Medicare Stars Steering Committee is composed of senior leadership for our Medicare Advantage product line, they are responsible for the strategic direction and governance of the Company's overall Medicare Advantage Stars program. The committee monitors the Stars dashboard's current and projected measure results, as well as related CMS announcements. Based on the monitoring, the Steering Committee identifies, assigns and approves various initiatives to ensure a 4+ Star quality rating. Stars workgroups are formed to address the specific measure. These workgroups delve into the issues impacting the Star results and report back to the committee.

VI. Annual QI Work Plan

The QI Work Plan is developed annually and applies to all lines of business. Initiatives are selected based upon input, a review of quality measures not attaining a 4 Star or 75th percentile rating, impact to member experience and satisfaction, and identified workflows needing improved efficiency or effectiveness. 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 follows the Plan-Do-Study-Act (PDSA) model for quality improvement.

2018 Goals and Objectives

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

- Move to a continuum of care model that aims to improve the quality and safety of clinical care our members receive
 - Achieve stated Quality Compass percentile goals on HEDIS 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
 - Achieve stated Quality Compass percentile goals on HEDIS measure specific to improving clinical care which include screening measures to keep members healthy.
 - Strengthen collaborative efforts internally and externally to avoid fragmented care.
 - 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 procedures.

Medical Mutual's Quality Improvement Work Plan is a dynamic document that lists the planned activities, objectives, goals, time frame and responsible departments. Detailed project plans with target dates are maintained by the project lead.

Medical Mutual used the 2017 HHS Chicago All Lines of Business (LOB) Average Regional Quality Compass Benchmark for this plan.

VII. Improving Quality of Clinical Care

The following clinical care issues have been identified for inclusion in the annual Workplan in 2018:

1. Adult Body Mass Index (BMI)
2. Breast Cancer Screening
3. Controlling High Blood Pressure
4. Comprehensive Diabetes Care/Continuity of Care
5. Cervical Cancer Screening
6. Colorectal Cancer Screening
7. Flu Vaccinations for Adults
8. Prenatal/Postpartum Care
9. Asthma Medication Ratio
10. Chlamydia Screening in Women
11. Managing Coexisting Conditions – Diabetes and Comorbid Depression
12. Follow-up after ER inpatient admission for Asthma
13. Transition from Pediatric to Adult Care

VIII. Improving Safety of Clinical Care

The following issues have been identified to improve safety of clinical care:

1. Identifying unsafe practices by tracking and trending reported quality cases related to serious reportable events, hospital acquired conditions, inpatient mortality and complaints against network providers and facilities.
2. Promoting medication safety through improved shared-decision making.
3. Promoting medication safety through monitoring for non-adherence of prescribed medicine and alerting physicians to unsafe practices.
4. Assuring follow-up care with the member's physician following a NurseLine referral to the ED.
5. Preventing hospital readmissions through early identification of needs and coordination of care at transitions from hospital to home.
6. Monitoring and improving appropriate use of psychotropic medications.

7. Evaluating member/provider compliance with appropriate metabolic monitoring for children and adolescents on antipsychotics.

IX. Improving Quality of Service

The following issues have been identified for improving the quality of service of the health plan:

1. Reducing the number of member appeals.
2. Increasing the rate of members satisfied with the health plan.

X. Improving Member Experience

The following issues have been identified for improving member experience with the health plan:

1. Improving the availability of in-network behavioral health practitioners and facilities to assure access to needed care.
2. Assuring accurate physician practice information is provided to our members.
3. Improving the process by which member complaints about accessibility are identified and reported to Quality.

Five issues were identified in 2017 that will be monitored and addressed in 2018.

1. Multiple concurrent contacts causing member abrasion. In the effort to communicate via multi-channels some members requested to be eliminated from future campaigns. Although the number of members was not high, Medical Mutual will be more cautious about the timing and outreach campaigns to avoid member abrasion.
2. Accuracy of current member phone numbers. Medical Mutual is evaluating the multiple touch-points whereby more accurate information can be gathered and stored. Not having accurate contact information negatively impacts outreach efforts and members do not receive important educational materials.
3. Accuracy of Provider phone numbers address and/or emails. The accuracy of provider data is being addressed as a quality improvement initiative due to the impact on member experience. Accurate practice information is vital to members in being able to select open practices and network providers. Information is also critical to the practices for their ability to receive information affecting our members.
4. Members attributed to a PCP. Coordination and continuity of care as well as overall health outcomes are enhanced when members are attributed to a PCP. Promoting member and PCP relationship will be ongoing in our communications to members.
5. Receipt of claims from vendors or non-contracted providers. Medical Mutual does not always receive claims for services such as flu shots done at health fairs, eye exams for members with diabetes done by a non-network provider or HbA1C done at biometric screenings where claims are not submitted. These sources will be further identified as a 2018 corporate initiative to improve receipt of data and its integrity.

XI. Evaluation of the QI Program

There are five components used for the annual evaluation of Medical Mutual's Quality Improvement Program. A comprehensive evaluation is completed as data and information become available. The responsibility of the QI Program lies with the Clinical Quality Improvement department with input from each responsible area and support from Health Information Management and Analytics. Final review is done by executive leadership and approval is provided by the Chief Medical Officer. The evaluation is reported to the CQRM Committee and outcomes, barriers and final recommendations are presented to the Corporate Quality Committee.

The five components for the annual evaluation are:

1. Each HEDIS, Stars and CAHPS clinical quality measures are evaluated against the prior year's performance. Quality Compass percentiles (national and regional) and Medicare Stars Ratings cut-points (as available).
2. Performance compared to established goals as stated within the Action Plan.
3. Barriers to improvement and root cause analysis.
4. Structure of the quality program and ability to meet areas of responsibilities.
5. Adequacy of appropriate resources dedicated and available to the quality program.

XII. Serving a Diverse Membership

Medical Mutual's 2018 objectives for serving a diverse membership are to:

1. Meet identified cultural and linguistic needs in materials and communications.
2. Assure network practitioners are available to meet the need of our members.
3. Identify healthcare disparities related to culture, language or race as detected during quality case reviews or analysis of member complaints.
4. Identify and reduce healthcare disparities if detected through reporting of geographic variances of healthcare outcomes or care gaps.
5. Reinforce identification of issues through staff training.

Health Information Management and Analytics (HIMA) analyzes Medical Mutual's membership as described below. Findings are reported in the Population Health Assessment.

A review of the language needs of potential members is conducted using the most current American Community Survey (ACS) Five Year Population Assessment data for language spoken at home published by the United States Census Bureau (U.S. Census Bureau) the ACS is tracked by county population and preferred language spoken. The goal is to identify any county in Ohio with at least 10% of the population speaking one language other than English and speaking English less than well. Membership in those counties is then identified and reviewed to determine if there are opportunities to enhance materials and communications.

Supplemental data is collected to further identify trends, needs and preferences, including:

- Reports on calls interpreted through the AT&T Language Line and documents translated by Transperfect.

- Member demographics from the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) health plan survey.
- Member demographics from Health Appraisal data.
- Contacts from members with special needs recorded in the Contact On-line Reporting System (CORS) by Customer Care Specialists for translation of complaint or appeal documentation.

The Network Management department utilizes membership data as reported by HIMA to determine if the number of network providers who speak languages other than English are available to meet the identified needs of our members. Findings are published in the Provider Network Availability report.

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

During quality case reviews reported to Clinical Quality Improvement, nurses will review findings to determine if culture, language or race affected individual health outcomes.

Culture, language and race are considerations when evaluating any geographic variance of health outcomes or care gaps. Should these be detected, root cause analysis would be conducted.

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.