

Quality Assessment Performance Improvement

CALENDAR YEAR 2026 PROGRAM DESCRIPTION

**Aetna Better Health of Michigan
Quality Management Department**



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Introduction

Aetna Better Health of Michigan's (ABHMI) quality assessment performance improvement (QAPI) program is designed to continuously improve and monitor medical care, member safety, behavioral health services, and the delivery of services to members. The QAPI program also completes ongoing assessments of program standards to determine the quality, accessibility and appropriateness of care, case management and coordination. A key focus of our quality program is improving the member's biological, psychological, and social well-being with an emphasis on quality of care and the non-clinical aspects of all services. When the member's condition is not amenable to improvement, our goal is to implement measures to assist the member to live safely in the least restrictive setting. Incorporating the continuous quality improvement (CQI) concept, our quality program is comprehensive and integrated throughout ABHMI and the provider network. We promote the integration of our quality management activities with other systems, processes, and programs throughout ABHMI.

The quality management program is a health plan-wide endeavor that uses an integrated and collaborative approach involving each functional area. Our quality program also includes a structure of oversight committees with representation not only from across ABHMI but from the provider network and member population as well. Evaluation of effectiveness of the prior year's quality management program forms the basis for the scope of work, goals and objectives, structure, and responsibilities of the QAPI program for the upcoming year.

Quality Management Program Overview

Program, Structure and Operations

The primary purpose of the QAPI Program is to provide the structure and processes necessary to identify and improve clinical quality, maximize safe clinical practices, and enhance member and provider satisfaction across the various settings of care within the care delivery system.

The QAPI Program strives to ensure that the services provided to ABHMI members conform to the standards and requirements of regulatory and accrediting agencies, including Michigan's Department of Health and Human Services (MDHHS) and the National Committee for Quality Assurance (NCQA).

Further, the purpose of the QAPI Program is to establish standards, criteria, and provide processes, procedures, and structures to review and monitor the care and services delivered, including accessibility, availability, and continuity of care. The quality department staff coordinates organizational participation in the assessment of quality of care, identification of issues, strategies to mitigate challenges, and follow-up activities and documentation.

The purpose of the quality management program includes the following:

- Promotion of improvement in the quality of care provided to enrolled members through established processes, including:
 - Annual and continuous monitoring, evaluation, and identification of trends and areas for improvement in the service delivery system, health outcomes, and provider network.
 - Continuous monitoring of progress on performance goals and objectives
 - Implementing action plans and activities to correct deficiencies and/or improve overall quality in the process of care and clinical operations.
 - Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.
 - Ensuring ongoing Quality Assessment and Performance Improvement services/programs including physical health, mental health, oral health

and Social Determinants of Health (SDoH) factors are monitored with identified trends, barriers and opportunities for improvement.

- Compliance with federal and state requirements.
- Define behavioral healthcare aspects of the program.
- Define physical healthcare aspects and core measures of the program.
- Define SDoH factors and Regional Analysis to address identified barriers and access to care issues.
- Complete an Oral Health Evaluation of program effectiveness with identified barriers and opportunities for improvement.
- Ensure involvement of designated physicians or providers in review of the QI program and activities.
- Ensure oversight of QI functions of the organization by the Quality Management Oversight Committee (QMOC).
- Support executive and management staff participation in quality management and performance improvement processes.
- Development and implementation of quality management and performance improvement activities that include contracted provider participation and information provided by members, their family/representatives and/or caregivers.
- Identification of the best practices for quality management and performance improvement.
- Continuous review, evaluation, and improvement in the quality and safety of clinical care and services considering demographic groups, races, ethnicities, members with special or complex health needs, care settings, and types of services provided to a culturally and linguistically diverse membership.

Scope of Program

The quality management program applies to all ABHMI departments and staff, members, and providers including:

- All member populations, age groups, disease categories, and special health care needs groups for physical, oral, and behavioral health.
- All sites and facilities where contracted and/or non-contracted providers deliver health care or services to members.
- The ABHMI network as well as out-of-network practitioners and providers who deliver care to ABHMI members.

- Internal ABHMI operations (e.g., programs and services, such as prior authorization, utilization management, care management, member services and provider experience.)
- All services, both clinical and non-clinical, provided to members by network or out-of-network providers or delegated entities at any point in the continuum of care and at any level of care.
- All customer interactions.
- Processes by which providers and members provide ABHMI with feedback and recommendations for improving services.

ABHMI integrates quality management and performance improvement processes into all departments, with each department responsible for selected processes, functions, and monitoring activities. Staff perform monitoring activities as a part of routine operations and report results to the appropriate internal departments, committees or external agencies as required.

QAPI Program Goals and Objectives

ABHMI strives to achieve the following primary goals:

- Implement a QM program that effectively promotes and integrates quality practices into the organizational structure and processes of the health plan
- Conduct continual monitoring and assessment of patient care services provided to health plan members
- Identify and analyze opportunities for improvement with implementation of appropriate actions and follow-up monitoring
- Encourage patient safety practices
- Maintain compliance with local, state, and federal regulatory requirements and accreditation standards

The Appendix section contains a detailed description of ABHMI goals and objectives (see [APPENDIX 1 - GOALS AND OBJECTIVES](#)).

Program Structure

Quality improvement activities that support the goals and objectives of the QAPI program are coordinated on an annual basis. The quality management program

cycle is based on the calendar year. The QM Director makes interim modifications to the QAPI program documents as needed. The following components form the framework to meet ABHMI goals and objectives:

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

QAPI Program Description

The QAPI Program Description outlines ABHMI's strategic plan and goals designed to meet or exceed the state's quality strategy, plan, and other requirements of the ABHMI contract. The quality management program design and methodology includes:

- A written description of the program including the program scope, purpose, and major components and activities
- Behavioral healthcare aspects of the program¹
- Methodology for assessing patient safety
- Collaboration with a designated physician overseen by the ABH Chief Medical Officer²
- Coordination with a behavioral healthcare practitioner for the behavioral aspects of the program³
- Oversight of QI functions by the QI Committee⁴
- Annual work plan
- Objectives for servicing a culturally and linguistically diverse membership
- ABHMI's specific QAPI program goals and measurable objectives
- Accountability to the board of directors
- Documentation of the Board of Director's approval of the QAPI program description, evaluation, and annual work plan
- Direction and oversight by the ABHMI Chief Medical Officer
- Committees authorized to advise and make recommendations about the QAPI program

¹ NCQA HPA 2025 QI1 A2

² NCQA HPA 2024 QI1 A3

³ NCQA HPA 2024 QI1 A4

⁴ NCQA HPA 2024 QI1 A5

- Resources, including data systems, allocated by ABHMI for the QAPI program
- ABHMI's administrative structure for QAPI oversight
- Documentation that appropriately qualified personnel are employed to effectively carry out QAPI functions
- Monitoring and evaluation of ABHMI's service delivery system and provider network to demonstrate compliance with state and federal regulatory requirements
- Integration of member rights and responsibilities into the QAPI program by providing informative education for members as well as the ABHMI provider network through ABHMI multi-modal communications
- Delegation oversight assessments and accountability of all delegated functions including credentialing, dental, vision, pharmacy, and more
- A description of processes used to confirm that medical records for each member reflect all aspects of patient care, including inpatient, residential, specialty and ancillary care
- ABHMI's process for grievance and appeal resolution as well as tracking and trending outcomes
- Documentation of planned activities to meet or exceed mandated performance measures and performance improvement project goals
- Evaluation of documentation of feedback from contracted or affiliated providers and members
- A program structure based on ABHMI policies and procedures
- Processes used by ABHMI's health information system to collect, integrate, analyze, and report data necessary to implement the QAPI program

Departmental staff reviews the QAPI program annually and makes revisions as necessary. The QAPI is submitted for review and approval to the Quality Management/Utilization Management (QM/UM) Committee and the Quality Management Oversight Committee (QMOC). The Board of Directors provides the final approval of the QAPI program. The plan communicates QAPI program information and performance to new and existing members, practitioners, and providers annually.

Annual QAPI Work Plan⁵

ABHMI documents and executes a QAPI annual work plan that is used to facilitate achievement of quality management goals for the year. Planned yearly activities included in the work plan address safety and quality of clinical care, quality of service, and members' experience. The QAPI work plan is an activity-tracking tool which provides a timeline and description of deliverables. The plan also includes quality management and performance improvement activities, utilization of resources, designated staff and/or department responsibilities, monitoring of previously identified issues and interventions, progress towards completion, and an annual evaluation of the QAPI Program. QM department staff use the tool as an action plan to document the status and changes in activities throughout the year. The Annual QAPI Work Plan should also include the following components:

1. Yearly planned QI activities and objectives.
2. Time frame for each activity's completion.
3. Staff members responsible for each activity.
4. Monitoring of previously identified issues.
5. Evaluation of the QI program.

QM department staff review the QAPI work plan at least quarterly, make revisions if necessary, and submit for approval to the Quality Management/Utilization Management Committee and the QMOC.

Annual Quality Management Evaluation⁶

QM department staff conducts an annual evaluation of the QAPI program to assess the overall effectiveness of ABHMI quality improvement program. The annual program evaluation provides an assessment of completed and ongoing activities that address quality of service and care as outlined by the QAPI Program Description. It also addresses barriers from the previous year and identifies barriers encountered during the calendar year evaluated, including data trends for performance measures, and provides ABHMI with the opportunity to amend the quality management program for the upcoming year. The evaluation includes all aspects of the QAPI program to determine the extent and effectiveness of improvements in the quality of care and services.

⁵ NCQA HPA 2025 QI 1B

⁶ NCQA HPA 2025 QI 1C

ABHMI reviews the annual evaluation and uses the findings to establish quality management and performance improvement goals for the upcoming year. Opportunities for improvement identified in the evaluation or articulated by state regulators or other key stakeholders drive the development of the goals and objectives.

The ABHMI Quality Management Department is responsible for preparing the annual evaluation and submitting it for review and approval to the QM/UM Committee, QMOC, and the Board of Directors.

Organization Structure and Administration

A formal committee structure allows for oversight of the QAPI program and the flow of information to and from the board of directors. The committee members integrate ABHMI medical functions, operations departments, network, and members into the quality management program through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements.

Board of Directors

The ABHMI Board of Directors has ultimate accountability for the QAPI program and related processes, activities, and systems. This includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through the health delivery network.

The Chief Executive Officer, on behalf of the QMOC, submits the QAPI Program Description and any subsequent revisions to the Board of Directors for approval. In addition, the Chief Executive Officer annually submits an evaluation of the previous year's QAPI activities, summary reports, data, outcomes of studies, and credentialing activities (i.e., annual evaluation) to the Board of Directors. The Board of Directors also reviews the proposed annual QAPI Work Plan. After evaluating the information, the Board of Directors will approve, approve contingent upon revision, or provide direction and recommendations to the Chief Executive Officer for enhancements to the QAPI Program Description and Work Plan. Should revisions be needed, the documents will be re-presented to the Board of Directors for approval.

Quality Management Oversight Bodies

Formal committees, subcommittees, and ad hoc work groups advise and guide the QAPI process. The committee members foster collaborative partnerships and integrate ABHMI medical functions, operations departments, the provider network, and members into the QAPI program through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements. The quality management department provides the administrative support for the coordination of committee meetings, meeting preparations, and follow-up activities. The QMOC provides executive oversight of

quality activities and their integration across the plan through its receipt and review of reports and minutes from the sub-committees.

ABHMI Committees

The Board of Directors receives quality management and performance improvement activities reports from the following committees:

- Quality Management Oversight Committee (QMOC)
- Regulatory Compliance Committee (RCC)
- Quality Management/Utilization Management Committee (QM/UM Committee)
 - Behavioral Health Committee
- Delegation Committee
- Aetna Credentialing and Performance Committee (CPC)
 - Aetna Practitioner Appeal Committee (PAC)
- Aetna National Quality Oversight Committee (NQOC)
- National Drug Utilization Review Board
- Pharmacy and Therapeutics Committee (P&T)
- Service Improvement Committee (SIC)
 - Grievance Committee
 - Appeals Committee
 - Provider Network Needs Committee (PNNC)
- Member Advisory Committee (MAC)
- Executive Compliance Committee (ECC)
- Policy Committee

Quorum

QM committee and sub-committees convene at regularly scheduled meetings, or more often as the chairperson deems necessary. A quorum consisting of 50% of the voting members must be present for any QM committee to conduct business. A simple majority vote of the quorum will constitute committee approval.

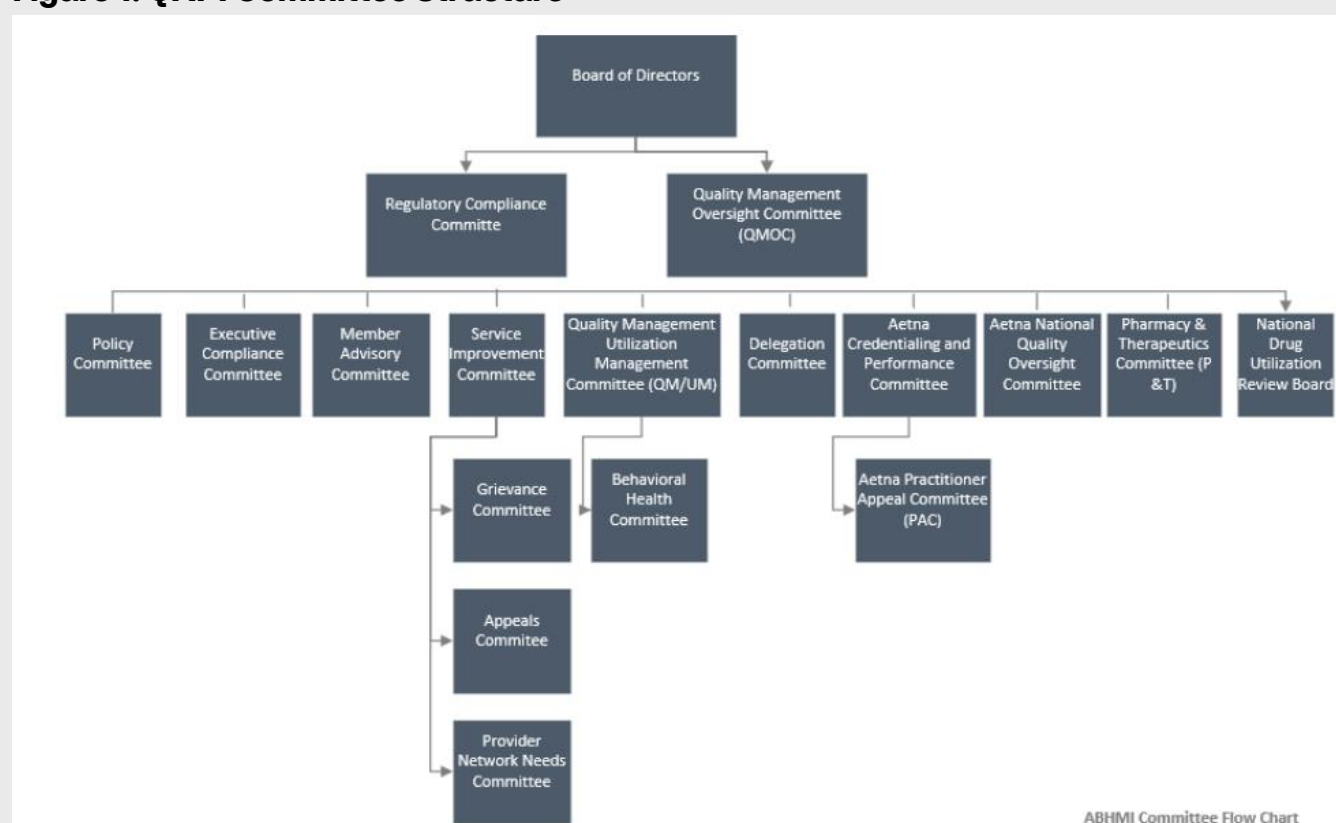
Membership Responsibilities

Participants are to be present and/or have a representative participate in the meetings to ensure that a quorum is present to conduct business.

Minutes

An assigned staff member records committee minutes for each committee meeting. Minutes include the name of the committee, date, list of members present, and list of guests, if applicable. The minutes reflect discussions, decisions, and recommendations put forth by committee members. Committee members review all minutes. After committee approval, an assigned staff member submits signed and dated minutes to appropriate committees and are then stored in confidential files.

Figure 1. QAPI Committee Structure



Quality Management Oversight Committee (QMOC)⁷

Authority

The primary purpose of the QMOC is to integrate quality management and performance improvement activities throughout the health plan and the provider network. The committee provides executive oversight of the QAPI program and

⁷ NCQA HPA 2023 QI1 A5

makes recommendations to the Board of Directors about ABHMI quality management and performance improvement activities, including development of the annual QAPI Program Description, QAPI Work Plan, and QAPI Program Evaluation. The QMOC also ensures that the QAPI plan is integrated throughout the organization, as well as all appropriate departments, delegated organizations, and network providers.

Major Responsibilities

- Ensure that the ABHMI QAPI program is integrated throughout the organization, among its departments, contractors, and stakeholders
- Ensure that the QAPI Work Plan is implemented and completed
- Ensure that quality activities are designed to improve the quality of care and services provided to members
- Review and revise the QAPI Program Description and Work Plan annually and submit a recommendation for their approval to the Board of Directors
- Review and approve committee reports from all medical committees
- Review, evaluate and make recommendations based on the results of QAPI initiatives; review member/provider satisfaction survey results
- Advise or make recommendations to improve the health plan
- Assist in developing action plans; review and approve submitted action plans/progress reports
- Recommend pertinent policy decisions involving quality
- Oversee recommendations and revisions to policies for effective operation of the QI program and achievement of QI program objectives
- Facilitate participating practitioner involvement in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings
- Identify actions to improve quality, prioritize them based on their significance and choose which to pursue, or oversee these functions if performed by an associated committee or subcommittee.
- Oversee the annual analysis and evaluation of the QI program, including effectiveness of QI activities, improvements in the access and quality of physical and oral healthcare and services for members as a result of quality assessment and targeted interventions carried out by ABHMI, and assess the results.

- Review and evaluate company-wide performance monitoring activities, including care management, customer service, credentialing claims, grievance and appeals, prevention and wellness, provider experience and quality, utilization management, and population health management.

Membership

- Chief Executive Officer – Chairperson (one voting member)
- Chief Operating Officer (one voting member)
- Chief Financial Officer (one voting member)
- Chief Medical Officer (one voting member)
- Director of Quality Management (one voting member)
- Director of Medical Management (one voting member)
- Compliance Officer (one voting member)
- Director of Network Contracting (one voting member)
- Director of Provider Relations (one voting member)
- Director of Member Services (one voting member)
- Director of Population Health Management (one voting member)
- Director or Senior Managers from other functional areas (as approved)
- Director of Behavioral Health Management (one voting member)

ABHMI members (nonvoting) and members of the Board of Directors (advisory) may also attend.

Meeting Interval

The QMOC meets a minimum of six times a year and more frequently if necessary. An assigned staff member documents committee minutes for all meetings and provides to the Board of Directors for review, comments, and approval. Minutes are kept safe, confidential, and protected.

Quality Management/Utilization Management Committee (QM/UM Committee)

Authority

The QM/UM Committee's primary purpose is to advise and make recommendations to the Chief Medical Officer on matters pertaining to the quality of care and service provided to members including the oversight and maintenance of the QAPI and utilization management programs. The QM/UM Committee functions as ABHMI's

provider advisory committee and allows providers to review and provide input/feedback into quality-related programs and documents. The QMOC receives summary reports from the QM/UM Committee for review and approval and submits them quarterly to the Board of Directors.

Major Responsibilities

- Review and evaluate data sets and other information, such as member demographics, costs, and performance indicator results along with recommended actions
- Review and approve studies, standards, and clinical guidelines
- Review trends in quality and utilization management measures, outcomes, and review results of provider medical record reviews
- Review and recommend approval, revision, or denial of medical review criteria
- Review and evaluate the results of QAPI activities (such as HEDIS^{®8} results, reports, data sets, study results, member and provider satisfaction survey findings, and general information related to programs, systems, and processes)
- Identify opportunities to improve the care and services provided to members, and recommend solutions to the Chief Medical Officer
- Assist in developing action plans, review and approve action plans submitted to the committee from other sources, and review action plan progress reports
- Review and approve the QAPI and Medical Management Program Description, Work Plan and annual Evaluations
- Conduct peer review and investigate quality of care or service and member safety issues, make recommendations for appropriate action to correct deficiencies to the Chief Medical Officer, and request follow-up by the Aetna Credentialing and Performance Committee (CPC), if appropriate
- Recommend and direct quality management activities and policy and operations changes
- Review utilization issues (cases) requested by the Chief Medical Officer
- Review quarterly utilization reports from delegated entities and make recommendations for improvement if necessary
- Review, evaluate, and recommend practitioner, provider, and member educational activities and interventions

⁸ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance

Membership

- Chief Medical Officer – chairperson⁹ (one voting member)
- Medical Director (one voting member)
- Behavioral Health Medical Director (one voting member)
- A cross representation of network providers, including primary care practitioners (PCPs) /medical homes, specialists, pediatricians, OBGYNs, behavioral health providers (one vote for each participating practitioner)
- Director of Quality Management (one voting member)
- Director of Medical Management (one voting member)
- Director of Population Health Management (one voting member)
- Support staff as requested

Meeting Interval and Documentation

The QM/UM Committee meets no less than ten times per year and as frequently as necessary to demonstrate follow-up on all findings and required actions. An assigned staff member records minutes and forwards to the QMOC for review. ABHMI maintains a process to ensure rules of confidentiality are followed in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members. ABHMI Board of Directors reviews approved minutes.

Delegation Committee

ABHMI does not delegate QAPI activities. ABHMI may delegate limited health plan activities at the discretion of executive leadership.

Authority

The Delegation Committee advises and makes recommendations to the QMOC about delegated relationships.

⁹ NCQA HPA 2023 QI1 A3

Major Responsibilities

- Evaluate each delegate or prospective delegate's quality assurance plan and ongoing reporting (such as prior authorization time standards and customer service)
- Review the results of oversight assessments conducted by ABHMI to monitor the performance of delegated or prospective delegated entities and make recommendations to the QMOC regarding delegation status and corrective action plans
- When deemed necessary, request and monitor corrective action plans (CAP) from delegated entities
- Monitor and evaluate delegated functions via regular reports, at least semi-annually through reporting as defined in the delegation agreement

Membership

- Chief Medical Officer – chairperson (one voting member)
- Chief Operating Officer or designee (one voting member)
- Director of Medical Management (one voting member)
- Director of Quality Management (one voting member)
- Director of Population Health Management (one voting member)
- Compliance Officer – (one voting member)
- Pharmacy Director – (one voting member)
- Other selected staff or departments (representatives from Member Services, Provider Relations and Grievance/Appeals departments)

Meeting Interval and Documentation

The committee meets quarterly and more frequently if necessary. An assigned staff member documents the minutes and stores them in a safe and confidential file.

Summary reports are sent to the QMOC and Board of Directors.

Aetna Credentialing and Performance Committee (CPC)

Authority

The ABHMI QMOC has delegated decision-making authority to the Aetna Credentialing and Performance Committee (CPC). This committee is responsible for credentialing and recredentialing individual providers (i.e., practitioners) who deliver

services to members. This committee is also responsible for conducting professional review activities involving the providers whose professional competence or conduct adversely affects or could adversely affect the health or welfare of members.

Major Responsibilities

- Receive and review, at a minimum, health practitioner/professional and provider credentials that do not meet Aetna’s credentialing criteria (i.e., that are not complete, “clean” as defined by Aetna, and approved by the Aetna Medical Director)
- Conduct peer review evaluations
- Make decisions regarding actions on the credentialing or recredentialing information presented

Membership

The committee is composed of participating practitioners of various specialties who are all voting members.

- Aetna Medical Director, facilitator
- Representatives from a range of participating practitioners in specialties that include primary care and high-volume specialists
- Other specialty practitioners may be included as necessary for peer review, e.g., dentists, chiropractors
- Behavioral health practitioners including a psychiatrist, a psychologist, and a master’s level behavioral health clinician

Meeting Interval

The Credentialing and Performance Committee meets at least every 45 days.

Aetna Practitioner Appeals Committee (PAC) - subcommittee to CPC

Authority

The ABHMI QMOC has delegated decision-making authority to the Aetna Practitioner Appeals Committee (PAC). The purpose of the Aetna Practitioner Appeals Committee (PAC) is to conduct professional review hearings of practitioners who appeal decisions made by the Aetna Credentialing and Performance Committee involving professional competence or conduct of the

practitioner. The committee, facilitated by an Aetna medical director, consists of practitioners appointed on an ad hoc basis.

Membership

The committee is composed of three to seven members, who are participating practitioners (all voting members):

- An Aetna medical director facilitates the meetings (non-voting)
- A majority of members are peers of the affected practitioner
- At least one peer who is licensed in the same state as each practitioner reviewed by the committee
- At least one voting member who practices in a specialty substantially similar to the specialty of the practitioner, if specialty knowledge is required by the nature of the appeal

Meeting Interval and Documentation

The Aetna Practitioner Appeals Committee meets as needed.

Aetna National Quality Oversight Committee (NQOC)

Authority

The ABHMI QMOC has delegated authority to the Aetna National Quality Oversight Committee (NQOC) to conduct the credentialing/recredentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors potential quality of care issues and complaints.

Major Responsibilities

- Review and evaluate identified potential quality of care concerns related to facilities/organizational providers/vendors.
- Make decisions regarding actions on the credentialing and recredentialing of facilities/organizational providers/vendors

Membership

The committee is a multidisciplinary committee composed of department representatives:

- Aetna Medical Director or designee as meeting chair
- Representatives from Quality Management, Behavioral Health Quality Management, Pharmacy Management, Clinical Services, Claims, Complaints, Grievance and Appeals, National Accounts, Network Management, Customer Service and Compliance

Meeting Interval

The Aetna National Quality Oversight Committee meets at least ten (10) times a year.

Service Improvement Committee (SIC)

Authority

The Service Improvement Committee advises and makes recommendations to the QMOC and/or ABHMI management about customer (member and provider) issues.

Major Responsibilities

The committee's responsibilities include the following:

- Review and evaluate data, surveys, and trends in member and provider complaints, grievances, and appeals to identify opportunities for improvement in member and provider satisfaction
- Formulate initiatives and recommendations to drive continuous improvement
- Review/evaluate and make recommendations about operational measures (such as prior authorization time standards, claims payment standards, customer service time standards, member enrollment and disenrollment reconciliation)
- Review/evaluate and make recommendations about compliance with standards for claim reporting
- Review the results of oversight assessments conducted by ABH to monitor the performance of delegated or prospective delegated entities and make recommendations to the QMOC regarding delegation status and corrective action plans.
- Review reports from the Member Advisory Committee and recommend action

Membership

- Director of Operations - chairperson (one voting member)

- Chief Medical Officer or designated medical director (one voting member)
- Representatives from Member Service, Provider Experience, Medical Management, Quality Management, Compliance and Grievance and Appeals departments (six voting members)
- Other selected staff or departments as required

Meeting Interval

The Service Improvement Committee meets at least quarterly.

Grievance Committee

Authority

The Grievance Committee reviews complaint/grievance trends and may resolve issues related to an expression of dissatisfaction filed by members or providers.

Major Responsibilities

- Review and evaluate member grievances on an ongoing basis
- Review, evaluate and make recommendations on identified opportunities for improvement
- Maintain records according to applicable regulations and contractual requirements

Membership

The committee members have status as relates to reviewing, evaluating, and making recommendations on identified opportunities for improvement.

- Grievance and Appeals Manager – chairperson (one voting member)
- Compliance Officer (one voting member)
- Grievance and Appeals Analyst
- Representatives from Member Services, Quality Management, Medical Management and Provider Experiences Departments
Note: If the grievance involves a clinical decision, the Medical Management representative will be a provider of the same or similar specialty not involved in any prior decision making on the issue (one voting member/department)
- At least one ABHMI member advocate

Note: The committee considers all documentation received as part of the grievance. If the grievance that is brought to Grievance Committee is related to a clinical issue such as an expedited grievance, then a clinical reviewer must resolve the issue. When reviewing a clinical issue, none of the voting members on the committee will have been involved in the original decision. The Chief Medical Officer (CMO) or designated medical director who is also not a subordinate of the original decision maker takes a vote and renders the final decision.

Meeting Interval and Documentation

The committee meets at least monthly and as needed. Assigned staff document meeting minutes and retain them in a safe, confidential, and protected file by the Appeal and Grievance Department. Summary reports are sent to the SIC.

Appeal Committee

Authority

The Appeal Committee reviews appeal trends and may render decisions on appeals filed by members or providers.

Major Responsibilities

- Review and render decisions on appeals
- Render decisions in accordance with contractual requirements
- Maintain records according to applicable regulations and contractual requirements

Membership

- Grievance and Appeals Manager – chairperson (one voting member)
- Compliance Officer (one voting member)
- Chief Medical Officer or designated medical director (one voting member)
- Representatives from Quality Management and Utilization Management departments
- If clinical issue – staff RN
- If clinical issue – physician with the same or similar specialty

Note: The committee considers all documentation received as part of the original denial and with the appeal. None of the voting members on the committee will have been involved in the original decision. The Chief Medical Officer (CMO) or designated

medical director who is also not a subordinate of the original decision maker takes a vote and renders the final decision.

Meeting Interval and Documentation

The committee meets at least monthly and as needed. Assigned staff document meeting minutes and retain in a safe, confidential, and protected file by the Appeal and Grievance Department. Summary reports are sent to the SIC.

Member Advisory Committee (MAC)

Authority

The Member Advisory Committee (MAC) provides feedback to ABHMI regarding strategies for improving member care and services including health education and other member materials.

Major Responsibilities

- Review and recommend strategies to improve clinical performance measures, cultural competency, member outreach plans, member educational materials (e.g., readability, content), prevention programs, satisfaction survey tools, and other initiatives requested by QMOC
- Solicit enrolled member feedback and opinions regarding issues related to access and quality of care and services provided to members, as well as potential programs, activities, and educational materials

Membership

The committee is advisory, and members do not have voting rights.

- Manager of Member Services (chairperson)
- ABHMI staff
- Quality Management representative
- ABHMI member representatives (maximum of fifteen representatives)

Meeting Interval and Documentation

The Member Advisory Committee meets quarterly. Minutes, along with summary reports, are recorded for all meetings and are provided to the QMOC and/or Service

Improvement Committee for review and consideration. ABHMI keeps minutes of meetings safe, confidential, and protected.

National Drug Utilization Review Board (DUR)

Authority

The DUR analyzes member and practitioner/provider drug utilization patterns to identify educational and/or interventional opportunities that promote patient safety and appropriate utilization. The DUR also monitors quality outcomes and works to drive cost-effective drug therapy.

Major Responsibilities

The DUR Board approves and monitors the impact of member and practitioner/provider educational materials and programs to address concerns including, but not limited to:

- Overutilization and underutilization
- Therapeutic appropriateness; incorrect drug dosage or duration of drug treatment
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindication and drug-drug interactions
- Clinical abuse/misuse and incorrect drug dosage or duration of drug treatment
- Frequency of patterns of fraud, abuse, gross overuse, inappropriateness, or medically unnecessary drug usage

Membership

The DUR is a national committee with core members, all of whom have equal voting rights. The number of committee members is subject to change based on the number of states where there are Aetna Medicaid plans offering pharmacy benefits.

- Aetna Medicaid Administrators LLC (AMA), Senior Medical Director – chairperson (one voting member)
- AMA VP Personalized Health (one voting member)
- AMA Chief Pharmacist (one voting member)
- AMA Senior Directors of Pharmacy (three voting members)
- AMA Medical Director (one voting member)

- AMA Senior Director Clinical Solutions (one voting member)
- AMA Director Pharmacy Service Operations (one voting member)
- AMA Director Clinical Pharmacy (one voting member)
- AMA Quality Management (one voting member)
- AMA Business Analytics (one voting member)

Meeting Interval

The DUR meets quarterly.

National Pharmacy and Therapeutics Committee (P&T)

Authority

The Pharmacy and Therapeutics Committee is responsible for advising and making recommendations to the QMOC and/or ABHMI Medical Director regarding the ABHMI pharmacy program.

Major Responsibilities

- Reviews and assists in development and maintenance of the formulary
- Advises and makes recommendations on member and provider educational materials and programs related to medications and other pharmacy products
- Monitors contracted pharmacy services and make recommendations for improvements
- Participate in the evaluation of new technology related to medications and other pharmacy products.

Membership

The Pharmacy and Therapeutics Committee is a national committee with core members, all of whom have equal voting rights. The number of committee members is subject to change based on the number of states where there are Aetna Medicaid plans offering pharmacy benefits.

- Aetna Medicaid Administrators LLC (AMA), Senior Medical Director – chairperson (one voting member)
- AMA Chief Medical Officer (one voting member for each representative state)
- AMA Chief Pharmacist (one voting member)
- AMA Directors of Pharmacy (one voting member for each representative state)

- AMA Senior Medical Director (three voting members representing different specialties)
- Aetna Medicaid Pharmacists including a pharmacy director of ABHMI (one voting member for each representative state)
- Aetna Medicaid Medical Directors including a medical director of ABHMI (one voting member for each representative state)
- Network pharmacists and physicians (one voting member for each representative)

Meeting Interval

The Pharmacy and Therapeutics Committee meets quarterly.

Regulatory Compliance Committee (RCC)

Authority

The Regulatory Compliance Committee, within the Board of Directors and at the senior management level (RCC), oversees, reviews, monitors, and assesses the effectiveness of ABHMI compliance programs.

Major Responsibilities

- Confirm health plan is meeting all state contractual requirements
- Confirm all elements of the Compliance Program are implemented
- Review all auditing and monitoring activities conducted by external regulatory agencies
- Analyze any identified compliance risks and mitigation strategies
- Review any significant new state regulatory requirements, state agency updates, and applicable laws, and support their implementation
- Consider, introduce, and support various strategies and approaches to promote overall health plan compliance
- Advise the compliance officer and assist in the implementation of the compliance program

Membership

- Compliance Officer, chairperson (one voting member who votes in cases of a tie)

- Chief Executive Officer (one voting member)
- Chief Operating Officer (one voting member)
- Chief Medical Officer (one voting member)
- Chief Financial Officer (one voting member)

Meeting Interval and Documentation

The Compliance Committee meets quarterly, or more frequently, as necessary. An assigned staff member documents the minutes along with summary reports for all meetings and provides to QMOC and the Board of Directors. Minutes and documents are kept in a safe, confidential, and protected file by the Compliance Department and/or other area approved by the Compliance Manager.

Executive Compliance Committee (ECC)

Authority

The Executive Compliance Committee (ECC) advises the Compliance Officer and assists in the implementation of the ABHMI compliance program.

Major Responsibilities

- Identify and raise internal issues of which the Board committee may not be aware
- Incorporate and address findings of Contract Compliance Reviews (annual, onsite, and ad hoc) by MDHHS, external quality reviews, and statewide focus studies
- Review and approve a compliance plan or an annual work plan of compliance activities which includes identifying yearly priorities, areas of risk, and vulnerabilities including those areas identified by the Office of Inspector General / Medicaid Program Integrity (MPI)
- Confirm the health plan is meeting all contractual requirements
- Analyze identified compliance risks as well as potential compliance risks and related corrective actions
- Be aware of new regulatory requirements, state agency updates, and applicable laws and support their implementation, including health plan policy and procedure changes
- Review External Quality Review (EQR) activities, audits, and related corrective action plan activity, and advise accordingly

- Review all auditing and monitoring activities conducted by any regulatory agency and recommend and/or review internal monitoring and corrective action plans
- Strategize to determine best practices for identifying non-compliant activity or fraud including anonymous hotline or other reporting mechanisms
- Review fraud reports and follow-up actions
- Review information regarding the performance of delegates related to compliance and/or fraud and abuse
- Consider various strategies and approaches to promote overall health plan compliance
- Discuss and provide input on proposed contract changes, new business opportunities and network expansion, and Requests for Proposal (RFPs) as they pertain to compliance
- Support the allocation of resources to address compliance corrective actions and compliance gaps
- Identify strategies and opportunities to further promote compliance as a core competency along with compliant business conduct and integrity within ABHMI operations

Membership

- Compliance Officer, chairperson (one voting member who votes in cases of a tie)
- Chief Executive Officer (one voting member)
- Chief Operating Officer (one voting member)
- Chief Medical Officer (one voting member)
- Director of Medical Management (one voting member)
- Director of Quality Management (one voting member)
- Director of Network Management (non-voting member)
- Manager of Grievances and Appeals (non-voting member)
- Government Liaison (non-voting member)
- Quality Management Consultant(s) (non-voting member)
- Provider Experience Manager (non-voting member)
- Behavioral Health coordinator (non-voting member)

Meeting Interval and Documentation

The Compliance Committee meets quarterly, or more frequently, as necessary. An assigned staff member documents the minutes along with summary reports for all meetings and provides to the QMOC and Board of Directors. Minutes and documents are kept in a safe, confidential, and protected file by the Compliance Department and/or other area approved by the Compliance Manager.

Policy Committee (PC)

Authority

The Policy Committee provides a forum for the consistent development, implementation, approval, and communication of all ABHMI policies.

Major Responsibilities

- Facilitate the development, implementation, approval, and dissemination of policies in accordance with all applicable accrediting and regulatory requirements
- Utilize standard policy and procedure templates to ensure comprehensive and consistent approach to policy development
- Serve as the repository for all policies and provide interdepartmental integration
- Facilitate annual review and approval of appropriate revisions by applicable committees
- Facilitate exchange of knowledge of departmental policies
- Identify any gaps in departmental policies

Membership

Participants are to be present and/or have a replacement participate in the meetings to ensure that a quorum is present to conduct business. Simple majority votes of the quorum will constitute committee approval. Each department maintains a policy grid and updates departmental-specific policies. The committee includes the following participants or designee:

- Compliance Officer – chairperson (one voting member)
- Manager, Member Services (one voting member)
- Director of Medical Management (one voting member)

- Director of Grievance and Appeals (one voting member)
- Director of Network Management (one voting member)
- Director of Quality Management (one voting member)
- Director of Provider Experience (one voting member)
- Finance (one voting member)
- Administrative support (non-voting member)

Behavioral Health Committee (BHC)

Authority

The Behavioral Health Committee is attended by BH professionals from our collaborative Prepaid Inpatient Health Plan (PIHP) partners, ABHMI BH team, and representation from our BH contracted providers. The BHC reports to the QM/UM Committee.

Major Responsibilities

- Facilitate the development, implementation, approval, and dissemination of policies in accordance with all applicable accrediting and regulatory requirements
- Review Joint Metrics and BH Quality Withholds or State/National requirements
- Review JOC and community collaboratives
- Review Vendor Performance and resources
- Serve as the repository for all policies and provide interdepartmental integration
- Facilitate annual review and approval of appropriate revisions by applicable committees
- Facilitate exchange of knowledge of departmental Subject Matter Experts (SME's)
- Identify any gaps in departmental processes or member gaps in care

Membership

Participants are to be present and/or have a replacement participate in the meetings to ensure that a quorum is present to conduct business. Simple majority votes of the quorum will constitute committee approval. Each department maintains a policy grid and updates departmental specific policies. The committee includes the following participants or designee:

- Compliance Officer – chairperson (one voting member)
- Manager, Member Services (one voting member)
- Director of Medical Management (one voting member)
- Director of Grievance and Appeals (one voting member)
- Director of Network Management (one voting member)
- Director of Quality Management (one voting member)
- Director of Provider Experience (one voting member)
- Finance (one voting member)
- Administrative support (non-voting member)

Provider Network Needs Committee (PNNC)

Authority

The PNNC reports through the Service Improvement Committee (SIC). According to the MDHHS contract, Aetna Better Health of Michigan (ABH) must maintain and monitor a network of Medicaid enrolled, qualified Providers in sufficient numbers, mix, and geographic locations throughout ABHMI's service area, including counties contiguous to ABHMI service area, for the provision of all Covered Services.

Major Responsibilities

- *Network Management, Network Contracting*
 - *Review monthly QUEST Analytic report for new and existing gaps*
 - *Identify opportunities to address gaps, as applicable*
 - *Composition by core provider types*
 - *Dental*
 - *Vision*
 - *Pharmacy*
 - *NEMT*
- Review open exceptions and actions to cure and/or review potential need for exception as applicable
- Review provider experience and satisfaction survey results
- Review of Credentialing and impact to network composition
- Review of Quality Management CAHPS and BH survey results and NCQA accreditation standard adherence
- Review of Regulatory Compliance and reporting requirements

Membership

- Chief Medical Officer
- Chief Operating Officer
- Director of Quality Management
- Director/Senior Manager of Provider Relations
- Director/Manager of Prior Authorization
- Director/Manager of Concurrent Review
- Director/Senior Manager of Corporate Compliance
- Director/Senior Manager of Appeals and Grievances
- Director of Regulatory Affairs

QAPI Program Resources

Chief Medical Officer

The ABHMI Chief Medical Officer is accountable for directing the development and implementation of the QAPI program. The Chief Medical Officer is a board certified and State-of-Michigan licensed physician who is familiar with the local standards of medical practice and nationally accepted standards of practice. With the assistance of the quality management department and medical committees, the Chief Medical Officer oversees quality management and performance improvement activities to assess whether the activities contribute to the achievement of Aetna Medicaid and health plan goals and objectives. The Chief Medical Officer is responsible for leadership of strategic medical management activities that contribute to the performance of the health plan and promote quality of care for our members.

The Chief Medical Officer's strategic medical management responsibilities include:

- Developing and implementing medical programs/policies
- Administration of all medical management activities
- Evaluating medical cost and return on investment (ROI) analyses
- Enhancing relationships with providers, facilities, and regulatory agencies
- Acting as a key business partner in network development, product design and strategic planning
- Oversees and participates in peer review, adoption of guidelines, credentialing, and other QAPI related functions

- In collaboration with designated medical directors, reviews potential quality/risk management referrals.
- The Chief Medical Officer serves as chairperson of the Quality Management/Utilization Management Committee and does not normally delegate this function to another physician. However, a designated medical director may chair other clinical committees on behalf of the Chief Medical Officer.

In addition, the ABHMI Chief Medical Officer:

- Serves as chair of Quality Management/Utilization Management Committee and as the liaison to the Board of Directors, accountable and for all QAPI activities and initiatives
- Allocates and manages, in collaboration with the Chief Executive Officer, resources necessary to successfully conduct all QAPI activities
- Reviews and approves all QAPI activities
- Is available to ABHMI staff for consultation on referrals, care management cases, denials, grievances, appeals, quality of care concerns and other issues (This may involve after hours consultation)
- Is directly involved in the ABHMI provider recruiting, medical home development and credentialing activities
- Is familiar with local standards of medical practice and nationally accepted standards of practice
- Has knowledge of due process for resolving issues between participating providers and the ABHMI administration, including those related to medical decision making and utilization review
- Is available to review, advise and act on questionable hospital admissions, medically necessary days, and all other medical care and medical cost issues
- Oversees the ABHMI prior authorization/concurrent review process and/or denial of services and timeliness of decisions
- Consults with providers on denied authorization or complex cases and participates in education and training of providers, e.g., use of evidence-based guidelines
- Has knowledge of current peer review standards and techniques
- Has knowledge of risk management standards
- Is directly accountable for all QAPI activities and oversees and is accountable for:

- Referrals to the department and appropriate agencies for cases involving quality of care that have adverse effects or outcomes
- HEDIS® activities and interventions that are conducted by ABHMI's Quality Management Department
- The process for potential practitioner/provider fraud and abuse investigation, review, sanctioning, and referral to the appropriate oversight agencies

Physical Health Medical Directors

ABHMI's physical health medical directors function as administrators providing oversight, as directed by the Chief Medical Officer, to the medical components of the organization, including responsibility for quality management, utilization management, case management, and credentialing. The physical health medical directors provide leadership for the medical health management teams using an integrative medical management model and actively participate in ongoing quality improvement initiatives along with local and state committees.

Behavioral Health Medical Director

ABHMI's behavioral health medical director is a doctoral-level practitioner and acts as an administrator providing oversight, as directed by the Chief Medical Officer, to the behavioral health components of the organization including responsibility for quality management, utilization management, case management, and credentialing. The behavioral health medical director provides leadership for the QM/UM Committee and the behavioral health management teams along with actively participating in ongoing quality improvement initiatives and local committees.

Quality Management Department¹⁰

Under the direction of the Chief Medical Officer, the Quality Management Department coordinates ABHMI's QAPI and provides administrative support for the health plan committees described above. The Chief Medical Officer reviews reports and information and submits to the appropriate committees and state agencies. The department's staff consists of a Director of Quality Management, HEDIS® project

¹⁰ NCQA HPA 2026 Q11 A1

manager, outreach coordinators, data analyst, quality provider liaison, and quality management nurses.

Department responsibilities include but are not limited to the following:

- Review and investigation of information received related to potential quality of care issues (patient safety)
- Coordination, as necessary, with case management, utilization management, and other ABHMI departments to conduct quality management and performance improvement activities
- Monitoring performance rates for the performance measures
- Documentation of quality management and performance improvement activities (e.g., reports, correspondence, minutes) and reports to the appropriate committees
- Maintaining databases for tracking quality of care/service issues, trends, and issue resolutions
- Annual review and revision, if applicable, of the QAPI Program Description
- Development and maintenance of the annual QAPI Work Plan, revising as necessary
- Implements improvement strategies related to HEDIS and Population Health Management outcomes and evaluates progress quarterly
- Coordination of activities involved in the preparation of the annual QAPI Evaluation
- Support and coordination of quality management processes and monitoring activities
- Performance Improvement Projects (focus studies) and coordination of member satisfaction surveys
- External Quality Review Organization (EQRO) coordination
- Develops or adopts performance improvement goals, objectives, activities, and system interventions to improve service delivery, physical, and oral health outcomes for members

Departmental staff maintains documents, medical records, and research documents in a safe, confidential, and protected manner.

The quality management department coordinates evaluation and follow-up on contacts from members, practitioners, providers, state/regulatory agencies, and

other referral sources. The quality management department is the central area for receiving and responding to potential quality and/or risk management and compliance issues and coordinating quality management and performance improvement activities. The department's role in initiating and coordinating communications about the program is critical in linking the entities involved (members, members' representatives/family members and caregivers, practitioners and providers, applicable state, and regulatory agencies, and other ABHMI departments and staff members) and in keeping information about quality management requirements and the status of activities current.

Informatics Population Health Analytics and Outcome Evaluation Departments¹¹

The ABHMI's QAPI program is supported by the Aetna Medicaid Informatics Population Health Analytics and Outcome Evaluation Departments. The Informatics Population Health Analytics team analyzes health and financial information to develop insights that support business decision-making about health care costs, trends, quality, and outcomes. They extract, collect, analyze, and interpret outcome, utilization, and financial data of diverse types from many sources. Informatics Population Health Analytics team uses the results to address business questions regarding population health management, health and economic outcomes, quality of healthcare, and healthcare program and product design. These activities require advanced technical, analytic, and consultative skills and an understanding of epidemiology, health care benefits, health care financing, health care delivery, and health data information systems.

The Outcomes Evaluation team, a subset of the Informatics Population Health Analytics team, provides technical support and analyses for monitoring and evaluation of QAPI performance improvement activities. Such support includes data management and statistical analyses to support the effective measurement of performance and execution of improvement projects.

Provider Experience Department

The Provider Experience Department supports the QAPI program. The department facilitates interactions between providers and ABHMI and coordinates the ongoing education of network providers. Provider Experience responsibilities include:

¹¹ NCQA HPA 2023 QI1 A1 (Resources / analytical support)

- Assisting providers with questions concerning member eligibility
- Collaborating with providers to become highly functioning medical homes
- Assisting providers with prior authorization and referral procedures
- Assisting providers with claim payment procedures and handling of provider disputes and issues
- Coordinating the provider satisfaction survey
- Conducting provider training and education on QAPI related activities
- Supporting implementation of provider interventions
- Monitoring network compliance for access and availability standards
- Providing and educating providers on profiling reports and overall performance
- Developing a process to respond to provider inquiries regarding current enrollment
- Evaluation of provider accessibility and facility assessment in accordance with office-site standards
- Measure the performance of providers and conduct peer review activities such as: identification of practices that do not meet Contractor standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers
- At least annually, provide performance feedback to providers, including detailed discussion of adopted clinical standards and expectations of the Contractor
- Develop and/or adopt, and periodically review, clinically appropriate practice parameters and protocols/guidelines. Submit these parameters and protocols/guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards and make these clinical practice guidelines available to enrollees upon request
- Ensure that where applicable, utilization management, enrollee education, coverage of services, and other areas as appropriate are consistent with practice guidelines
- Evaluates access to care for members according to the established standards and those developed by MDHHS and implements processes to ensure network providers meet and maintain the standards. The evaluation includes an analysis of the accessibility of services to members with disabilities
- Develops, adopts, and periodically reviews, clinically appropriate practice parameters and protocols/guidelines. Submits parameters and

protocols/guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards and makes these clinical practice guidelines available to enrollees upon request

The Provider Experience department is responsible for educating network providers on the latest ABHMI policy and procedures. Provider Experience communicates changes either by face-to-face visits or through written communication including the provider manual, provider newsletters, and on the ABHMI website.

Other ABHMI Departments

In addition to the key staff and departments described above, all other areas within ABHMI play an active role in supporting the QAPI program. For example:

- Member Services leads the Member Advisory Committee, monitors call center performance metrics (such as call volume, percent of calls answered within targeted number of seconds, average speed to answer; average call time, abandonment rate), administers the member satisfaction survey, and accepts and resolves member complaints.
- Utilization Management monitors performance metrics (such as call volume, percent of calls answered within targeted number of seconds, average speed to answer, average call time, abandonment rate), trends in authorization decisions (approvals and denials), trends in utilization metrics by category of expense, bed-days, readmission rates, changes in prior authorization grid, and results of integrated reliability assessments.
- Care Management monitors the volume of members outreached, enrolled, engaged, and closed. CM also monitors new member assessments and new member care plans, health outcomes changes to intervention strategies, and program evaluation while recommending changes to improve outcomes. Additionally, the ABHMI case managers provide a clinical interface with community-based care management teams to identify high- and moderate-risk members with behavioral health conditions that would benefit from care management services. Additionally, the case managers collaborate with providers to build programs and interventions that consider the psychosocial complexity of our members and that assist members in gaining access to the necessary support and services that will allow these individuals to remain in the community while promoting recovery and resilience.

- Grievance and Appeals monitors the trends in volume and types of grievances and appeals. They also monitor volumes by grievance and appeal levels as well as volumes of appeals over-turned and analysis for over-turned appeals.
- Business Operations maintains and supports system applications to provide support to the QAPI program, including state reporting, reports for NCQA health plan accreditation, and the EQR process as well as the generation of key indicator reports across all operational areas.

All ABHMI departments and personnel are integral components of the ABHMI QAPI program. Each department is responsible for reporting performance and monitoring metrics to the quality committees. Based upon the results and trends identified, the committees collaborate with the ABHMI personnel to develop and implement processes and programs that meet regulatory and contractual requirements and to facilitate the continuous growth in the quality program. ABHMI's QAPI program and committee structure is designed to foster an environment of continuous quality improvement with the stated goal of improving the continuity, quality, safety, accessibility, availability, and cost effectiveness of health care provided to members.

Quality Management Functions, Activities, and Initiatives

Population Health Management

The ABHMI Population Health Management (PHM) strategy is comprehensive and meets the care needs of members across the continuum of care. It includes programs or initiatives that are directed towards members and providers. Member programs may be interactive or non-interactive to help members achieve their personal health goals. Non-direct member programs focus on collaboration with practitioners and providers to help lower costs through more efficient and effective patient management. The PHM strategy applies to all membership.

Population Characteristics

ABHMI annually performs a population assessment to evaluate membership characteristics such as age, gender, race/ethnicity, and eligibility categories and monitor population changes such as geographic distribution, language preferences, cultural diversity trends, and changes in age distribution within the health plan's membership. Departmental staff uses the comprehensive assessment to ensure that member needs such as provider accessibility and availability, interpretation services, provision of services to members with complex health care needs, and continuity and coordination of care meet the highest standards.

The purpose of the population assessment is to provide a comprehensive assessment of the demographics of the Aetna Better Health Michigan and to:

- Assess membership characteristics and use results to evaluate ABHMI processes and effectiveness of services to meet the needs of the population
- Promote the delivery of culturally and linguistically effective health care services
- Develop programs with emphasis on health promotion and disease prevention while incorporating community-based health and wellness strategies, focusing on the social determinants of health, creating health equity, and supporting efforts to build more resilient communities
- Provide health promotion and disease prevention services in a manner that is informed by the life experiences, personal preferences, desires, and cultures

of target populations and is the responsibility of the Case Management and Quality Improvement teams to monitor and implement improvements as necessary

- Ensure the equitable distribution of physical and oral health care services to our population, including members of racial/ethnic minorities, those whose primary language is not English, those in rural areas, and those with disabilities
- Identify demographic shifts, making network adjustments as appropriate
- Support Case Management in coordinating access to specialists
- Facilitate access to care by providing appropriate language interpretation and transportation services
- Manage enrollment information

PHM strategy addresses the health care needs of its membership and outlines programs and services that address the following: keeping members healthy, managing members with an emerging risk, addressing patient safety and adverse outcomes across settings, and managing multiple chronic illnesses.

PHM strategy is evaluated annually to measure if goals were met and identify areas with opportunities to improve members' health.

Performance Improvement Projects (Focused Studies)

ABHMI conducts Performance Improvement Projects (PIPs) in accordance with state requirements. The goal is to design projects to improve performance in the quality and appropriateness of service provision. PIP topics are identified either from areas of importance or weaknesses identified by regulators or by the health plan itself. Examination of relevant clinical, survey, financial, demographic, and/or encounter data that relate to quality of care, utilization of services, or other factors that impact membership, providers, or the larger community precede design and implementation of PIP activities. When not specified by a regulator, selection of PIP activities should consider the prevalence of conditions among members, the need for specific services, identified barriers to service, demographic characteristics, identified racial disparities, and health risks among members or the community served by ABHMI and should incorporate the work of the Community Collaboration Project into the overall QAPI program. The Chief Medical Officer, QM/UM Committee and QMOC review and approve PIP proposals.

The goal of each PIP selected by ABHMI is to achieve demonstrable improvement and to sustain the improvement over time. Each PIP includes performance objectives that are objective, measurable and outcome oriented. If available, national or community standards of care are used.

ABHMI uses reliable proven statistical methodologies in designing and evaluating performance improvement activities, taking significant efforts to provide accurate and reliable data. Evaluation and analysis of the data source ensures it is appropriate to answer the study questions and is the most current available.

PIP topics and related monitoring activities reflect the needs or issues of ABHMI's population in terms of age, disease categories, and special risk status. ABHMI utilizes the National PIP monitoring tool for the purpose of tracking current completion status milestones and timelines associated with each PIP. In the event a new PIP needs to be selected, due to completion of current PIP, a PIP committee will be convened to evaluate current status and potential candidates for PIP replacements. Indicators associated with studies and monitoring activities are objective, measurable, and based on national benchmarks or historical data.

PIP components include, but are not limited to, the following:

- Title
- Implementation date
- Activity name
- AIM statement
- Reason for selecting topic
- Population studied (inclusion and exclusion criteria)
- Clinical focus areas (e.g., prevention of acute or chronic conditions, care of acute or chronic conditions)
- Indicators/criteria to measure and trend performance
- Sample selection and size of identified population
- Description of data collection and methodology (including survey instruments, software programs, data sources and data analysis)
- Determination of baseline measurements
- Analysis of data

- Opportunities for improvement and/or interventions, if appropriate based on analysis
- Re-measurement methodology
- Analysis of findings from re-measurement, including impact assessment of interventions implemented since baseline study

The Chief Medical Officer reviews results and forwards to the QM/UM Committee and QMOC. ABHMI practitioners receive results to encourage input for continuous quality improvement strategies.

Health Management

Patient Safety

The goal of the patient safety program is to provide an environment conducive to improving the safety of care delivered to members and support practitioners and providers (e.g., hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, behavioral health facilities) in their efforts to monitor and reduce the incidence of medical errors. To achieve this goal, activities provided by ABHMI include member, physician, provider, and employee education about patient safety efforts and information that can help constituents make informed health choices. Some of the health plan activities monitored to ensure patient safety for ABHMI members include but are not limited to the following:

- Prescription drug utilization review and tracking and trending of adverse events
- Prior authorization of pharmacy claims to verify medical appropriateness and prevent unsafe prescribing
- Analysis of procedure and/or diagnosis codes to identify opportunities for improvement in medical practices and communication of any findings directly to the practitioner and/or provider involved
- Education of providers and members about prevention and detection of unsafe practices

Quality of Care Review¹²

ABHMI's integrated quality review process ensures that issues involving quality of care or service, safety, complaints, or other areas of dissatisfaction are systematically evaluated. ABHMI requires any employee who perceives a potential quality, risk management, or safety issue to refer the issue to the Quality Management Department. A referral may originate in any ABHMI department. The referring department staff documents the issue on a potential quality of care (PQoC) concerns investigation form and forwards to the Quality Management Department for evaluation. Quality management nurses may review and assign a different functional area within the organization to review and address the needs as indicated (i.e., grievance and appeals). The Quality Management Department staff will document and track potential quality of care issues in the PQoC business applications system.

The Chief Medical Officer or designated medical director oversees the peer review investigation of issues referred in accordance with the quality review process that includes:

- Concurrent or retrospective evaluation of medical records to determine the quality of the care and services provided
- Referral of potential issues to the QM/UM Committee and/or Aetna Credentialing and Performance Committee for review and recommendation
- Notification to the board of directors indicating the decision and course of action rendered by the Aetna Credentialing and Performance Committee
- Analysis of identified issues for tracking and trending
- Reporting of findings to designated committees quarterly
- Notification by ABHMI to the appropriate regulatory board or agency if a provider's contract is terminated, suspended, or limited due to quality of care issues
- Development and implementation of corrective action plans as necessary
- Providing Fair Hearing rights to practitioners

Indicators used to identify potential quality, risk management, and safety issues are specific to ABHMI and approved by the QM/UM Committee, and the QMOC.

¹² NCQA HPA 2026 ME 7A

Peer Review Process

ABHMI utilizes a well-documented peer review process to monitor and evaluate potential quality, risk, or service issues that occur during the provision of care or services to an ABHMI member.

ABHMI policies and procedures describe the peer review/appeal process and the actions ABHMI may take upon identification of a quality issue. Such actions may include, but are not limited to, development of a corrective action plan with a description of the period for improvement, evidence of education, counseling, development of policies and procedures, monitoring and trending of data, and/or limitation or discontinuation of the practitioner/provider's contract with the plan.

The peer review process focuses on the issue identified, but, if necessary, could extend to a review of utilization, medical necessity, cost, and/or health provider credentials as well as other quality issues.

The Quality Management Department coordinates peer review activities although they may require the participation of Medical Management, Provider Experience, or other departments. ABHMI may request external consultants with special expertise (e.g., in oral surgery, cardiology, oncology) to participate in peer review activities, if applicable.

The ABHMI peer review process adheres to ABHMI policies. Applicable state and federal laws govern the peer review process and contain immunity and confidentiality provisions that protect the peer review process. ABHMI keeps all peer review documents safe, protected, and confidential.

Fair Hearing Appeal Process

The right of appeal is available to practitioners/providers whose participation in the ABHMI network was limited or terminated for a reason based on the quality of the care or services provided. ABHMI policy describes appealable actions that include the restriction, reduction, suspension, or termination of a contract under specific circumstances.

The appeal process adheres to federal and state laws and regulations and ABHMI - approved policies including the requirement for ABHMI to report actions that result

in suspension or termination of a practitioner/provider's contract. The Aetna Practitioner Appeal Committee conducts the appeal process. Providers and members receive reports of final decisions upon completion of due process actions. The committee tracks and trends all decisions.

Member Grievance and Appeals

The member grievance and appeals process includes the review of member concerns and their resolution in a satisfactory and timely manner. The appeals process addresses denied claims or services relative to a member's benefits. The process provides a member the opportunity to attend a meeting before the Appeal Committee for review and final determination.

The appeals and grievance manager, in collaboration with the Member Services department and Provider Experience department, is responsible for informing and educating members and practitioners about a member's right to file a grievance or appeal or request a Fair Hearing and for assisting members in filing a grievance or appeal or in requesting a Fair Hearing.

The Provider Experience Department gives each practitioner information about the member complaint, grievance, appeal, and Fair Hearing process at the time they enter a contract with ABHMI as well as through a variety of other sources, including the provider manual, provider newsletters, and on the ABHMI website.

Members receive information about the grievance, appeal, and Fair Hearing process in the member handbook and in notice of action letters issued in conjunction with the utilization review process. The appeals and grievance manager works collaboratively with the Chief Medical Officer or designated physician, Quality Management, Medical Management, Member Services, and Provider Experience departments to facilitate the resolution of all complaints and grievances.

Behavioral Health¹³

Integration of quality management behavioral health activities into the QAPI program occurs through regular reporting of behavioral health metrics and through

¹³ NCQA HPA 2026 Q11 A2

regularly scheduled workgroup meetings that provide ongoing monitoring of behavioral healthcare services. Implementation of corrective action plans is on an as-needed basis. The QMOC reviews and approves quality management behavioral health reports integrated with health plan reports annually.

A behavioral health practitioner serves as a member of the QMOC and QMUM committees.¹⁴ Collaboration occurs among all health plan departments to facilitate continuity of care between medical and behavioral health practitioners. Examples of this collaboration include working closely with network hospitals and practitioners to confirm that members hospitalized with a behavioral health diagnosis receive a timely follow up appointment at discharge. The Prepaid Inpatient Health Plan and ABH case managers also have care coordination rounds and joint care planning for members identified as having received services from both entities.

Oral Health Program

The Aetna Better Health of Michigan Oral Health Program is comprehensive and aimed at meeting the dental care needs of the Healthy Michigan membership, kids, and pregnant members and their access to oral health .

The ABHMI Oral Health Program:

- Analyzes the processes and outcomes of care using currently accepted dental clinical standards from recognized medical authorities
- Analyzes data, including identified Health Related Social Needs and Social Determinants of Health, to determine underlying reasons for variations in the provision of care to enrollees
- Establishes clinical and non-clinical priority areas and indicators for assessment and performance improvement and integrates the work of the Community Collaboration Project into the QAPI program
- Uses data measures to analyze the differences in quality of care and utilization, over and under-utilization of services, disease management strategies, and outcomes of care using data from multiple sources such as dental records, encounter data, claims processing, provider and customer grievances, and utilization review for this activity
- Compares Oral Health QAPI program findings with established program goals and/or past performance and available external standards

¹⁴ NCQA HPA 2023 Q11 A4

- Measures the performance of providers and conducts peer review activities such as:
 - identification of practices that do not meet Contractor standards
 - recommendation of appropriate action to correct deficiencies
 - monitoring of corrective action by providers
- At least annually, provides performance feedback to providers, including detailed discussion of clinical standards and expectations of Aetna Better Health
- Develops, adopts, and periodically reviews clinically appropriate practice parameters and protocols/guidelines. Submits parameters and protocols/guidelines to providers with sufficient explanation and information to enable the providers to meet the established standards and makes these clinical practice guidelines available to enrollees upon request. Ensures that where applicable, utilization management, enrollee education, coverage of services, and other areas as appropriate are consistent with the practice guidelines
- Implements improvement strategies related to program findings and evaluate progress at least annually

Clinical Practice Guidelines and Preventive Service Guidelines

The evidence-based clinical practice guidelines (CPGs), which include physical health, oral health, behavioral health conditions, and Social Determinants of Health, represent best practices based on national standards, reasonable medical evidence from recognized medical authorities, and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the Chief Medical Officer, applicable medical committees and, if necessary, external consultants. Clinical practice guideline review occurs at least every two years, or as often as new information is available. In addition, Aetna Better Health endorses guidelines processed through the Michigan Quality Improvement Consortium (MQIC). CPGs are the basis for the Disease Management and Health Education Programs.

ABHMI makes clinical guidelines available to practitioners on the ABHMI website and in the Provider Manual. ABHMI distributes a provider newsletter or other written forms of communication to notify practitioners and providers of the availability of new guidelines and updates. Practitioners may request a copy of a guideline at any

time by contacting their Provider Experience representative or the ABHMI office of the Chief Medical Officer.

ABHMI uses individual provider profiles to evaluate over- and underutilization of services and determine the need for member and/or provider education to improve practice patterns. The use of guidelines is important in the development and monitoring of special member programs such as chronic condition management (e.g., for asthma, heart failure, coronary artery disease, chronic lung disease, depression, sickle cell disease, kidney disease, and diabetes) and perinatal case management. Feedback is given to providers on their individual performance and ABH's performance.

Continuity and Coordination of Care

ABHMI recognizes the importance of maintaining continuity of care and service whenever a member's care setting or practitioner/provider changes. ABHMI integrates processes to guard against interruptions of care into ABHMI systems and departmental processes. Integrated systems and interdepartmental processes include, but are not limited to, the integrated business application system, which is accessible by all departments involved in coordinating services for a member. The system allows departments to share member, practitioner, and provider information, to coordinate procedures such as discharge planning, transitioning a member from an institutional setting back into the community, authorization of post-hospital services, and follow-up on complex cases or emergency room care.

ABHMI maintains policies and procedures for monitoring the services members receive during transitions, either individual or group, between health plans and during transitions within ABHMI from one practitioner or ancillary provider to another. During such transitions, members identified with high-risk conditions or special needs are monitored to ensure maintenance of the previous level of care and/or service. The Member Services Department is available to assist members in selecting or changing their primary care provider assignment. ABHMI's Care Management staff assist members who meet certain criteria in coordinating needed services during a change in the member's level of care (i.e., integrated care management model).

Using the physical health-behavioral health integrated model, ABHMI collaborates with participating behavioral health specialists to monitor and improve coordination between medical and behavioral health care for members with complex care needs. ABHMI acts, as necessary, to improve continuity and coordination of care across the health care network based on routine assessments. Continuity and coordination of care activities between medical and behavioral health care include:

- Attendance at daily integrated rounds
- Monitoring data trends for opportunities to improve the exchange of information
- Assessment of the appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care
- Assessment of the appropriate uses of psychopharmacological medications
- Assessment of the management of treatment access and follow-up for members with coexisting medical and behavioral disorders
- Implementation of primary or secondary preventive behavioral health programs
- Assessment of needs of members with severe and persistent mental illness

Clinical Measurement Activities and Performance Measures

Health Care Effectiveness Data and Information Set (HEDIS®)

ABHMI's performance is measured annually based on HEDIS® or other performance indicators that are mandated by the state regulator or specified in contract agreements. The Chief Executive Officer is responsible for confirming that ABHMI maintains the resources and functions necessary to support HEDIS® or other performance measurement activities. The Chief Executive Officer designates the Chief Medical Officer to direct the initiatives and see that they conform to state, federal, local, and Aetna Medicaid mandates. Under the Chief Medical Officer's direction, HEDIS® activities and interventions are conducted by ABHMI's Quality Management Department. Improving HEDIS® or other performance indicator rates are a companywide endeavor, with operating responsibilities shared by departments designated by the chief executive officer.

The ABHMI's Quality Management Department responsibilities include:

- Review and oversight of data collection, document review, inter-rater reliability (IRR) assessments and measurement reporting.

- Participation on the EQRO oversight team, as applicable, to coordinate review and attestation of data integrity and both preliminary and final results by the ABHMI Chief Executive Officer, Chief Medical Officer, and HEDIS® coordinator.

Any ABHMI department involved in HEDIS® or other performance measurement activities will comply with federal, state, and local privacy regulations during review and/or transport of medical records and information. Analysis and comparison of performance results to national benchmarks provides the basis for the design and implementation of appropriate interventions. If ABHMI does not meet targeted goals, the Quality Management Department will develop a corrective action plan and submit to the chief medical officer and ABHMI administration for review.

Both the ABHMI strategic work plan and QAPI work plan incorporate HEDIS® activities and performance measurement goals.

Experience / Satisfaction Surveys

Assessments of member, practitioner, and provider experiences with health care services provide insight to processes that are working well and reveals opportunities for improvement. An ABHMI approved vendor conducts surveys using nationally standardized survey materials. ABHMI conducts additional focused surveys of specific populations or users of identified services at the discretion of the Chief Executive Officer and the QMOC.

Member Experience

ABHMI assesses member experience through administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)¹⁵ surveys, Behavioral Health Member Experience Surveys, Care Management and Population Health program surveys as well as by evaluation of member grievance and appeal information. The health plan collects data to:

- Assess member satisfaction with services and quality of care provided by the health plan
- Document health plan performance

¹⁵ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

- Improve quality of care

CAHPS® surveys include questions related to a range of health care services at multiple levels of the delivery system such as Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Plan Customer Service, Health Promotion and Education, and Coordination of Care. The survey includes global ratings questions that are answered on a 0-10 scale regarding the member's rating of their Personal Provider, Specialist Seen Most Often, All Health Care Received, and Health Plan.

ABHMI uses the CAHPS® survey tool to collect information about consumer-reported experiences with health care. The survey measures how well the health plan is meeting members' expectations which ABHMI uses to identify areas of opportunity for improvement to improve the quality of care and service provided to members. The health plan provides survey results to both members and providers.

Member Experience Behavioral Health Survey

The Behavioral Health Member Experience Surveys, both adult and child versions, evaluate member experiences with behavioral health care services. These two surveys include questions related to member experience with accessibility, communication, provider satisfaction, member services, and overall satisfaction with behavioral health care services.

Care Management and Population Health Survey

The Care Management and Population Health Management member experience surveys (both adult and child versions) evaluate overall satisfaction with the programs including program staff, usefulness of disseminated information, members' ability to adhere to recommendations and percentage of members indicating the program helped them achieve their health goals.

ABHMI uses information from grievance and appeals for trending and analyses that may be correlated with member survey data in the assessment of opportunities for improvement and for the development of action plans for both physical and behavioral health.

Provider Satisfaction

The Provider Satisfaction Survey assesses provider satisfaction with services that are important to ABHMI network of providers and overall provider satisfaction with the health plan. Annually, the survey is administered to a sampling of practitioners and providers. Information obtained from the survey allows ABHMI to measure how well the health plan is meeting expectations and needs. Practitioner and provider surveys address satisfaction with ABHMI's utilization management procedures (prior authorization, concurrent review), claims processing, and ABHMI's response to inquiries.

The Provider Experience department, in collaboration with Quality Management, Member Services, and administration support staff, coordinates satisfaction surveys. Comparison and analysis of results to prior ABHMI results and national benchmarks provide information to identify areas that changed or require additional improvement. ABHMI reports the analysis of results and applicable follow-up actions developed to address unfavorable results to the QM/UM Committee and QMOC.

Quality Improvement Based on Member and Provider Satisfaction

ABHMI uses a formal process to evaluate potential areas for improvement identified from member and provider surveys as well as other sources (such as member complaints, grievances/appeals, or PIPs). ABHMI prioritizes identified issues, addresses concerns, implements interventions, and reassesses issues to determine change in satisfaction. The formal process includes appropriate member and practitioner/provider communications and reporting to the QM/UM Committee, QMOC, and the Board of Directors documented in committee minutes.

Other Quality Improvement Activities

Medical Records Review

ABHMI requires network providers to maintain an organized, confidential system for documenting and storing members' medical information. At any time, the Chief Medical Officer, QM/UM Committee, or Aetna Credentialing Committee may request a review of a practitioner or provider's medical records.

The ABHMI Quality Management Department is responsible for coordinating the review process. If the results of the review indicate the practitioner/provider records do not meet ABHMI standards, ABHMI may require the practitioner/provider to develop and implement a corrective action plan approved by ABHMI. The Quality Management Department is responsible for monitoring applicable follow-up activities and documenting the reviews and corrective actions. The Quality Management Department maintains confidential files to store the medical record review results used in quality management reviews.

The ABHMI Chief Medical Officer and the QM/UM Committee review reports of results from ABHMI reviews and corrective action plans. ABHMI submits summary reports to the QMOC and to the Board of Directors.

Medical record reviews are conducted in compliance with ABHMI policies, federal, state, and local laws, and requirements, including relevant sections of the Health Insurance Portability and Accountability Act (HIPAA), that provide member privacy rights and place restrictions on uses and disclosures of protected health information and that provide standards for professional review activities.

Practitioner and Provider Contracting

The ABHMI Provider Experience Department ensures that contracts between ABHMI and practitioners or providers conform to QAPI requirements. ABHMI policies and procedures describe practitioner and provider contracting processes in detail and meet standards set forth in state and/or federal regulations.

NCQA Health Plan Accreditation

Accreditation provides a current, rigorous, and comprehensive framework for quality improvement and measurement and bases results on clinical performance and consumer experience. The national standards are used as a roadmap to perform gap analysis and align improvement activities.

Health Plans are evaluated on:

- Clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS)
- Member experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

- Quality Management and Improvement
- Population Health Management
- Network Management
- Utilization Management
- Credentialing and Recredentialing
- Member Experience

Cultural Competency: Promoting Organizational Diversity, Equity, and Inclusion

To meet plan objectives, it is necessary to understand the needs of ABHMI members. ABHMI strives to understand the cultural and linguistic needs of its members. This understanding enables ABHMI to provide culturally competent services and the ability to assess where disparities in health care outcomes exist.

ABHMI is committed to ensuring that all members, providers, and staff are treated with respect concerning their culture, values, race, age, language, sexual orientation, gender identity, ethnic background, religion, and disability status.

ABHMI maintains cultural competency initiatives to address specific cultural/language needs that might challenge a member's ability to access care or understand healthy practices that lead to optimum health outcomes. Clinical and nonclinical internal staff are subject to ABHMI's cultural competency measures. ABHMI efforts comply with applicable federal and state cultural competency requirements and include:

- Assessing ABHMI's ability to meet federal and state Limited English Proficiency (LEP) requirements annually
- Identifying opportunities to remove linguistic/cultural barriers to availability and accessibility to care
- Increasing internal awareness of activities that will increase Aetna Better Health of Michigan's cultural competence
- Annually training staff members about the need for understanding of and respect for cultural differences when interacting with members and developing services that better meet the needs of minority populations
- Educating providers and practitioners about cultural competency and healthcare equity
- Providing members and network practitioners with access to interpreter and sign language services for ABHMI members

- Promoting development of qualified, diverse, and culturally competent employees
- Assessing applicable feedback from members about programs, quality initiatives, member materials, and other education and outreach tools

ABHMI's workforce goal is to hire and promote colleagues who are the best qualified for the role and are a great fit for the working environment. Further, we recognize that we best serve a diverse community of patients, clients, and other stakeholders when our colleagues reflect the communities they serve. To these ends, it is critical that we adhere to an effective, legally compliant, fair, and efficient process when making staff selection decisions, including hiring of new staff and internal promotions. It is our policy to recruit, hire, train, develop, and promote the best people available, based solely upon job-related qualifications. ABHMI is committed to the principle of equal employment opportunity and takes affirmative action to recruit, hire, employ, develop, compensate, promote, and advance in employment based on an individual's job-related qualifications, abilities, and job performance. ABHMI only hires and promotes qualified individuals and does not hire or promote individuals based on gender, race/ethnicity, or other protected categories.¹⁶

Conflict of Interest

Participants and support staff of ABHMI's Board of Directors and quality committees are obligated to properly use and safeguard confidential information used in committee proceedings and to identify and resolve potential conflicts of interest. ABHMI policies describe confidentiality and conflict of interest requirements and comply with federal, state, and local laws and requirements for handling protected health information (including relevant sections of HIPAA). They describe the classes of member, provider, and business information that are considered confidential and include guidelines for using and safeguarding the information.

ABHMI requires committee participants to disclose actual or potential situations concerning issues under review in which a participant or the committee has a direct or indirect interest in the outcome or has two separate and distinct duties. ABHMI policy describes processes for disclosing and evaluating conflicts of interest, for limiting participation in activities in which there is a declared interest, and for handling perceived violations of the policy.

¹⁶ NCQA HPA 2023 QI 1E

Participants are required to sign a statement annually acknowledging their responsibilities regarding confidentiality and conflict of interest and agreeing to comply. At each meeting, a written statement on the committee sign-in form reminds participants of their obligation to safeguard confidentiality and avoid conflicts of interest. The Quality Management Department maintains signed document files.

ABHMI evaluates all processes that require the use or disclosure of protected health information to ensure the safeguard and confidentiality of information. Assessment of the confidentiality of patient information occurs at provider offices during on-site evaluations.

ABHMI compliance department is responsible for monitoring ABHMI's compliance with federal, state, and local laws and regulations governing use and disclosure of PHI. ABHMI compliance helps evaluate and respond to requests for use and disclosure of PHI. In conjunction with the ABHMI privacy official (ABHMI Compliance Official or designee), ABHMI compliance department shall monitor internal processes for compliance with use and disclosure requirements.

Documentation and Retention of Records

Committees produce meeting minutes within one month of the meeting or by the date of the next meeting. The chairperson dates and signs approved minutes to indicate validation that the minutes accurately represent official findings, decisions, and actions of the committee. Minutes of committee meetings along with reports, worksheets, results of reviews, corrective action plans, studies, and summaries of quality management and performance improvement activities are retained for at least five years, either in the original form, or on electronic or other media.

Copies of medical records will be destroyed or filed in accordance with ABHMI policies if the Chief Medical Officer or designee or the QM/UM Committee determines there is no quality management issue.

Claims and Encounters

ABHMI conducts both random and focused reviews of processed claims for payment, financial accuracy, and procedural accuracy. ABHMI uses established guidelines to conduct the audits. Under the direction of the Chief Executive Officer,

these audits are conducted daily and on an ad hoc basis. The claims quality review unit audits an established number of incoming provider telephone inquiries for each claims/claims research (CICP) representative monthly. ABHMI shares audit results with claims management and provide reports to Service Improvement Committee and the QMOC.

Regulatory Compliance and Confidentiality

The QAPI program is designed to comply with all applicable state laws and regulations as well as CMS requirements. The QM department, in collaboration with the compliance department, monitors state and federal laws and regulations specific to quality and is accountable for implementation of actions needed to assure compliance. The Board of Directors is accountable for compliance with applicable state and federal laws and regulations. ABHMI modifies policies as necessary to meet state and federal regulatory requirements.

ABHMI considers member protected health information (PHI) private and confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. Participating network practitioners/providers, vendors, and consultants who help administer the health plan are required by contract to keep PHI confidential, as required by applicable law and/or regulation. Health care practitioners and providers also must give members access to their medical records within a reasonable time after any request.

When necessary for a member's care or treatment, the operation of a health plan, or other related activities, ABHMI uses PHI internally, shares it internally, and discloses such information to health care practitioners/providers, payers (employers who sponsor self-funded health plans, health care provider organizations, and others who may be financially responsible for payment for the services or benefits a member receives under a plan), vendors, consultants, government authorities, and their respective agents. These parties are required to keep PHI confidential, as provided by applicable law. ABHMI provides members notice of our privacy practices as required by law. Members can also obtain information about the policies concerning use and disclosure of their PHI and how they can access or amend information about themselves.

Communications

Through member and provider communication and outreach, ABHMI's goal is to empower Medicaid enrollees to take control of their health and well-being. We are committed to communicating openly with members, their families and caregivers, providers, advocates, regulators, and other stakeholders, using a variety of tools. For example, upon enrollment and annually, members and providers receive tools such as handbooks and manuals with essential information regarding ABHMI benefits and programs. The expected benefits of our global communications and outreach strategy are improved health outcomes and increased satisfaction, enrollment, and retention for both members and providers.

ABHMI writes materials, including our web site at a sixth grade reading level. Our communications are culturally aware, accommodating of special needs, and inclusive of diverse communities. All member materials are translated and available in Spanish.

ABHMI submits all written member and marketing materials and Medicaid Marketing Approval Worksheets for review and uses only after written approval by state regulators. All member communications and outreach efforts take place only after approval by state regulators.

Outreach goals and communication to members and providers (*in compliance with state marketing requirements*) include the following types of information:

- Educate and inform members of their benefits, rights and responsibilities, and available services
- Bring critical health education and tools directly to members, demonstrating that healthy living can be part of their lives
- Engage the provider community in delivery of quality care, access to care, and health interventions to members at elevated risk of chronic physical and behavioral health issues
- Active participation in an integrated, coordinated outreach plan with member and provider-facing departments at the health plan to engage members in self-care and chronic condition management and assist members in adopting health-promoting behaviors
- Act on health-related news
- Explore ways to effectively promote our health programs

- Expand healthy living programs with a focus on HEDIS improvement goals
- Coordinate and facilitate dissemination of member and provider communications timely and within budget
- Create brand awareness

Quality Outreach Programs

Prevention and Wellness

ABHMI works to improve member health status through prevention and wellness activities. Prevention and wellness initiatives are based on ABHMI's strategic plan, population assessments, prior year activity results, identified gaps in care, care management goals, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services along with other special programs. Activities integrate outreach and educational programs for all members with initiatives to address specific populations such as:

- Members with certain disease states or conditions (e.g., asthma, diabetes, HIV/AIDS, heart failure)
- Members identified with gaps in care
- Members who use EPSDT services (including dental and lead screening services)
- Pregnant members
- Children with special needs
- People with special health care needs
- Members who use mental health and/or substance abuse services
- Adults with developmental delays or disabilities
- People who are homeless
- People who are categorized as aged, blind, or disabled
- Adult men and women for whom recommended screenings are appropriate (e.g., for breast cancer, cervical cancer, prostate cancer, and hypertension)
- Hepatitis C education, testing, and treatment

ABHMI facilitates the adoption of healthy behaviors, specifically regarding; oral health, physical health, mental health, SdoH, alcohol and substance abuse, tobacco use, health eating/physical activity, stress, and immunization status offered in a manner that is informed by the life experiences, personal preferences, desires, and cultures of the target population. We ensure members have access to evidence-

based/best practices, educational programs, referrals to local public health/community-based programs that increase members’ understanding of common risk factors, and evidence-based/best practices wellness programs to engage and track members participation in activities that reduce the impact of common risk factors.

Initiatives may take the form of member as well as provider-focused activities. Examples of activities include:

Table 1. Prevention and Wellness Activities

ABHMI Prevention and Wellness Activities	
Member Focused	Provider Focused
Educational programs	Educational programs reviewing ABHMI requirements and best practices
Community and Individual Outreach	Evidence-based preventive guidelines
Written communications such as member newsletters, notifications, letters, mailings, and the member handbook about available services	Collaboration on member outreach activities
Reminders	
Websites, social media vehicles, and in health care offices and facilities	

Goals for initiatives are determined using national standards (e.g., HEDIS®) and/or performance thresholds with analysis of data to evaluate the effectiveness of prevention and wellness activities.

Service / Operational

Availability and Accessibility of Practitioner and Providers

ABHMI monitors practitioner and provider accessibility and availability on an ongoing basis to maintain the network in accordance with established standards for reasonable geographical location, ratio of practitioners to members, hours of

operation, appointment availability, and coverage for emergency care and after-hours services. Monitoring activities may include provider surveys, on-site visits, evaluation of member satisfaction surveys, evaluation of concern/complaint, grievance and/or appeal reports, evaluation of provider to member ratios, and monitoring of closed primary care provider panels. Upon identification of deficiencies, ABHMI collaborates with providers and practitioners to develop corrective action plans followed by reassessment for compliance. The ABHMI QMOC and the Board of Directors review accessibility and availability data and reports.

The quality management and provider experience staff work together to monitor the availability of practitioners and the accessibility of medical and behavioral health services. Quality management staff assists provider experience staff in developing benchmarks for availability and accessibility measures that meet network standards, analyzing data collected in the monitoring process, and assisting in preparation of information for the QMOC. If the reported data indicate the need for an action plan or additional studies, quality management will assist in developing tools and reporting results and outcomes to the QMOC and Board of Directors.

The Provider Experience Department is responsible for monitoring the practitioner/provider network to confirm that a sufficient number and types of primary care providers and specialty physicians, dentists, and ancillary services are available to meet members' medical and behavioral health needs.

The Member Services Department monitors member telephone access to ABHMI services. The Member Services department also monitors the system call-tracking module and/or manual documentation to identify trends in member complaints and grievances about the timeliness of appointments and after-hours access to practitioners. ABHMI evaluates data obtained against performance standards and when indicated implements interventions for improvement. Continual monitoring of improvements provides data to determine whether the interventions are effective and sustained over time.

Practice Transformation Associates

ABHMI utilizes Practice Transformation Associates (PTA) who report within the Quality Department to drive continuous improvement and ensure that healthcare

practices meet the highest standards of care. The primary purpose of this position includes the following objectives:

- **Facilitate Change Management:** The PTA plays a crucial role in guiding healthcare teams through the process of transformation. This includes educating staff on new protocols, fostering a culture of quality, and ensuring that all team members are engaged and committed to quality improvement efforts.
- **Data Analysis and Reporting:** The PTA collects and analyzes quality metrics to assess the effectiveness of current practices. By generating reports, the PTA provides actionable insights to leadership and staff, enabling informed decision-making and strategic planning.
- **Collaboration and Communication:** The PTA serves as a liaison between various departments, ensuring that quality initiatives are communicated effectively across the organization. This collaboration fosters a unified approach to quality improvement and encourages shared accountability among all team members.
- **Patient and Stakeholder Engagement:** The PTA actively seeks feedback from patients and stakeholders to understand their experiences and expectations. This input is invaluable in shaping quality improvement initiatives that are patient-centered and responsive to community needs.

The PTA role is essential for fostering a culture of excellence within healthcare practices. By focusing on continuous improvement, data-driven decision-making, and effective communication, the PTA helps to elevate the quality of care provided to members, ultimately leading to better health outcomes and enhanced member and provider satisfaction.

Clinical Evaluations

ABHMI monitors and evaluates both clinical and operational functions to identify opportunities to improve the use of quality management and performance improvement resources. Monitoring of clinical care includes, but is not limited to the following:

- Diagnoses or complex conditions that place members at risk for serious consequences if care does not meet national guidelines and community standards or is not medically indicated
- Aspects of care that occur most frequently or affect large numbers of members
- Processes involved in the delivery of care or service which, if improved, could affect a higher level of performance and patient safety
- Annual analysis of plan-specific demographic and epidemiological data
- High-cost, high-volume, or problem-prone aspects of service
- Performance improvement projects and HEDIS® outcomes

The Quality Management/Utilization Management Committee and the QMOC review results of tracked and trended clinical monitoring. The monitoring process includes the following:

- Establishment of specific performance and safety measures
- Collection of appropriate data
- Analyses of data
- Identification of opportunities to improve performance
- Implementation of guidelines when applicable
- Measurement of effectiveness of interventions and/or conformance to guidelines
- Definition of performance goals/benchmarks for re-measurement
- Reevaluation for further performance improvements

ABHMI uses process- and outcome-based indicators to monitor the quality of medical care and service delivered to members. The indicators may be based on state or federal requirements, on HEDIS® specifications, or may be developed by the plan.

ABHMI administration and quality committees evaluate service and clinical data and outcome results. To assess the need for improvement or change, results will be compared to benchmarks, where available, or targets established by ABHMI, and to results of other plans and health care entities. If applicable, action plans are developed and implemented to improve the rate of compliance with ABHMI, HEDIS®, and/or other indicator standards. ABHMI continually monitors results and

provides reports to the Chief Medical Officer, appropriate medical committees, providers and the ABHMI Utilization Management Department.

Operational Evaluations

ABHMI reviews, monitors, tracks, and trends the following processes:

- Prior authorization and concurrent review (timeliness of decisions)
- Claims and encounters (timeliness of processing)
- Member services (timeliness of telephone responses)
- Appeals and grievances
- Agreements between ABHMI and practitioners and providers, as well as companies that provide services to members
- Medical record keeping practices
- Internal operations of ancillary service providers, such as nursing facilities, providers of ambulatory care home health, infusion therapy, durable medical equipment, outpatient surgery and dialysis, transportation companies and other providers that deliver services to ABHMI members
- Member disenrollment patterns

Performance standards related to ABHMI telephone service (answering times, call abandonment rates, etc.) are monitored by the Member Services Department. The Member Services Department monitors grievance resolution to assess health plan services provided to members. The Claims Department monitors the claims payment process for accuracy and timeliness of payments and coordination of benefits. ABHMI bases its standards on national standards of performance and applicable state and federal requirements.

The information is reported to the Service Improvement Committee or other designated committee, the QM/UM Committee (for review and recommendation for action), then to the QMOC and the Board of Directors.

Quality Management and Medical Management Collaboration

Integrated Care Management

The primary goal of Aetna Medicaid's Integrated Care Management (ICM) Program is to coordinate and facilitate the seamless delivery of high quality, person centered, medically informed care and services for our members. Our program ensures that

the care and services members receive aligns with their preferences, needs, and goals, utilizing motivational interviewing to optimize their self-empowerment and self-sufficiency.

The focus of ICM is to address the biopsychosocial needs of our members, while integrating cultural humility into our practices to enhance members' quality of life. Our case managers partner with members, providers, caregivers, and support systems. Each member's characteristics and potential barriers associated with social determinants of health (SDoH) are considered when addressing acute illnesses, chronic conditions, and functional and social (biopsychosocial) needs to support improved outcomes.

The ICM program is designed to identify members who may benefit from care management services. Members choosing to participate receive an evaluation of their risk and at a minimum, receive education to support their adoption of healthy behaviors and self-management. Care coordination services are also included with the appropriate resources to address Health Related Social Needs and reduce socioeconomic barriers, including access to safe and affordable housing, employment, food, fuel assistance, and transportation to health care appointments. Those at higher risk are engaged to recognize their personal strengths and barriers, determine health goals, and develop interventions to help them meet those goals. Based on their needs, members receive ongoing support and services through integrated case rounds, interdisciplinary care team meetings, scheduled contacts, and ad hoc communications.

The following responsibilities reflect ABHMI's approach to Care Management:

- *Move from disease focus to member focus:* Evaluate every member for physical, behavioral, and social risks to their current and future health, incorporating members' values, needs, and priorities using a culturally sensitive approach. Holistically integrate and coordinate healthcare services that support members' individual physical, behavioral, and social needs.
- *Identify and employ the most effective intensity of evidence-based, plan-covered systems and services:* Manage the continuum of member care needs by providing anything from acute and purposeful interventions to complex care management, long term services and supports, and end-of-life assistance, always aiming to keep members in the most integrated and least restrictive care environment possible.

- *Employ behavioral engagement for change:* Utilize a case manager as the single point of contact collaborating with the member, member supports, and integrated care team to create a plan of care. The care plan includes mutually agreed upon member-centered goals and actions for the member and member supports.
- *Team with the member, their families, community supports, community-based case managers, providers, and practitioners to enhance care outcomes:* Work as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psychosocial, complex, and challenging relationships with members and their families.
- *Collaborate with state regulators to influence benefit designs that support continuity and coordination of care:* Focus on coordinating and integrating fragmented services into a system of care that addresses each member's individual needs within the context of their family and cultural community.

ABHMI's tools and services assist members to improve health and well-being, decreasing the need for unnecessary and invasive care and promoting self-management. Additionally, ABHMI's care management teams collaborate across all healthcare disciplines. These teams work in partnership with:

- Members' family/representatives and/or caregivers
- Medical homes/PCPs
- Specialists
- Hospitals (inpatient/outpatient)
- Behavioral health providers
- Dental providers
- Home and community-based services (HCBS) providers
- Skilled nursing and Intermediate Care/Developmental Disabilities facilities
- Community-based organizations and social service/advocacy groups as necessary

Members are educated about the availability of the ABHMI integrated care management program through the member handbook, new member welcome packets, mailings, and direct communications (e.g., member newsletter). ABHMI educates providers about the program through the provider manual, mailings, and direct communications. ABHMI also makes information about the integrated care management program available on the ABHMI website.

Health Assessments

ABHMI utilizes two tools to identify members that would require or benefit from care management services, require a referral for needed services or other prevention and wellness services:

- *Health Risk Questionnaire*: ABHMI administers a health risk questionnaire to all new members specified by ABHMI policy. This questionnaire allows members to self-report and track their health and behaviors. Results from the questionnaire are securely transferred electronically into ABHMI systems and then Care management staff uses the risk score from the questionnaire to identify members for integrated care management.
- *Health Related Social Needs (HRSN)*: ABHMI utilizes a tool that was developed by the Centers for Medicare & Medicaid Services (CMS) to systematically identify and address the health-related social needs and Social Determinants of Health for its members. By implementing this tool, ABHMI seeks to identify root causes of health disparities to help members achieve health equity. Results of the HRSN tool help care management staff determine differences in quality of care and utilization and understand the underlying reasons for variations in the provision of care for members. Care management staff then use information from the HRSN to guide member treatment plans and make referrals for community resources and services.

Member Profiling

Member profiles play a pivotal role in the management of member care both by ABHMI's integrated care management team, as well as by the member's medical home/PCP. Member profiles:

- Identify members who have under-or-over utilized health services, including emergency department services, hospital admissions, and prescribed medications, and could benefit from integrated care management services
- Identify members who may lack appropriate access to needed services or could benefit from education about how to best utilize the health care system (e.g., persons with high emergency room utilization, or lack of preventive service utilization)
- Identify medical homes/PCPs that do not appear to be following recommended clinical practice guidelines or who need to reach out to their

assigned members more effectively and facilitate better management of the member's care

- Assist in supporting other internal health plan operations, such as concurrent review decisions, member appeals, and fraud and abuse detection

Practitioner Profiling

ABHMI uses the practitioner profile to monitor practitioner utilization practices along with members' health outcomes to identify opportunities for improvement. The objectives of practitioner profiles are to:

- Identify practitioner utilization patterns that vary significantly from peer network practitioner groups
- Identify trends and address them through practitioner outreach
- Provide information to network practitioners about their practice patterns
- Provide information for use as a component of quality management oversight
- Provide information for use as a component of practitioner incentive compensation

The Medical Management Department is responsible for operations to oversee the profile process, including validation of data reasonableness, and activities to monitor use of the profiles (e.g., site visits, mailings, tracking outcomes over time). The Aetna Informatics and Actuarial Systems departments are responsible for operations to maintain and regularly refresh the central database. All information regarding member and provider profiles is maintained in applications with secure access.

The Chief Medical Officer or designated medical director is responsible for accessing the profile interface quarterly to review identified practitioners' utilization patterns, trends, and costs during the previous year. The profiles are distributed to applicable network practitioners via a secure web portal. If a profile reflects practices that do not further ABHMI health care missions, e.g., low performance of Healthcare Effectiveness Data and Information Set (HEDIS®) measures, the Chief Medical Officer may request that the practitioner develop a corrective action plan.

Performance Standards for Clinical Operations

Quality Management, Utilization Management, and Care Management departments use established standards to monitor the performance of selected clinical personnel. Specially designed tools used to periodically review the performance of

prior authorization and concurrent review nurses, case managers, and medical directors assist in determining consistency in applying criteria used in making medical decisions (inter-rater reliability) and adherence to ABHMI policies and procedures.

National standards of performance and applicable state and federal requirements are the foundation for standards used by ABHMI. Individual departments are responsible for reporting results and trending of performance indicators to the QM/UM Committee. Departmental and committee collaboration to develop and implement intervention strategies promotes continual ABHMI program performance improvement.

Health Equity Programs (HEP)

ABHMI recognizes that a person's cultural norms, values, and beliefs shape how they approach and utilize health care services. Numerous cultural variables including, but not limited to, ethnicity, race, gender, age, socio-economic status, primary language, English proficiency, spirituality, religion, and literacy level influence the way in which a person seeks and utilizes health services and the way a person approaches and manages recovery.

ABHMI has a clear history and long-standing commitment to ensuring the equitable distribution of physical and oral health care services to their entire population, including members of racial/ethnic minorities, sexual orientation, and gender identities, those whose primary language is not English, those in rural areas, and those with disabilities. Aetna is dedicated in supporting our members and the communities we serve to attain health equity and achieve the best possible health outcomes by establishing clinical and non-clinical priority areas and indicators for assessment and performance improvement, integrating the work of the Community Collaboration Project, linking members to programs, tools, and resources for equitable care. By reducing or eliminating factors that may interfere with a person living their healthiest self, we can contribute to reducing health disparities.

The Health Equity Program has been developed to ensure that members receive care that is delivered in a culturally and linguistically sensitive manner. Our HEP focuses on effective and equitable care and services by respecting and honoring each member's cultural health beliefs, practices, preferred language, special needs,

and socioeconomic background. The HEP is comprehensive and incorporates all members, employees, and providers, and supports individual differences by recognizing that respecting the diversity of our membership has a significant and positive effect on outcomes of care. We believe that cultural responsiveness is part of the fabric of our organization and should infuse every aspect of member interaction as well as local, community-based care delivery.

Health equity interventions are evidence-based practices that have a demonstrated ability to address Social Determinants of Health and reduce Health Disparities to all individuals who qualify for those services. Collaborations with high-volume primary care practices to develop, promote, and implement targeted, evidence-based interventions to the extent that Community Health Innovation Regions (CHIRS) are functioning within the service area to develop, promote and implement these interventions. Reported evidence-based interventions demonstrate the ability to reduce health disparities which address each individual members' social determinants of health. New members are stratified monthly using medical and dental claims data, pharmacy data, and laboratory results, supplemented by UM data (including but not limited to high utilization of Emergency Services), health risk assessment results, and eligibility, and measure status to monitor for health disparities.

Our goal of health equity is achieved through the delivery of culturally sensitive services, communications, and programs through a focus on three pillars:

Increasing cultural competency – We are committed to understanding and honoring every member's cultural and language preference. Through robust employee and provider education, we guide care management teams to continuously increasing levels of cultural competence. We engage members in ongoing conversation through member advisory groups and in-person web based health education sessions to ensure that we meet member needs with cultural awareness and respect.

Reducing health disparities – We are dedicated to identifying disparities and working collaboratively to develop actionable solutions. Using member demographics, utilization, and social determinants of health data, we identify gaps in

healthcare, implement solutions in select markets, and then scale the implementation of the solutions as appropriate.

Improving health literacy – We are committed to supporting our members to feel confident and knowledgeable when interacting with health care providers and health systems. We partner with community organizations to seek literacy learning opportunities for our members. For members with limited English proficiency or limited vision, we provide appropriate interpretation services to reduce health care education gaps when applicable. We inform members of their rights to language assistance, train our staff and providers to identify and respond to needs for language assistance, and conduct our own assessments of member language preferences and service quality.

Our health equity policies embrace principles of:

- Equitable access and nondiscriminatory practices
- Identifying and understanding the needs and help-seeking behaviors of individuals and families
- Working with natural, informal support and helping networks within culturally diverse communities

Health Equity training emphasizes that:

- Personal and organizational values impact healthcare delivery
- Communication and empathy create connections
- Knowledge and skill integration improve outcomes

Health Equity strategic direction includes that:

- Assessing population health is necessary to determine community needs
- Addressing targeted needs helps determine interventions
- Best practice solutions can only be implemented based on proven interventions for the target population
- Measurement is an essential component to evaluate practice effectiveness

ABHMI also incorporates Culturally and Linguistically Appropriate Services (CLAS) Standards into all care delivery models. The U.S Office of Minority Health (OMH) within the Department of Health and Human Services (DHHS) developed the CLAS

Standards to promote health equity, improve overall health quality, and eliminate health care disparities. These fifteen standards are organized by themes:

- Principal Standard (Standard 1)
- Governance, Leadership, and Workforce (Standards 2-4)
- Communication and Language Assistance (Standards 5-8)
- Engagement, Continuous Improvement, and Accountability (Standards 9-15)

The standards are intended to be inclusive of all cultures and not limited to any population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that may experience unequal access to health services. An annual report is submitted which assesses the effectiveness of evidence-based interventions to reduce health disparities.

Health Equity Accountable Leadership Council (HEAL)

The Aetna Health Equity Accountable Leadership Council is comprised of representatives from each of the sixteen Aetna Medicaid health plans called Health Equity Champions/Leads. The purpose of the HEAL team is to utilize available data, evidence-based practice, multi-plan collaboration, and known social determinants of health to develop, implement, and monitor programs that will best meet the healthcare needs of plan members. The HEAL team will also create a network of support for colleagues so that innovative, effective, and powerful strategies can be utilized throughout the organization, benefiting patients, practitioners, and providers in the most impactful ways possible.

The annual goals of the HEAL Team are as follows:

- Reinstatement of quarterly conversations within the organization
- Increase engagement with National Health Equity Organizations
- Develop a comprehensive Enterprise-level Health Equity Executive report
- Ensure all Health Equity Leads have support both locally and nationally
- Oversee the maintenance of Health Equity Accreditation in Medicaid markets
- Implement targeted interventions to address multiple health disparities

Each Health Equity Champion/Lead must:

- Commit to attend each Council meeting or ensure coverage by a designee who is fully briefed and able to speak to the local plan's health equity strategy and programs
- Engage local plan colleagues and shared services via operational meetings or other Councils / Committees to gather feedback and/or input to focus the work of the HEAL Council
- Engage consumers and community through local advisory boards or committees to ensure strategies, reporting, or other practices are responsive to local need
- Be a stakeholder with local community-based partners, to obtain insight and recommendations for the development of the Health Equity Plan that is driven by the strategy and outlines programs offered
- Share HEAL Council updates to appropriate audiences and seek input from stakeholders (internal or external) to ensure continuity and decreased duplication of efforts
- Complete the Striving for Health Equity 101 training and promote the completion amongst other executives, leaders, and colleagues
- Ensure the completion of health equity training by other plan executives, leaders, and colleague per Medicaid requirements and NCQA Health Equity standards.
- Assist other Medicaid leaders and executives to identify equity implications in business decisions for areas overseen
- Facilitate achievement of goals with key partners when quarterly targets are missed, or a detected need and deployed activities are misaligned
- Facilitate local plan activities for the represented market, ensuring HEAL Co-Chairs can integrate plan feedback as much as possible into the standard strategy and planning process.

The HEP, CLAS, and HEAL programs are intended to ensure the equitable distribution of physical and oral health care services regardless of linguistic and cultural considerations including but not limited to:

- Race, Ethnicity, Age, and Geographic Location
- Gender Identity and Sexual Orientation
- Physical Limitations
- Primary Language, English Proficiency, Literacy
- Economic Status, Family Roles, Community Networks
- Spiritual Practices and Beliefs

Population Health Management (PHM)

ABHMI recognizes that Population Health management is built on a detailed understanding of the distribution of social, economic, familial, cultural, and physical environmental factors which impact health outcomes among different geographic locations and groups (such as socioeconomic, racial/ethnic, gender identity, sexual orientation, or age), and the distribution of health conditions, health related behaviors, and outcomes. The population is stratified using medical and dental claims data, pharmacy data, laboratory results, UM data, Health Risk Assessment results, and eligibility status to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, appropriate interventions, and complex care management services for targeted populations including:

- Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level
- Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender identity, age, sexual orientation, primary language, deaf and hard hearing, ability, geographic location, or income level
- Persons with high prevalence Chronic Conditions, such as diabetes, obesity, cardiovascular disease, and oral health disease
- Members in need of Complex Care Management, including high risk members with dual behavioral health, and medical and oral health diagnoses who are high utilizers of services
- Women with a high-risk pregnancy
- Children's Special Health Care Services (CSHCS) program
- People with Special Health Care Needs (PSHCN)
- Other populations with unique needs such as children in foster care, and homeless members

ABHMI systematically stratifies populations along with newly enrolled members monthly to identify who qualifies for intensive care management services, moderate intensity care management services, and low intensity care management services. The entire population is systemically re-stratified at intervals designated by MDHHS to ensure members with increasing physical and oral health risks and social needs

are identified for Population Health Management services. Reporting includes disease prevention programs, outreach, referral, and follow up activities as related to membership with participation rates. An annual multi-year plan to support population health is updated regarding implementation, noting compliance with respect to plan timeline, corrections to realign activities to the timeline, and timeline revisions if necessary. The health plan reports annually to MDHHS on the effectiveness of the population health initiative. The report contains the following:

- The number of members experiencing unequal level of social needs or education identified by The Health Care Equity tool, which is imbedded in our business application system
- The number of members participating in additional in-person support services such as CHW, patient navigator, MIHP or health promotion and prevention programs delivered by a community-based organization
- Changes in health services utilization and health outcomes that are pertinent to the population served

Aetna Better of Health of MI has relationships in place with large provider partners to meet members in the community where they are being served. The Community Health Worker (CHW) will:

- Assist with PCP engagement, and re-engage as appropriate to resolve health services utilization and improve health outcomes
- Conduct home visits to assess barriers to healthy living and accessing health care
- Set up medical and behavioral health office visits
- Explain the importance of scheduled visits to members
- Remind members of scheduled visits multiple times
- Accompany members to office visits, as necessary
- Participate in office visits, as necessary
- Advocate for members with Providers
- Arrange for social services (such as housing and heating assistance) and surrounding support services

- Work to locate and communicate with members when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care
- Help boost members' morale and sense of self-worth
- Provide members with training in self-management skills
- Provide members with someone they can trust by being dependable, nonjudgmental, consistent, open, empathetic, and accepting
- Serve as a key knowledge source for services and information needed for members to have healthier, more stable lives

ABHMI participates in initiatives to develop, implement within an agreed upon timeframe, and continually improve reports for primary care practices that will support practice activities to improve Population Health management, including, but not limited to an actionable list of members for primary care practices that identify the targeted populations. We participate in initiatives to develop a core set of Social Determinants of Health, community-based support service provisions, utilization, and physical and oral health outcomes that Providers will submit to for inclusion in performance measure reports, including agreements on how data must be submitted by Providers to minimize the administrative burden.

ABHMI recognizes that Population Health Management interventions are designed to address the Social Determinants of Health, reduce disparities in health outcomes experienced by different subpopulations of members, and achieve health equity.

Protocols are developed for providing Population Health Management services where telephonic and mail-based care management is not sufficient or appropriate, including the following settings:

- Adult and family shelters for members who are homeless
- Members' homes
- Schools and places of employment

Member Centric Initiatives

EPSDT Program

ABHMI's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services to applicable members. EPSDT is a key service to ensure that children and adolescents under age 21 receive appropriate preventive physical, dental, mental health, developmental, and specialty services. ABHMI informs applicable members that services are available highlighting the importance of well-child/well-adolescent care and age-appropriate immunizations.

The Chief Executive Officer is responsible for confirming that ABHMI maintains the resources and functions necessary to support EPSDT activities. The Chief Executive Officer designates the Chief Medical Officer or designee to direct the program and see that it conforms to state, federal, and Aetna Medicaid mandates. Improving the EPSDT compliance rates is a company-wide endeavor, with operating responsibilities shared by departments designated by the Chief Executive Officer. The Quality Management Department staff, with the assistance of other departments (such as Member Services and Provider Experience) is responsible for the day-to-day operations necessary to conduct the program (e.g., identifying and notifying members, conducting outreach activities, and monitoring the utilization of the services). ABHMI reports EPSDT performance information annually as required by state contract.

Lead Management Program

As part of the Michigan Department of Health and Human Services (MDHHS) collaborative lead screening program, Michigan has an established statewide lead registry that all Michigan providers are expected to utilize. The MDHHS follows the American Academy of Pediatrics lead screening guideline which requires children to be tested for blood lead toxicity at 12 and 24 months of age. In addition, the Centers for Medicare & Medicaid Services (CMS) mandates that if a child is covered by Medicaid, is between 36 and 72 months of age, and has not been tested for blood lead, the child must be tested. As part of the collaboration, MDHHS provides lead screening registry results electronically to the health plan every month. Aetna care managers contact the member and provider if the blood level is $\geq 3.5 \mu\text{g/dL}$. The care manager educates the parent/ guardian about potential lead environmental

risks and symptoms of lead toxicity. The care manager also educates the parent/guardian about community resources that are available. The provider is notified of the health plan care manager contact with the member and the member's lead level. Aetna participates in lead health outreach events in collaboration with MDHHS and Wayne Health's mobile care unit. Connection to local health departments and community resources are offered at these events in addition to lead health education. Our goal is to ensure every child 6 years and younger has been tested for lead and those that have an elevated blood lead level are connected to their local health department, PCP, and community resources for treatment and to improve their health outcomes and home environment.

Credentialing and Recredentialing Process

Practitioners

The credentialing/recredentialing process confirms the qualifications of the following practitioners who participate in the ABHMI network:

- Contracted practitioners who provide care to members because of a direct referral by a participating practitioner
- Contracted practitioners who provide care outside of the inpatient or outpatient hospital setting or freestanding facilities
- Contracted practitioners who are facility-based, but who are contracted as primary care physicians
- Contracted practitioners who are facility-based, but also provide consultation in an office-based practice outside the hospital
- Contracted dentists who provide care under the organization's medical benefits
- Contracted practitioners who are listed in provider directories distributed to members or in web-site provider listings available to members
- ABHMI medical directors

ABHMI policies, based on nationally recognized accreditation standards as well as applicable state and federal requirements, define the credentialing and recredentialing processes. The credentialing/recredentialing process includes primary source verification consistent with NCQA, Utilization Review Accreditation Commission (URAC) and CMS standards, as well as Aetna national credentialing requirements. Primary source verification is performed by Aetna's Credentialing

Department, a NCQA certified and URAC accredited Credentials Verification Organization (CVO), as well as an external NCQA certified CVO.

Credentialing is conducted prior to participation and is repeated every three years, or as required by state regulation. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, as well as for conformity to the organization's utilization and quality management requirements.

As part of an intercompany arrangement, the ABHMI QMOC has delegated authority for credentialing/recredentialing and peer review of practitioners to the Aetna Credentialing and Performance Committee. The Aetna regional medical director may review and approve 'clean' files per the Aetna policies. The Aetna Credentialing and Performance Committee has dotted line accountability to the ABHMI QM/UM Committee. The ABHMI quality management staff reviews all potential quality of care issues and forwards all appropriate issues to the Chief Medical Officer or designated medical director for review and when appropriate to the Aetna Credentialing and Performance Committee. The Chief Medical Officer or designated medical director reviews all information and based on policy and clinical judgment, determines the appropriate action such as:

- Track and trend
- Forward to the Credentialing and Performance Committee
- Forward to the QM/UM Committee for peer review

The Credentialing and Performance Committee has the authority to make the final determinations for those applicants being considered for exceptions to established requirements for professional competence and conduct. If a practitioner's contract is terminated due to quality-of-care, utilization, or service provision issues, notification is made to the appropriate regulatory board or agency and law enforcement, if appropriate.

Organizational Providers

ABHMI credentials and recredentials designated organizational healthcare providers. At a minimum, ABHMI will evaluate and credential the following:

- Hospitals
- Home health agencies

- Free-standing surgical centers
- Skilled nursing facilities
- Other ancillary providers as specified by ABHMI or the state

Aetna policies, based on approved nationally recognized accreditation standards, define the credentialing and recredentialing process for organizational providers. The Aetna medical director and/or the National Quality Oversight Committee review and approve credentialed organizational providers. Upon approval, credentialed providers are recredentialed every 36 months.

Delegation

Oversight of Delegated Providers

Under specific circumstances, ABHMI may delegate to designated contractors the responsibilities for medical management functions such as credentialing, recredentialing, and ongoing monitoring of certain long-term care facilities and services. Although ABHMI may delegate the authority to perform functions, it does not delegate accountability for the quality of care or services provided by the contractor. ABHMI does not delegate quality management, appeals, or member service activities.

As part of the QAPI program, a comprehensive set of policies and procedures manage the delegation of responsibility for any program function that may be delegated. Prior to deciding to delegate, ABHMI assesses:

- The business need for delegation
- The cost/benefit and the delegate's readiness to assume the delegation (includes financial integrity, management expertise, and Information Technology (IT) capabilities of the delegate)
- The potential impact on clinical care and service to members
- Appropriate Diversity, Equity, and Inclusion (DE&I) policies and practices to effectively meet the needs of the highly diverse ABHMI population

A delegation pre-assessment questionnaire is used in the decision-making process. The ABHMI delegation process includes a review of the prospective delegate's program for adherence to health plan and NCQA standards as well as compliance with applicable federal and state regulations. The appropriate staff reviews relevant

documentation prior to an assessment. The prospective delegate's program is assessed, evaluated, and documented using standardized ABHMI audit tools. The completed report serves as documentation of the strengths and opportunities for improvement of the prospective delegate's program and is utilized by the committee responsible for approval of delegated relationships. An assessment of each delegated entity is performed at least annually with results reported to the QM/UM Committee and QMOC. In addition to the annual assessment, there is ongoing monitoring and oversight through review and analysis of periodic reporting at least semi-annually.

ABHMI policies require all delegation arrangements to be supported by a written, signed delegation agreement, which outlines the responsibilities of the parties, defines their collaborative relationship, specifies how the delegate's performance will be monitored, and sets forth remedies if either party is not meeting contractual obligations. The written agreement also outlines on-going monitoring activities, including the provision of semi-annual reports that include information appropriate to the scope of delegated functions.

When a delegated entity contracts with another entity (that is not wholly owned or a sister organization to the delegated entity) to perform a delegated function, it is considered sub-delegation and requires oversight on the part of ABHMI as well as reports of oversight from the delegated entity. Sub-delegated arrangements must be approved by ABHMI, who retains ultimate accountability. Provisions for sub-delegation are part of the delegation agreement.

DentaQuest

DentaQuest is our delegated vendor for dental services including restorative, diagnostic, and preventative treatments. DentaQuest also provides teledentistry and emergency dental services with 24/7 coverage which helps our members to get the dental care they need in a timely manner. The Quality team meets with DentaQuest quarterly to examine claims, inbound call volumes, grievances/appeals, and resolutions based on the extensive data reports and utilization analyses provided. Partnership with DentaQuest allows the Quality team to regularly evaluate the dental care provided to our members and effectively make adjustments or additions to ensure high quality preventative and acute dental treatment is always available to our ABHMI members.

DentaQuest providers complete the following services for ABHMI members:

- Preventative Care
 - Oral exam: Covered every six months for routine dental check-ups.
 - Cleaning: Covered every six months for professional dental cleanings to maintain oral hygiene.
 - X-rays: Covered every six months for diagnostic purposes.
 - Fluoride treatments: Covered for members aged 19-21 to prevent tooth decay.
 - Sealants: Covered based on age requirements to protect teeth from decay.
- Treatments
 - Fillings: Covered for restoring cavities and damaged teeth.
 - Crowns: Covered for restoring severely damaged or decayed teeth.
 - Root canals: Covered for treating infected or damaged tooth roots.
 - Extractions: Covered for tooth removal when necessary for oral health.
 - Other care covered for various dental treatments deemed medically necessary.
- Additional Services:
 - Emergency dental care for covered urgent dental needs
 - Teledentistry services for remote advice and consultations

DentaQuest provides the following resources and services to ABHMI so we can improve members' oral health, their access to oral health, and meet the dental needs of our members more effectively:

- Utilization Analysis and Management: comprehensive utilization analysis to identify patterns and trends in member usage of healthcare services
- Data-Driven Insights: data is supplied in actionable insights by analyzing program performance, utilization trends, and other key performance indicators (KPIs). This data is provided monthly, quarterly, and on an ad-hoc basis to help ABHMI make informed adjustments and drive continuous improvement in dental care

JVHL Joint Venture Hospital Laboratories

JVHL provides ABHMI and our members with appropriate and expansive laboratory services. Members and providers can easily locate available service centers to streamline efficient laboratory testing and specimen collecting. Data reports including member utilization of services and customer satisfaction are also provided to ABHMI to ensure appropriate quality member services.

Access2Care Transportation Benefit

Access2Care is a transportation management company utilized by ABHMI that facilitates transportation services for its members to ensure consistent and timely access to medical, dental, and behavioral healthcare. Access2Care relies on partnerships with diverse local transportation providers to ensure quality transportation availability. These transportation providers vary in size and type, ranging from small companies with a few vehicles to larger providers with hundreds of vehicles, as well as public transit agencies and individual volunteer drivers. Despite their differences, all Access2Care's transportation provider partners share a commitment to quality service and professionalism in their interactions with ABHMI members. Access2Care also provides data to ABHMI to ensure that our members are utilizing our transportation offerings to fulfill their healthcare activities.

VSP Vision Care

ABHMI utilizes VSP Vision Care to support members in caring for their vision health. The VSP Vision Care Program aims to improve clinical and operational processes and outcomes through continuous measurement, assessment, and improvement activities. All VSP Vision Care services are patient-centered, safe, timely, efficient, and equitable and are delivered consistently with ABHMI throughout the organization and provider networks. ABHMI and VSP Vision Care ensures adherence to regulatory requirements, guidelines, standards, and criteria set by all government, accrediting agencies, and other regulatory agencies. In collaboration with ABHMI, VSP staff work to ensure the following quality activities are established:

- Determining standards of care used as a basis for benefit plan design and non-covered services
- Reviewing quality-of-care and service issues
- Annual interrater reliability audits
- Adverse outcomes and management of care complaints and grievances

- Satisfaction survey reports
- Medical record reviews
- Reviewing clinical practice guidelines and keeping care standards current

Data from these quality activities is provided regularly to ABHMI to ensure that we are providing comprehensive and quality vision care to our members.

PIHP-BH Behavioral Health Prepaid Inpatient Health Plans

In Medicaid markets that have behavioral health as a carve out benefit, it is imperative to have a mechanism in place that allows for bi-directional information sharing among providers. In order to address this need, data sharing meetings are held, which also help to support the integration of behavioral health and physical health services for members.

In accordance with the Comprehensive Health Care Program (CHCP) contract from the Michigan Department of Health and Human Services (MDHHS), monthly data sharing meetings are held between ABHMI and each contracted Pre-Paid Inpatient Health Plan (PIHP). During these meetings, the Behavioral Health Clinical Liaison and other team members, including CHWs, pharmacists, medical directors, and behavioral health providers discuss enrollees shared by both entities who have significant behavioral health and complex physical health co-morbidities. In this process, ABHMI and the PIHP work collaboratively to develop shared care management interventions and to identify and coordinate services for members. ABHMI and the PIHP will work together to create a single treatment plan that addresses both physical and mental health needs and also considers unmet needs such as substance abuse treatment, while helping the individual access his/her natural community supports based on his/her strengths and preferences. Care Connect 360 houses a care management tool that allows the involved entities to jointly document their care plan and track contacts, services, or any issues regarding the member.

Member Rights and Responsibilities

ABHMI maintains policies and procedures formally acknowledging and listing member rights and responsibilities. Policies reflect federal, state, and local law requirements.

ABHMI ensures that a member's freedom to exercise his/her rights will not adversely affect the member's treatment by ABHMI or by providers.

ABHMI informs members of their rights and responsibilities in the member handbook and member newsletters. Providers are educated about members' rights in the provider manual and the provider newsletters.

Quality management processes provide members and providers a venue to express concerns about member rights and responsibilities through tracking complaints, grievances, and appeals as well as through member surveys. The Service Improvement Committee evaluates trends and reports to the Quality Management Oversight Committee and the Board of Directors.

Appendix 1 - Goals and Objectives

ABHMI		
Organizational Goals and Objectives		
Goals		Objectives
Implement a QM program that effectively promotes and builds quality into the organizational structure and processes of the health plan.		
1	Promote business and operational excellence to affect process improvement with the objective of continuous quality improvement (CQI).	• Develop a comprehensive, effective, and soundly executed QM strategy. • Offer process improvement training to ABHMI quality management staff. (ABX –training is available through the Aetna Learning Center. White belt courses are required for all employees.) • Conduct quarterly organization-wide meetings to enhance communications throughout the organization and promote continuous improvement. • Develop and enhance relationships and partnerships with community organizations, businesses, health departments and local government agencies in disparate populations, and MDHHS emphasizing primary and preventive care in the safest and least restrictive environment possible. • Conduct regular quality management committee meetings to provide oversight of quality improvement functions.

ABHMI Organizational Goals and Objectives		
Goals		Objectives
2	Promote consistent processes and collaboration among ABHMI departments to allow for the collection and sharing of quality management data and monitoring of outcomes.	• Maintain a formal reporting structure including organizational and quality management committees that incorporate collaboration, data sharing, and evaluation of outcomes. The ABHMI Quality Work Plan identifies frequency of organizational meetings. • Record minutes for all formal committee meetings
3	Collaborate with providers to improve the quality of care provided to members.	• Maintain systems for monitoring and tracking practitioner and provider quality management and performance improvement trends and medical record keeping practices. • Maintain credentialing and delegation oversight, with reporting at scheduled intervals. • Implement provider performance programs and corrective action plans as indicated.
4	Maintain an effective communication system that provides opportunities to obtain, educate and provide feedback to members and their family/representative and/or caregiver, advocates, practitioners, providers, and ABHMI staff about quality management and performance improvement activities, and ways to improve members' health.	• Provide communications to members, practitioners, providers, and plan staff that include member rights and responsibilities, status and success of QM activities, and health outcome information. • Solicit information from members and providers to assist in driving quality initiatives (i.e., Member Advisory Committee meetings)
5	Maintain a program that meets the needs of the culturally and linguistically diverse population served by ABHMI and promote cultural competence.	• Facilitate and support integrative clinical programs and HEDIS® based initiatives that address cultural and linguistic needs of ABHMI members • Conduct cultural competence training for ABHMI employees annually • Promote initiatives to address racial and ethnic disparities in health care • Assess ABHMI's ability to meet federal and state Limited English Proficiency (LEP) guideline

ABHMI Organizational Goals and Objectives		
Goals		Objectives
		• Assess capability of the Network to meet the cultural and linguistic needs of the population being served • Provide members and network practitioners with access to interpretive and sign language services for ABHMI members
6	Develop, maintain, and increase awareness of prevention and wellness, and outreach programs available to members (to include programs addressing chronic and catastrophic illness, behavioral health, population health, long-term care, and care management)	• Establish prevention and wellness outreach programs and evaluate effectiveness annually • Evaluate the effectiveness of chronic condition management interventions annually • Evaluate the effectiveness of quality management and prevention and wellness initiatives annually
7	Educate providers and members and their family/representative and/or caregiver on appropriate and efficient utilization of health care services and facilities	• Distribute appropriate communications to members and providers annually
8	Maintain technical business information systems to support quality management and performance improvement activities and improve them as necessary to meet program needs	• Maintain organizational databases (i.e., potential quality of care and grievance databases) and provide monthly reporting to appropriate committees and regulatory bodies
Conduct continual monitoring and assessment of patient care, health care providers, and services to health plan members to ensure that they meet accepted and appropriate medical practice standards and the needs of the health plan members.		
9	Promote involvement of members and their family/representative and/or caregiver and	• Conduct Member Advisory Committee meetings (quarterly / semi-annually).

ABHMI		
Organizational Goals and Objectives		
Goals		Objectives
	practitioners in the quality management program and related activities by encouraging feedback.	
10	Define criteria for measuring clinical performance and assessing the outcomes against established standards and benchmarks.	Evaluate and report annual HEDIS® scores.
11	Establish standards of clinical care and service utilizing objective criteria and processes to evaluate and continually monitor for improvement.	- Evaluate clinical practices against national practice guidelines to improve the safety and effectiveness of care. - Adopt and approve clinical practice guidelines at least every two (2) years.
12	Improve the satisfaction of members, practitioners, and providers with health care delivery.	- Conduct annual CAHPS® surveys - Conduct an annual survey to assess members' experience with behavioral health services - Conduct an annual provider satisfaction survey - Conduct an annual provider appointment availability study - Conduct an annual provider accessibility study - Conduct member experience surveys to evaluate the effectiveness of care management and population health management programs. - Provide routine evaluation of Member Services activities (i.e., translation/interpretation services, call wait times) - Assist members with navigating the health care delivery system - Collect and report grievance and appeals data (including office site assessments) monthly
13	Identify, monitor, and evaluate high-volume, problem-prone, or high-risk aspects of health care and service.	- Manage quality and risk management referrals to promote quality care and service - Assess data on high volume/ high risk procedures

ABHMI Organizational Goals and Objectives		
Goals		Objectives
14	Maintain mechanisms for reviewing the entire range of care delivery systems, including all demographic groups, care settings, and services available to the member.	• Use enrollment metrics to provide annual reports that include all demographic groups, care settings, and services available to the member.
15	Monitor the provider network's capacity to accommodate the membership while considering the diverse needs of the member population, including behavioral health and special health care as well as specific language or cultural needs and preferences.	• Annually evaluate and generate accessibility and availability analyses on the network providers and implement corrective action if necessary. • Conduct annual continuity and coordination of care evaluations. • Evaluate monthly/quarterly credentialing and recredentialing reports.
16	Promote optimum quality of care and service.	• Monitor outpatient and inpatient services to identify deviations from standard of care/service. • Perform ongoing off-cycle quality of care and quality of services reviews. • Manage quality and risk management referrals.
17	Inform and educate members and their family/representative and/or caregiver, practitioners, providers, and other stakeholders about quality and health improvement programs available to increase the utilization of preventive health care, care management and other services.	• Distribute annual notifications (Member handbook, provider manual, member and provider newsletters, postcards, website communications).
18	Provide oversight of practitioner/provider quality and utilization management and act if needed to promote improvement.	• Conduct annual IRR testing.

ABHMI Organizational Goals and Objectives		
Goals		Objectives
19	Measure effectiveness of the population health strategy and implement interventions to improve performance.	• Conduct an annual population health management effectiveness analysis.
20	Promote equitable access to care and services by identifying and affecting reduction of racial and ethnic disparities in health care, social risks, and Social Determinants of Health that could negatively impact quality health care.	• Conduct annual population assessment analysis and develop annual Health Equity program
Identification and analysis of opportunities for improvement with implementation of actions and follow-up		
21	Identify and evaluate quality and risk issues.	• Implement follow-up measures and action plans to resolve issues and prevent recurrences. • Monitor actions for continued effectiveness. • Implement rapid response process (i.e., Rapid Response Team meetings). • Present findings at appropriate committee meetings.
22	Evaluate utilization issues.	• Initiate actions on identified opportunities for improving member outcomes and monitor for continued effectiveness.
23	Identify opportunities to improve health care outcomes for members.	• Maintain and/or improve HEDIS® annual scores for targeted measures. • Identify and act on opportunities for improvement. • Monitor the effectiveness of initiatives.

ABHMI		
Organizational Goals and Objectives		
Goals		Objectives
Encourage patient safety and maintain compliance with local, state, and federal regulatory requirements and accreditation standards.		
24	Develop, implement, and monitor patient safety awareness and initiatives promoting effectiveness of continuous quality improvement activities throughout the organization.	• Maintain a formal potential quality of care reporting structure. • Annually distribute communications that expand knowledge about clinical safety (Member and provider newsletters). • Establish standards and perform audit functions for medical record documentation.
25	Credential and re-credential network practitioners and providers in a thorough and timely manner, in accordance with state and NCQA standards.	• Maintain a formal credentialing process and reporting system (Credentialing Performance Committee). • Conduct credentialing delegation oversight for non-common delegates.
26	Operate the QM program in compliance with and responsive to applicable requirements of plan sponsors, federal and state regulators, and appropriate accrediting bodies.	• Maintain NCQA Health Plan accreditation. • Complete annual External Quality Review (per state requirements).
27	Facilitate continuity and coordination of care between medical practitioners as well as between medical and behavioral health practitioners.	• Monitor and identify opportunities for improvement for continuity and coordination of care between medical and behavioral health care practitioners.

Guidance Source:

2025 NCQA Quality Program Standards

☐ [2025 Health Plan Accreditation \(HPA\)](#)

☐ [2024 Health Equity Accreditation \(HEA\)](#)

Appendix 2 – 2026 Performance Improvement Projects

Desired Outcome: Reduce health disparities in Controlling Blood Pressure (CBP)	
Priority Population: Black/African American, Hispanic, and White members 18-85 years of age with a diagnosis of hypertension	
Business Owner(s): Jonathan Gardner	Team: Quality Management
Opportunity Statement: Eliminate the existing disparity in the CBP HEDIS measure without a decline in the rate of adherence in African American, Hispanic, and White populations.	
Goal (SMART): Improve CBP adherence in African American, Hispanic, and White populations by: Monitoring CBP adherence outcomes monthly, deploying interventions monthly to support improved outcomes, collaborate and share rate adherence and evident disparities across departments quarterly. Collaborate with providers and community health organizations to educate on the importance of consistently monitoring blood pressure of members with HTN. Determine barriers to care due to SDoH and fill gaps with appropriate measures to ensure an increase in CBP HEDIS measures of 2% year over year.	
Start Date: 1/1/2025	End Date: 12/31/2027
KPI: MY2025 CBP rate HEDIS IDSS	Baseline: MY2024 CBP rate
Frequency of Monitoring: Monthly/ Quarterly/ Annually	

Desired Outcome: Increase MI Child CAHPS survey response rate	
Priority Population: Parents of children Medicaid enrolled on Aetna's behalf	
Business Owner(s): Jonathan Gardner	Team: Quality Management
Opportunity Statement: Improve the response rate for the ABHMI CAHPS survey amongst the child population.	
Goal (SMART): Increase the member response rate on the MI Child CAHPS Survey by 1.5% year over year.	
Start Date: 1/1/2025	End Date: 12/31/2027
KPI: MY 2025 Child CAHPS Response Rate	Baseline: MY2024 2024 Child CAHPS Response rate
Frequency of Monitoring: Monthly/ Quarterly/ Annually	

Desired Outcome: Increase the rate of Immunizations for Adolescents (IMA-2)	
Priority Population: Adolescents age 13	
Business Owner(s): Jonathan Gardner	Team: Quality Management
Opportunity Statement: Improve HEDIS IMA-2 vaccine adherence in the adolescent population (one dose meningococcal, one dose Tdap, 3 dose HPV) by age 13.	
Goal (SMART): Monitor IMA-2 adherence outcomes monthly, deploying specific interventions monthly and quarterly to support improved outcomes, collaborate and share rate adherence and evident disparities across departments quarterly for collaborative efforts such as community events and provider engagement to educate about the importance of the appropriate vaccine schedule for adolescents to improve IMA-2 HEDIS measure by 3% year over year.	
Start Date: 1/1/2025	End Date: 12/31/2027
KPI: MY2025 IMA-2 rate HEDIS IDSS	Baseline: MY2024 IMA-2 rate
Frequency of Monitoring: Monthly/ Quarterly/ Annually	
Frequency of Monitoring:	Monthly

Desired Outcome: Increase the rate of Preventative Dental Exams for Diabetic Members (component of Comprehensive Diabetic Care)	
Priority Population: Members with a diabetes diagnosis in priority zip codes/counties	
Business Owner(s): Jonathan Gardner	Team: Quality Management
Opportunity Statement: Eliminate the existing disparity affecting African American and Hispanic Diabetic Members getting at least one Preventative Dental Service annually without creating a decline in other racial/ethnic groups	
Goal (SMART): Increase the rate of yearly Preventative Dental Exams in Diabetic patients. Improve the rate of Preventative Diagnostic Dental Care of Diabetic Patients by: Monitoring the number of Preventative Dental Services for Diabetic Patients monthly, quarterly, and annually to discover gaps in services and barriers to care, deploying interventions monthly to support improved outcomes, collaborate and share rate adherence and evident disparities across departments quarterly to work cohesively to improve rates and outcomes for diabetic members by 2% year over year.	
Start Date: 1/1/2025	End Date: 12/31/2027
KPI: MY2025 CBP rate HEDIS IDSS	Baseline: MY2024 CBP rate
Frequency of Monitoring: Monthly/ Quarterly/ Annually	

Desired Outcome: Increase the rate of Follow Up Care Within 30 Days for Members After Hospitalization for Mental Illness (FUH-30)	
Priority Population: All members with an inpatient behavioral health hospital stay, that have been authorized and eligible for services by both the MHP and PIHP.	
Business Owner(s): Jonathan Gardner	Team: Quality Management
Opportunity Statement: Complete targeted interventions and activities in collaboration with our PIHP partners to improve the rate of follow up care for members/adults/children that have been hospitalized for mental illness.	
Goal (SMART): Complete targeted interventions and activities to improve the rate of all members receiving follow-up care post mental illness hospitalizations (FUH-30) HEDIS rate by 2% year over year for the Adult/Child population.	
Start Date: 1/1/2025	End Date: 12/31/2027
KPI: MY2025 FUH-30 rate HEDIS IDSS	Baseline: MY2024 FUH-30 rate
Frequency of Monitoring: Monthly/ Quarterly/ Annually	

Desired Outcome: Increase the rate of Lead Screening in children at age 12 months and 24 months (LSC2-CH)	
Priority Population: Children who turned two years old during the measurement period who were enrolled in the same plan during the 12 months preceding the child's second birthday and who had no more than one gap in enrollment and were enrolled in the health plan as of the day of their second birthday.	
Business Owner(s): Jonathan Gardner	Team: Quality Management
Opportunity Statement: Complete targeted interventions to increase the percentage of lead screening protocol adherence in two year old children requiring at least one test by their second birthday (performance indicator one) and children requiring one test at age one and a second test at age two (performance indicator two) during the remeasurement period.	
Goal (SMART): Complete targeted interventions and activities to increase the rate of lead screening protocol adherence in children before 12 months and 24 months of age by 3% year over year.	
Start Date: - Baseline: 1/1/2025 - Remeasure 1: 1/1/2026 – 12/31/2026 - Remeasure 2: 1/1/2027 – 12/31/ 2027	End Date: 12/31/2027
KPI: MY2025 LSC rate using April 2026 PMR report	Baseline: MY2024 LSC rate using April 2025 PMR report
Frequency of Monitoring: Monthly/ Quarterly/ Annually	

Desired Outcome: Increase the number of completed HRSN Health Related Social Needs screening tool for new and existing members	
Priority Population: Members 18+ years as of January 1 of the measurement year who were either newly enrolled during Jan 1 – Dec 31 of the measurement year or who were enrolled in December of the previous year or earlier and remain enrolled in January of the measurement year	
Business Owner(s): Jonathan Gardner	Team: Quality Management
Opportunity Statement: Complete targeted interventions and activities in collaboration with our PIHP partners to improve the rate of follow up care for members/adults/children that have been hospitalized for mental illness.	
Goal (SMART): Increase the percentage of HRSN screenings that are completed for new and existing members by 3% year over year	
Start Date: • Baseline: 1/1/2025 • Remeasure 1: 1/1/2026 – 12/31/2026 • Remeasure 2: 1/1/2027 – 12/31/ 2027	End Date: 12/31/2027
Evaluation Elements: 1. Consistent Methodology used across measurements 2. Any improvement in performance indicator rates 3. Statistically significant improvement in performance rates 4. Sustained significant improvement in performance rates	Pre Baseline: MY2024 HRSN Screening Template data
Frequency of Monitoring: Monthly/ Quarterly/ Annually	

