GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

State Fiscal Year 2020 External Quality Review Technical Report for Integrated Care Organizations

April 2021

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services they provide, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

MDHHS administers and oversees the MI Health Link program, which provides integrated services to individuals eligible for both Medicare and Medicaid benefits. The MI Health Link program's MCEs include seven integrated care organizations (ICOs) contracted with MDHHS to provide primary, acute, behavioral health, and long-term services and supports (LTSS) to dual-eligible members in Michigan. The ICOs contracted with MDHHS during state fiscal year (SFY) 2020 are displayed in Table 1-1.

Table 1-1—ICOs in Michigan

ICO Name	ICO Short Name
Aetna Better Health Premier Plan (Aetna Better Health of Michigan)	AET
AmeriHealth Caritas VIP Care Plus (AmeriHealth Caritas)	AMI
HAP Empowered	HAP
MeridianComplete (Meridian Health Plan)	MER
Michigan Complete Health	MCH
Molina Dual Options MI Health Link (Molina Healthcare of Michigan)	MOL
Upper Peninsula Health Plan MI Health Link (Upper Peninsula Health Plan)	UPP

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-1] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality of, timeliness of, and access to care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher performing healthcare delivery systems for their dual-eligible Medicare-Medicaid members. For the SFY 2020 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each ICO. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Quality Improvement Projects (QIPs)	This activity verifies whether a QIP conducted by an ICO used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by an ICO are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which an ICO is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the extent to which an ICO has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy*
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] Analysis	This activity assesses member experience with an ICO and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

*This activity will be mandatory effective no later than one year from the issuance of the associated EQR protocol.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: February 24, 2021.

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Statewide Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the ICOs' performance in providing quality, timely, and accessible healthcare services to MDHHS' dual-eligible members. For each ICO reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the ICO's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all ICOs were also compared and analyzed to develop overarching conclusions and recommendations for MDHHS and the MI Health Link program. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for MDHHS to further promote its goals and objectives in its quality strategy. Refer to Section 6 for more details.

Table 1-3—Statewide Substantive Findings

Program Strengths
• Through their participation in the state-mandated QIP, *Follow-Up After Hospitalization for Mental Illness*, the ICOs focused their efforts on specific quality outcomes—particularly timeliness and access to care and services—which should ultimately result in better health outcomes for MI Health Link program members diagnosed with, and hospitalized for, mental illness. Members receiving appropriate and timely follow-up care with a mental health practitioner after discharge promotes recovery, while reducing the risk of suicide,[1-3] repeat hospitalization, and the overall cost of healthcare.
• As determined through the PMV activity, the ICOs were able to consistently and accurately report on the total number of members who visited the ED and had a primary diagnosis related to behavioral health; the total number of members with a completed care plan who also had at least one documented discussion of care plan goals; and the number of members receiving LTSS who had a critical incident or abuse report. Additionally, the ICOs successfully demonstrated their readiness to report on the *Minimizing Institutional Length of Stay* measure. Accurate and meaningful information on healthcare quality is useful for the ICOs and MDHHS to identify and implement initiatives that will lead to overall improvement in the quality of care being provided to MI Health Link members.
• Through MDHHS' annual compliance review activities, the ICOs demonstrated areas of strength in conforming to and abiding by federal Medicaid managed care and MDHHS-specific monitoring standards, which support quality, timely, and accessible care for members enrolled in the MI Health Link program. The MI Health Link program demonstrated full compliance in the Assurance of Adequate Capacity and Services, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, and Health Information Systems standards, indicating the ICOs had the systems, staff knowledge, processes, and procedures in place to effectively support full implementation of all reviewed managed care requirements in these program areas.
• Through the NAV activity, MDHHS is able to more effectively discern potential areas of opportunities in the ICOs' provider networks that could not be obtained through the limited time-distance and provider

[1-3] National Action Alliance for Suicide Prevention. *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care*, November 2019. Available at: https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf. Accessed on: Feb 24, 2021.

Program Strengths
count analyses activities. The comprehensive data available to MDHHS can be used to identify areas of opportunity in the provider networks and inform future targeted compliance reviews. • The CAHPS Home and Community Based Services Survey[1-4] identified that members receiving LTSS have positive experiences with their personal assistance and behavioral health staff, homemakers, and case managers as demonstrated by the three global ratings (Rating of Personal Assistance and Behavioral Health Staff, Rating of Homemaker, and Rating of Case Manager) all receiving mean scores above 95 on a rating scale of 0 to 100.

Program Weaknesses
• **Behavioral Health Services and Integration—**Although MDHHS has a vision for care integration that will bring together physical and specialty behavioral health services to better meet the whole-person needs of the members it serves, mild-to-moderate behavioral health needs are currently managed by the ICOs while specialty behavioral health services are provided through the prepaid inpatient health plans (PIHPs). Although the ICOs are required to contract directly with PIHPs for delivery of Medicare-covered behavioral health services, the separation of systems and responsibilities creates challenges that may contribute to poor health outcomes,[1-5] especially for members with mental illness, while also posing challenges to the MI Health Link program when implementing efforts to improve program performance related to behavioral health. – Although the ICOs developed methodologically sound *Follow-Up After Hospitalization for Mental Illness* QIPs, the goal of demonstrating significant improvement was not achieved for six of the seven ICOs during the first remeasurement, with a decrease in performance for two of the ICOs' QIPs. – While not presented within this EQR, MDHHS compared ICO statewide average results to national averages, and the ICOs' rates fell below the national average for all measures included in the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-6] Behavioral Health domain, and four of the ICOs experienced substantial drops in HEDIS performance from the prior year. – As reported by the ICOs through the follow-up to EQR recommendations and QIP activity, delays in timely data sharing, lack of collaborative care coordination, and a lack of clearly defined responsibilities for member management with the PIHPs could be impeding timely member follow-up and negatively impacting timely access to behavioral health services. • **Care Planning and Coordination of Care—**Care coordination is a foundation of the MI Health Link program. Every MI Health Link member has a care coordinator to assist in accessing services; provide support through care transitions; and coordinate care with existing providers and coordinating agencies, including the PIHPs. In alignment with the expectations set by MDHHS,[1-7] the ICOs' care coordinators are

[1-4] Centers for Medicare & Medicaid Services. *CAHPS Home and Community Based Services Survey*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey/index.html. Accessed on: Feb 24, 2021.

[1-5] Michigan Department of Health and Human Services. *Michigan's Public Behavioral Health System: Proposed New Approach* (Virtual Forum), February 6, 2020. Available at: https://www.michigan.gov/documents/mdhhs/2020.02.06_Future_of_BH_680766_7.pdf. Accessed on: Feb 24, 2021.

[1-6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-7] MI Health Link. Care Coordinator Responsibilities and Expectations. Available at: https://www.michigan.gov/documents/mdch/MI_Health_Link_Care_Coordinator_RE-FINAL_488265_7.pdf. Accessed on: Feb 24, 2021.

Program Weaknesses
responsible for supporting an ongoing person-centered planning process, which includes developing a care plan that is specific to the member's needs and preferences; facilitating timely access to services and medications, and supporting transitions of care; and engaging the member in other activities or services as needed to optimize his or her health status. Additionally, ICO staff members are required by contract and Minimum Operating Standards for the MI Health Link program and MI Health Link HCBS waiver[1-8] to have procedures for identifying, preventing, and reporting member neglect, abuse, exploitation, and critical incidents. The ICOs are responsible for tracking and responding to individual critical incidents using the MI Health Link Critical Incident Reporting System. Although these robust measures have been implemented by MDHHS to ensure members in the MI Health Link program maintain optimal health, results from the EQR identified potential gaps that may lead to poor experiences of care, reduced health outcomes, and increased costs of care. – Although all of the ICOs received a *Reportable (R)* designation for Michigan-specific measures, MI2.3 and MI3.1, five of the ICOs had findings that resulted in resubmission of data for either MI2.3—*Members With Documented Discussion of Care Goals* or MI3.1—*Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*, indicating opportunities exist for improving care coordination system documentation and accurate reporting of measures. – From the SFY 2019 compliance review of all program standards, three areas required significant opportunities for statewide improvement, including the standards related to coordination and continuity of care and coverage and authorization of services. In the SFY 2020 corrective action plan (CAP) review, three ICOs continued to have deficiencies in these program areas, requiring additional remediation to ensure members were being care managed in accordance with their person-centered care and supports plan. – While the ICOs' remediation plans from the SFY 2020 CAP reviews supported appropriate actions and interventions to correct the previously identified deficiencies in the Subcontractual Relationships and Delegation standard, some of the ICOs' remediation plans had not been fully implemented at the time of the review. This demonstrated an overall opportunity for continued focus on the comprehensive monitoring and oversight of the ICOs' delegates, including the PIHPs and other agencies providing member-facing services. Additionally, conversations during technical assistance sessions with the ICOs and information provided in the follow-up to EQR recommendations process confirmed that enhanced collaboration, data-sharing, and timely communication are necessary to support safe and effective care for MI Health Link members, while also ensuring ICOs are meeting their obligations under their contract with MDHHS and CMS (e.g., critical incident and abuse reports, utilization data, joint care planning).

[1-8] Michigan Department of Health and Human Services, Medical Services Administration. *Minimum Operating Standards For MI Health Link Program and MI Health Link HCBS Waiver*, Version 8, July 22, 2019. Available at: https://www.michigan.gov/documents/mdhhs/Minimum_Operating_Standards_for_MI_Health_Link_March_2017_557197_7.pdf. Accessed on: Feb 25, 2021.

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal and/or Objective**
• MDHHS could consider conducting a program-wide survey/interview of members who have recently received inpatient or emergency services for a behavioral health condition to determine potential barriers members have to accessing timely care.	**Goal #1:** Ensure high quality and high levels of access to care. **Goal #2:** Strengthen person and family-centered approaches. **Goal #3:** Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external). **Goal #4:** Reduce racial and ethnic disparities in healthcare and health outcomes.
• Based on the SFY 2019 EQR findings and technical report recommendations, MDHHS elected to conduct a targeted compliance review of specific program areas in SFY 2021, including a comprehensive review of the ICOs' implementation of processes and procedures for monitoring and overseeing their delegated entities. HSAG recommends MDHHS use the SFY 2021 targeted compliance review results to develop interventions and initiatives to improve program performance, including performance related to delegation oversight processes and overall performance of the ICOs' delegates.	
• While MDHHS is monitoring ICO performance and statewide averages in comparison to national averages, MDHHS could consider developing a concentrated effort and focus for ICOs to align improvement efforts based on this monitoring. HSAG recommends that MDHHS focus on improvement in domains that include a significant number of measures that fall below the national average, including the Behavioral Health domain, to consistently improve ICO performance overall.	

2. Overview of the Integrated Care Organizations

Managed Care in Michigan

In Michigan, management of the Medicaid program is spread across two different administrations and four separate divisions within MDHHS. Physical health, children's and adult dental services, and mild-to-moderate behavioral health services are managed by the Managed Care Plan Division in the Medical Services Administration (MSA). LTSS are implemented by three different MDHHS program areas including the Long-Term Care Services Division (MI Choice Program), the Integrated Care Division (MI Health Link Medicaid/Medicare Dual Eligible Demonstration and the Program of All-Inclusive Care for the Elderly), and the Behavioral Health and the Developmental Disabilities Administration (BHDDA) Quality Division. BHDDA also administers Medicaid waivers for people with intellectual/developmental disabilities, mental illness, and serious emotional disturbance, and it administers prevention and treatment services for substance use disorders (SUDs). Table 2-1 displays the Michigan Medicaid managed care programs, the MCE(s) responsible for providing services to members, and the MDHHS division accountable for the administration of the benefits included under each applicable program.

Table 2-1—Medicaid Managed Care Programs in Michigan

Medicaid Managed Care Program	MCEs	MDHHS Division
Comprehensive Health Care Program (CHCP), including: • Children's Health Insurance Program (CHIP)—MIChild • Children's Special Health Care Services (CSHCS) Program • Healthy Michigan Plan (HMP) (Medicaid Expansion) • Flint Medicaid Expansion Waiver	Medicaid Health Plans (MHPs)	MSA
Managed LTSS, including: • MI Health Link Demonstration	ICOs PIHPs	MSA
Dental Managed Care Programs, including: • Healthy Kids Dental • Pregnant Women Dental • HMP Dental	Prepaid Ambulatory Health Plans (PAHPs)	MSA
Behavioral Health Managed Care	PIHPs	BHDDA

MI Health Link Program

The MI Health Link program was developed in 2014 in response to the CMS Financial Alignment Initiative opportunity. With goals to align financing of Medicare and Medicaid programs, as well as to integrate primary, acute, behavioral health, and LTSS for individuals eligible for both programs, Michigan received approval and initial grant funding to create and implement the MI Health Link program. The MI Health Link program offers integrated service delivery for all covered Medicare and Medicaid services, including care coordination for members 21 years of age or older who reside in one of four geographical regions throughout the state. The MI Health Link program is governed by a three-way contractual agreement between CMS, MDHHS, and the ICOs selected to deliver services to the dual-eligible members.

Overview of ICOs

During the SFY 2020 review period, MDHHS contracted with seven ICOs. These ICOs are responsible for the provision of services to MI Health Link members. Table 2-2 provides a profile for each ICO. Figure 2-1 shows a visual representation of the counties included in each region served.

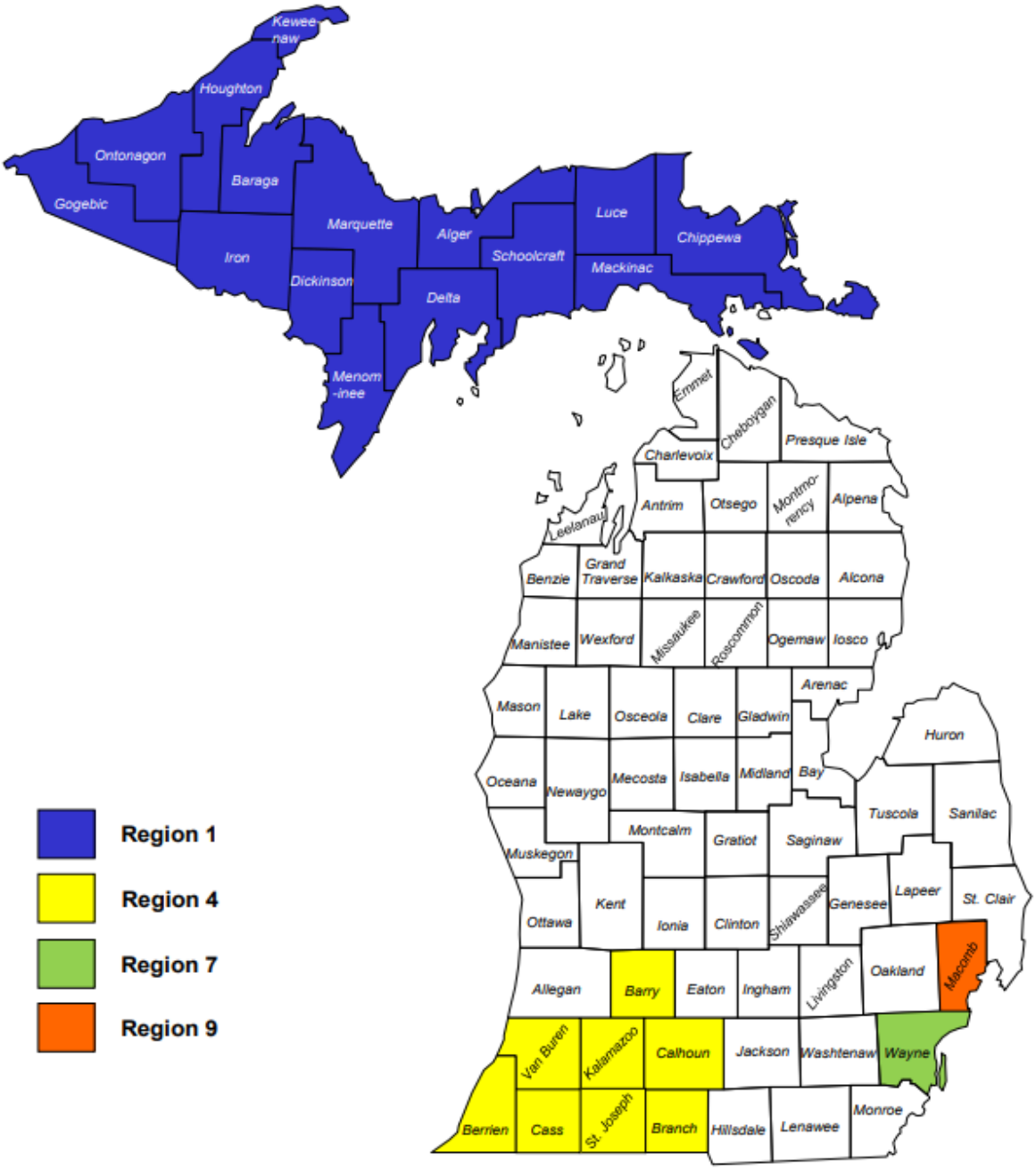
Table 2-2—ICO Profiles

ICO	Covered Services[2-1]	Service Area/Regions Served[2-2]
AET	All ICOs cover medically necessary services such as the following: • Medical services, including preventive care and screening, physician visits, lab tests and X-rays, therapy, and hospital stays • Dental, vision, and hearing services • In-home services • Community-based long-term care services • Community mental health services • Nursing facility care • Medications • Equipment and supplies • Transportation	Regions 4, 7, and 9
AMI		Regions 7 and 9
HAP		Regions 7 and 9
MER		Region 4
MCH		Regions 7 and 9
MOL		Regions 7 and 9
UPP		Region 1

[2-1] Michigan Department of Health and Human Services. *MI Health Link*. Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html. Accessed on: Feb 25, 2021.

[2-2] Michigan Department of Health and Human Services Integrated Care Division. *MI Health Link Enrollment Dashboard.* Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077-543624--,00.html. Accessed on: Feb 25, 2021.

Figure 2-1—ICO Regions[2-3]



[2-3] Michigan Department of Community Health. *MI Health Link Regions*. Available at: https://www.michigan.gov/documents/mdch/MI_Health_Link_Counties_468767_7.pdf. Accessed on: Feb 25, 2021.

Quality Strategy

The 2020–2023 MDHHS Comprehensive Quality Strategy (CQS) provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including the MI Health Link program. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 CQS, MDHHS strives to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The CQS also aligns with CMS' Quality Strategy and the United States (U.S.) Department of Health and Human Services' (HHS') National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. The MDHHS CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3, and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and specifically were designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

Table 2-3—MDHHS CQS Goals and Objectives[2-4]

MDHHS CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start	Expand and simplify safety net access	**Objective 1.1:** Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations.
		Objective 1.2: Assess and reduce identified racial disparities.
		Objective 1.3: Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services.
		Objective 1.4: Ensure care is delivered in a way that maximizes consumers' health and safety.
		Objective 1.5: Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care.

[2-4] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Feb 25, 2021.

MDHHS CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #2: Strengthen person and family-centered approaches		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 2.1**: Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.
		Objective 2.2: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.
		Objective 2.3: Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches.
		Objective 2.4: Encourage community engagement and systematic referrals among healthcare providers and to other needed services.
		Objective 2.5: Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a networkwide, effective approach to healthcare within the community.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
		Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.3: Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.

MDHHS CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start MDHHS Pillar #3: Serve the whole person	Improve maternal-infant health and reduce outcome disparities Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.
		Objective 4.2: Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process.
		Objective 4.3: Promote and ensure access to and participation in health equity training.
		Objective 4.4: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.
		Objective 4.5: Expand and share promising practices for reducing racial disparities.
		Objective 4.6: Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities.
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform		
NQS Aim #3: Affordable Care MDHHS Pillar #4: Use data to drive outcomes	Drive value in Medicaid Ensure we are managing to outcomes and investing in evidence-based solutions	**Objective 5.1:** Promote the use of value-based payment models to improve quality of care.
		Objective 5.2: Align value-based goals and objectives across programs.

The CQS also includes a common set of performance measures to address the required Medicaid Managed Care and CHIP Managed Care Final Rule. The common domains include:

- Network Adequacy and Availability
- Access to Care
- Member Satisfaction
- Health Equity

These domains address the required state-defined network adequacy and availability of services standards and take into consideration the health status of all populations served by the MCEs in Michigan. Each program also has identified performance measures that are specific to the populations it serves.

MDHHS employs various methods to regularly monitor and assess the quality of care and services provided by the managed care programs. MDHHS also intends to conduct a formal comprehensive assessment of performance against CQS performance objectives annually. Findings will be summarized in the Michigan Medicaid Comprehensive Quality Strategy Annual Effectiveness Review, which drives program activities and priorities for the upcoming year and identifies modifications to the CQS.

Quality Initiatives and Interventions

Through its CQS, MDHHS has also implemented many initiatives and interventions that focus on quality improvement. Examples of these initiatives and interventions include:

- **Accreditation**—MCEs, including all MHPs and some ICOs and PIHPs, are accredited by a national accrediting body such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehabilitation Facilities (CARF), and/or the Joint Commission.
- **Opioid Strategy**—MDHHS actively participates in and supports Michigan's opioid efforts to combat the opioid epidemic by preventing opioid misuse, ensuring individuals using opioids can access high quality recovery treatment, and reducing the harm caused by opioids to individuals and their communities.
- **Health Home Models**—Michigan established three Health Home models in accordance with Section 2703 of the Affordable Care Act including the Opioid Health Home, MI Care Team, and the Behavioral Health Home. These Health Homes focus on high-need/high-cost members with chronic conditions, provide flexibility to create innovative and integrated care management models, and offer sustainable reimbursement to affect the social determinants of health. Federally mandated core services include comprehensive care management and care coordination, health promotion, comprehensive transitional care and follow-up, individual and family support, and referral to community and social services. Participation in the Health Home models is voluntary, and enrolled beneficiaries may opt out at any time.
- **Behavioral Health Integration**—All Medicaid managed care programs address the integration of behavioral health services by requiring plans to coordinate behavioral health services and services for persons with disabilities with the Community Mental Health Services Programs (CMHSPs)/PIHPs. While contracted plans may not be responsible for the direct delivery of specified behavioral health and developmental disability services, they must establish and maintain agreements with MDHHS-contracted local behavioral health and developmental disability agencies or organizations. Plans are also required to work with MDHHS to develop initiatives to better integrate services and to provide incentives to support behavioral health integration.

- **Value-based Payment**—MDHHS employs a population health management framework and intentionally contracts with high-performing plans to build a Medicaid managed care delivery system that maximizes the health status of members, improves member experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology/health information exchange, and a robust quality strategy. Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on the social determinants of health, creating health equity and supporting efforts to build more resilient communities. MDHHS supports payment reform initiatives that pay providers for value rather than volume, with "value" defined as health outcome per dollar of cost expended over the full cycle of care. In this regard, performance metrics are linked to outcomes. The Medicaid managed care programs are at varying degrees of payment reform; however, all programs utilize a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize quality improvement and improved outcomes.
- **Health Equity Reporting and Tracking**—MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the healthcare services provided to Medicaid members. Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs, as indicated by the CQS goal to reduce racial and ethnic disparities in healthcare and health outcomes.

3. Assessment of ICO Performance

ICO Methodology

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2020 review period to evaluate the performance of ICOs on providing quality, timely, and accessible healthcare services to MI Health Link members. Quality, as it pertains to EQR, means the degree to which the ICO increased the likelihood of desired outcomes of its members through its structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the ICOs were at successfully demonstrating and reporting on outcome information for the availability and timeliness of services.

To identify strengths and weaknesses and draw conclusions for each ICO, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the MI Health Link program. The composite findings for each ICO were analyzed and aggregated to identify overarching conclusions and focus areas for the ICO in alignment with the priorities of MDHHS. For more details about the technical methods for data collection and analysis, refer to Appendix A.

Validation of Quality Improvement Projects

For the SFY 2020 validation, the ICOs continued their MDHHS-mandated QIP topic reporting Remeasurement 1 study indicator outcomes. The QIP topic *Follow-Up After Hospitalization for Mental Illness* addresses follow-up visits with a mental health practitioner within 30 days of discharge for a hospitalization for mental illness. This topic has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. The purpose of the QIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time. HSAG's QIP validation ensures that MDHHS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities conducted by the ICO during the project.

Table 3-1 outlines the selected study indicator for the QIP for all ICOs.

Table 3-1—QIP Topic and Study Indicators

ICO	QIP Topic	Study Indicator
AET	*Follow-Up After Hospitalization for Mental Illness*	Improve the percentage of follow-up visits within 30 days with a mental health practitioner after discharge from an acute hospitalization with mental illness diagnosis.
AMI		The percentage of discharges for members 21 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses on or between January 1 and December 1 and who had a follow-up visit with a mental health practitioner within 30 days of discharge.
HAP		Percentage of members who had a follow-up visit within 30 days of a discharge for selected mental illness or intentional self-harm.
MER		The percentage of discharges for members 21 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses on or between January 1 and December 1 and who had a follow-up visit with a mental health practitioner within 30 days of discharge.
MCH		A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.
MOL		The percentage of MMP [Medicare-Medicaid plan] member discharges for which the member received follow-up within 30 days of discharge.
UPP		Follow-up after hospitalization for mental illness within 30 days.

Performance Measures

Performance Measure Validation

The purpose of PMV was to assess the accuracy of performance measures reported by ICOs and to determine the extent to which performance measures reported by the ICOs followed Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements. For the SFY 2020 PMV, HSAG validated the ICOs' data collection and reporting processes used to calculate specific performance measure rates selected by MDHHS for validation.

Table 3-2 lists the performance measures calculated by the ICOs for calendar year (CY) 2019 (i.e., January 1, 2019, through December 31, 2019), along with the performance measure number. The performance measures are numbered as they appear in the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements*[3-1] and the *Medicare-Medicaid Capitated Financial Alignment*

[3-1] The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements*. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-

Reporting Requirements: Michigan-Specific Reporting Requirements[3-2] technical specification manuals. Since data were not available for one performance measure (i.e., Core Measure 9.3—*Minimizing Institutional Length of Stay*) for CY 2019,[3-3] HSAG conducted a readiness review of information systems and processes used for data collection and reporting that will be used to calculate future performance measure rates.

Table 3-2—Performance Measures for Validation or Readiness Review

Performance Measure	Description
Core Measure 9.1	*Emergency Department (ED) Behavioral Health Services Utilization*
Core Measure 9.3*	*Minimizing Institutional Length of Stay*
MI2.3	*Members With Documented Discussion of Care Goals*
MI3.1	*Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*

*HSAG conducted a readiness review for this measure.

Performance Measure Rates

MDHHS and CMS also required each ICO to contract with an NCQA-certified HEDIS vendor and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS 2019, reporting year (RY) 2018, performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and risk-adjusted utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR. The HEDIS measures and performance areas reviewed by HSAG are included in Table 3-3.

Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CoreReportingReqsCY2020.pdf. Accessed on: Feb 25, 2021.

[3-2] The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements: Michigan-Specific Reporting Requirements*. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MIReportingRequirements2019.pdf. Accessed on: Feb 25, 2021.

[3-3] Core Measure 9.3 was a new measure added in CY 2020.

Table 3-3—HEDIS Measures

HEDIS Measure
Prevention and Screening
ABA—Adult Body Mass Index (BMI) Assessment
BCS—Breast Cancer Screening
COL—Colorectal Cancer Screening
COA—Care for Older Adults—Advance Care Planning
COA—Care for Older Adults—Medication Review
COA—Care for Older Adults—Functional Status Assessment
COA—Care for Older Adults—Pain Assessment
Respiratory Conditions
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
Cardiovascular Conditions
CBP—Controlling High Blood Pressure
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%
Diabetes
CDC—Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)
CDC—Comprehensive Diabetes Care—Eye Exams
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%
Musculoskeletal Conditions
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
OMW—Osteoporosis Management in Women Who Had a Fracture
Behavioral Health
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days

HEDIS Measure
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days
Medication Management and Care Coordination
MRP—Medication Reconciliation Post-Discharge
Overuse/Appropriateness
*Prostate-Specific Antigen (PSA)—Non-Recommended PSA-Based Screening of Older Men**
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**
Access/Availability of Care
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total
IET—Initiation of Alcohol and Other Drug Dependence Treatment
IET—Engagement of Alcohol and Other Drug Dependence Treatment
Risk-Adjusted Utilization
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**

*Measures where lower rates indicate better performance.

Compliance Review

The ICO compliance review consisted of an evaluation of each ICO's performance in 11 program areas, called standards, identified in Table 3-4. These standards encompassed all federally mandated requirements under 42 CFR §438.358(b)(iii) and state-specified contract requirements in effect in SFY 2019. Following the comprehensive assessment of all standards evaluated during the SFY 2019 compliance review, ICOs were required to develop a CAP for each element that did not achieve full compliance. For the second year of the three-year cycle (SFY 2020 review period), MDHHS requested that HSAG conduct a comprehensive desk review of the completed SFY 2019 CAPs.

Table 3-4—Compliance Review Standards

Standard
Standard I—Availability of Services
Standard II—Assurance of Adequate Capacity and Services
Standard III—Coordination and Continuity of Care
Standard IV—Coverage and Authorization of Services

Standard
Standard V—Provider Selection
Standard VI—Confidentiality
Standard VII—Grievance and Appeal Systems
Standard VIII—Subcontractual Relationships and Delegation
Standard IX—Practice Guidelines
Standard X—Health Information Systems
Standard XI—Quality Assessment and Performance Improvement Program

Network Adequacy Validation

During SFY 2020, HSAG collaborated with MDHHS to design NAV tasks that complemented the annual CMS validation without duplicating the provider types or validation approaches covered by CMS. As such, HSAG conducted two activities assessing different aspects of the ICOs' network adequacy:

1. Administration of a provider data structure questionnaire and enhancement of NAV process documentation (i.e., provider network data structure and processes).
2. Development and implementation of a secret shopper survey among dental provider locations (i.e., secret shopper survey).

Provider Network Data Structure and Processes

To align with the timing of CMS' NAV for services covered by Medicare, MDHHS opted to retain its existing NAV process for Medicaid and LTSS, in progress from October 2019 through March 2020.[3-4] To prepare for the SFY 2021 NAV activities scheduled to begin with the ICOs' October 1, 2020, network data submissions, MDHHS collaborated with HSAG from January through August 2020 on the following SFY 2020 tasks:

1. Development and administration of a questionnaire to collect network data structure information from the ICOs, including information on how each ICO identifies Medicaid and LTSS providers in its data systems.
2. Collaboration with MDHHS to enhance existing network process documentation and implementation of the enhanced documentation with the ICOs for their October 1, 2020, network adequacy reporting.

[3-4] During SFY 2020, MDHHS contracted validation of the ICOs' Medicaid and LTSS network adequacy reporting to Optum, with MDHHS maintaining responsibility for communicating with the ICOs regarding validation results and corresponding data resubmissions.

To complete the SFY 2020 activities, HSAG used a desk review approach following the process outlined in Figure 3-1.

Figure 3-1—SFY 2020 NAV Process for MI Health Link Medicaid and LTSS Providers

Secret Shopper Survey

During September and October 2020,[3-5] HSAG completed a secret shopper telephone survey of dental providers' offices contracted with one or more ICOs under the MI Health Link program. A "secret shopper" is a person employed to pose as a patient to evaluate the validity of available provider information (e.g., accurate ICO and program affiliation information). The secret shopper telephone survey allows for objective data collection from healthcare providers while minimizing potential bias introduced by knowing the identity of the surveyor. The primary purpose of the survey was to collect appointment availability information for routine dental care for new ICO members. As a secondary survey objective, HSAG evaluated the accuracy of selected provider data elements related to members' access to dental practitioners.

[3-5] Survey calls for the MI Health Link dental provider secret shopper survey were originally scheduled to take place beginning in March 2020; however, MDHHS instructed HSAG to postpone the survey due to the coronavirus disease 2019 (COVID-19) public health emergency. MDHHS approved HSAG to begin survey calls on September 9, 2020, after receiving the ICOs' confirmation that routine dental services were available.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

For SFY 2020, HSAG administered the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members enrolled in the ICOs who met age and enrollment criteria. The primary objective of the CAHPS 5.0H Adult Medicaid Health Plan Survey is to effectively and efficiently obtain information on members' experiences with their healthcare and health plan. This survey covers topics that are important to consumers, such as the communication skills of providers and the accessibility of services. Sampled adult Medicaid members completed the surveys from March to June 2020 and received an English version of the survey with the option to complete the survey in Spanish. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with positive experiences in a particular aspect of their healthcare.

CAHPS Home and Community Based Services Survey

For SFY 2020, HSAG also administered the CAHPS Home and Community Based Services Survey (HCBS CAHPS Survey) to adult members enrolled in the ICOs who received a qualifying personal care service or were currently enrolled in the MI Health Link HCBS waiver. The primary objective of the HCBS CAHPS Survey is to effectively and efficiently obtain information on members' experiences with the LTSS they receive. Sampled adult members completed the survey from June to August 2020 over the telephone in either English or Spanish. For purposes of reporting members' experience with care results, CMS requires a minimum of 11 respondents per measure (i.e., a minimum cell size of 11). Due to the low number of respondents for each ICO and CMS suppression rules, HSAG could not present individual plan-level results for the HCBS CAHPS Survey measures; therefore, results are only presented for the MI Health Link program in this report.

EQR Activity Results

Aetna Better Health of Michigan

Validation of Quality Improvement Projects

Performance Results

Table 3-5 displays the overall validation status, the baseline and Remeasurement 1 results, and the ICO-designated goal for the QIP topic.

Table 3-5—Overall Validation Rating for AET

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	Improve the percentage of follow-up visits within 30 days with a mental health practitioner after discharge from an acute hospitalization with mental illness diagnosis.	47.1%	54.9% ⇔		56%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 3-6 displays the interventions implemented to address the barriers identified by the ICO using quality improvement and causal/barrier analysis processes.

Table 3-6—Remeasurement 1 Interventions for AET

Intervention Descriptions	
Worked with members and their providers to improve communication and schedule integrated care team (ITC) meetings regularly.	Received weekly reports on inpatient admissions from the PIHP and utilized internal inpatient alerts to outreach to members as soon as notification of an inpatient admission was received.
Assessed for social determinants of health such as homelessness, familial and/or natural supports, and community-based supports. Worked with the PIHPs and community-based partners to identify social determinants of health, triggers/barriers, and assisted members with housing needs.	Provided members with education and support regarding the importance of taking their medication.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength: Aetna Better Health of Michigan** designed a methodologically sound QIP.
	Strength: Aetna Better Health of Michigan used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.
Weaknesses	**Weakness:** Although **Aetna Better Health of Michigan** demonstrated improvement in the study indicator outcomes for the first remeasurement, the goal of significant improvement was not achieved. **Why the weakness exists: Aetna Better Health of Michigan** experienced challenges coordinating with one of the PIHPs. **Recommendation:** HSAG recommends that **Aetna Better Health of Michigan** continue to identify methods to improve collaborative efforts with the PIHPs. **Aetna Better Health of Michigan** should also revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. **Aetna Better Health of Michigan** should also continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measures

Performance Results

Performance Measure Validation

HSAG evaluated **Aetna Better Health of Michigan**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system, medical services data system (e.g., claims and encounters), care coordination system, enrollee protections system (e.g., critical incident and abuse reporting), data integration, and readiness to generate data to report Core Measure 9.3—*Minimizing Institutional Length of Stay*.

Aetna Better Health of Michigan received a measure designation of *Reportable (R)* for all measures (other than the new measure for SFY 2020 in which data were not available and received a designation of *Not Applicable*), signifying that **Aetna Better Health of Michigan** had reported the measures in compliance with Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-7—Measure-Specific Validation Designation for AET

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in compliance with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**NOT APPLICABLE (N/A)** The ICO demonstrated sufficient evidence of readiness to report this measure in compliance with MMP Core Reporting Requirements.
MI2.3: *Members With Documented Discussion of Care Goals*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI3.1: *Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-8 shows each of **Aetna Better Health of Michigan**'s audited HEDIS measures, rates for HEDIS 2018 and HEDIS 2019 to demonstrate year-over-year performance, and the HEDIS 2019 MI Health Link statewide average performance rates. HEDIS 2019 measure rates performing better than the statewide average are notated by green font.

Table 3-8—Measure-Specific Percentage Rates for AET

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Prevention and Screening			
ABA—Adult BMI Assessment[1]	95.86	99.03	92.70
BCS—Breast Cancer Screening[1]	53.09	54.82	58.79
COL—Colorectal Cancer Screening[1]	43.07	41.12	50.88
COA—Care for Older Adults—Advance Care Planning	49.64	54.99	47.24
COA—Care for Older Adults—Medication Review	76.64	59.12	73.75
COA—Care for Older Adults—Functional Status Assessment	61.80	61.80	64.24
COA—Care for Older Adults—Pain Assessment	72.99	65.69	73.71
Respiratory Conditions			
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]	26.92	26.45	26.46

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	76.47	76.12	70.19
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	85.81	86.16	88.90
Cardiovascular Conditions			
CBP—Controlling High Blood Pressure[2]	—	67.40	63.90
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack[1]	88.89	89.47	92.35
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	76.79	75.79	78.14
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	69.30	70.37	74.77
Diabetes			
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	88.32	87.10	88.73
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**[1]	28.47	28.71	39.12
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	60.34	63.26	51.40
CDC—Comprehensive Diabetes Care—Eye Exams[1]	48.91	50.12	64.20
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	94.89	93.19	93.21
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90[1]	62.29	64.72	60.41
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	68.68	68.91	72.48
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	69.43	73.11	75.38
Musculoskeletal Conditions			
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[1]	78.13	72.31	70.18
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	8.00	7.69	14.94
Behavioral Health			
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	59.18	60.00	61.55
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	41.33	43.08	46.28
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	24.22	20.26	24.42
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	56.52	47.06	48.69
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[2]	—	21.88	21.02
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[2]	—	46.88	41.36
Medication Management and Care Coordination			
MRP—Medication Reconciliation Post-Discharge	36.25	40.63	42.40

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Overuse/Appropriateness			
*PSA—Non-Recommended PSA-Based Screening of Older Men**	19.95	17.61	21.68
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	42.93	42.70	42.87
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	21.21	24.25	19.39
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	11.63	14.20	12.76
Access/Availability of Care			
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years[1]	85.03	82.06	85.00
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years[1]	93.34	93.29	94.39
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older[1]	89.63	89.80	91.46
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total[1]	90.06	89.55	91.25
IET—Initiation of Alcohol and Other Drug Dependence Treatment	36.09	36.85	33.75
IET—Engagement of Alcohol and Other Drug Dependence Treatment	4.26	4.94	4.26
Risk-Adjusted Utilization			
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)** [1]	0.76	0.69	0.66
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[1]	0.75	0.65	0.68

*Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1]Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2018 and HEDIS 2019 be considered with caution.
[2]Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2018 and HEDIS 2019; therefore, HEDIS 2018 rates are not displayed and comparisons to benchmarks are not performed for this measure.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Aetna Better Health of Michigan demonstrated overall strengths in the accuracy and consistency of its data related to reporting performance measures Core Measure 9.1, MI2.3, and MI3.1, and its readiness to report Core Measure 9.3.

Weaknesses

Weakness: Aetna Better Health of Michigan fell below the statewide average in 29 of the 43 reported HEDIS measures (67 percent), demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory

Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care.

Why the weakness exists: Over half of the measures included in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care domains fell below the statewide average, indicating **Aetna Better Health of Michigan** was not performing as well as other ICOs in some measures within these domains.

Recommendation: HSAG recommends **Aetna Better Health of Michigan** focus on improving upon the performance for measures included in these domains.

Weakness: Aetna Better Health of Michigan's rate for the *COA—Care for Older Adults—Medication Review* measure indicator significantly dropped by nearly 18 percent from 2018 to 2019, indicating that some adults 66 years and older are not always having their medication reviewed during the measurement year, which may have a negative impact on members' overall quality of life. As the population ages, physical and cognitive function can decline and pain becomes more prevalent, which may require more complex medication regimens.[3-6]

Why the weakness exists: The rate for the *COA—Care for Older Adults—Medication Review* measure indicator fell between 2018 and 2019, suggesting barriers to having medication reviewed during the measurement year exist for some adults 66 years and older.

Recommendation: HSAG recommends **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some adults 66 years and older are not always having medication review completed. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *COA—Care for Older Adults—Medication Review* measure indicator.

Compliance Review

Performance Results

Table 3-9 presents an overview of the combined results of the prior and current years' compliance reviews for **Aetna Better Health of Michigan**. The table shows the number of elements for each of the 11 standards that received a score of *Met* in the prior year's (SFY 2019) compliance review. Table 3-9 also presents the number of elements that required a CAP during the prior year's compliance review and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

[3-6] National Committee for Quality Assurance. *Care for Older Adults (COA)*. Available at: https://www.ncqa.org/hedis/measures/care-for-older-adults/. Accessed on: Feb 25, 2021.

Table 3-9—Summary of Results for the Prior and Current Years' Compliance Reviews for AET

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	Availability of Services	11	9	2	2	0	**100%**
II	Assurance of Adequate Capacity and Services	6	6	0	-	-	**100%**
III	Coordination and Continuity of Care	17	14	3	2	1	**94%**
IV	Coverage and Authorization of Services	19	18	1	1	0	**100%**
V	Provider Selection	10	9	1	0	1	**90%**
VI	Confidentiality	7	6	1	1	0	**100%**
VII	Grievance and Appeal Systems	33	29	4	4	0	**100%**
VIII	Subcontractual Relationships and Delegation	5	5	0	-	-	**100%**
IX	Practice Guidelines	4	4	0	-	-	**100%**
X	Health Information Systems	8	8	0	-	-	**100%**
XI	Quality Assessment and Performance Improvement Program	11	10	1	1	0	**100%**
	Total	**131**	**118**	**13**	**11**	**2**	**98%**

M = *Met*; ***NM*** = *Not Met*

Dash (–) = Standard received full compliance in the SFY 2019 review; and therefore, a CAP review was not required during the SFY 2020 review.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Prior Year: The total number of elements within each standard that achieved a score of *Met* or required a CAP in the SFY 2019 review.

Number of Elements: The number of elements that required a CAP in the SFY 2019 review that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

Total Compliance Score: Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in the SFY 2019 review were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: **Aetna Better Health of Michigan**'s plans of correction remedied 11 of 13 identified deficiencies noted during the compliance reviews, indicating **Aetna Better Health of Michigan** implemented sufficient strategies to bring most deficiencies into compliance.

Strength: **Aetna Better Health of Michigan** received a score of 100 percent in nine of the 11 standards reviewed, indicating **Aetna Better Health of Michigan** developed the necessary policies, procedures, plans, and systems to operationalize most of the managed care regulations under 42 CFR §438 and the aligned state-specific contract requirements, and is capable of providing quality and accessible services to its members.

Weaknesses

Weakness: While **Aetna Better Health of Michigan** had two continued deficiencies after the CAP review, no trends of weakness were identified in any program areas.

Recommendation: While no trends of weakness in program areas were identified, HSAG recommends that **Aetna Better Health of Michigan** prioritize the remediation of the remaining two deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **Aetna Better Health of Michigan** should focus on the inclusion of a provider-specific quality data review during the recredentialing process and verify that its care management auditing process of non-waiver Integrated Individualized Care and Supports Plans (IICSPs) includes an evaluation of member outreach to confirm contacts are made in accordance with time frames required by contract.

Network Adequacy Validation

Provider Network Data Structure and Processes

Performance Results

Aetna Better Health of Michigan participated in the questionnaire process and responded to HSAG's email requests for clarification. Because of the qualitative nature of the provider data structure questionnaire in supporting future NAVs, a determination of performance was not applicable in SFY 2020. HSAG will report on the NAV performance results beginning in SFY 2021.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** The SFY 2020 NAV evaluation considered only program-level strengths, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.
Weaknesses	**Weakness:** The SFY 2020 NAV evaluation considered only program-level weaknesses, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs. **Why the weakness exists:** Not applicable. **Recommendation:** HSAG offers no ICO-specific recommendations for improvement based on the SFY 2020 NAV evaluation.

Secret Shopper Survey

Performance Results

Table 3-10 and Table 3-11 present the SFY 2020 secret shopper survey results for **Aetna Better Health of Michigan** by contracted MI Health Link region. Overall, HSAG attempted to contact 326 sampled provider locations (i.e., "cases"), with an overall response rate of 78.2 percent (255 cases) among Regions 4, 7, and 9 for **Aetna Better Health of Michigan**. Of the responsive cases, 86.7 percent (221 cases) reported accepting **Aetna Better Health of Michigan**, and 61.5 percent (136 cases) of those cases stated that the office accepted patients enrolled in the MI Health Link program. Moreover, among the survey respondents who accepted **Aetna Better Health of Michigan** and the MI Health Link program, 94.1 percent (128 cases) reported accepting new patients, with 78.9 percent (101 cases) offering an appointment date to the caller.

Table 3-10—Summary of Secret Shopper Survey Results for AET by Region

Region	Total Survey Cases[1]	Cases Reached	Accepting ICO	Accepting MI Health Link	Accepting New Patients[2]	Cases Offered an Appointment
Region 4	49	36	32	20	13	6
Region 7	173	133	118	77	77	66
Region 9	104	86	71	39	38	29
AET Total[1]	**326**	**255**	**221**	**136**	**128**	**101**

[1] Total survey cases represent unique ICO and location combinations, as one location may have been sampled for more than one region if the ICO indicated that the location was contracted to serve MI Health Link members in multiple regions.
[2] Sampled cases included dental provider locations from each ICO and were not limited to locations with providers that were accepting new patients.

The average appointment wait time was 16.8 calendar days among the 101 cases offering an appointment date for a new patient enrolled in MI Health Link with **Aetna Better Health of Michigan**.

Table 3-11—Summary of Secret Shopper Survey Appointment Availability Results for AET by Region

Region	Cases Offered an Appointment		Appointment Wait Time (Calendar Days)			
	Number	Rate[1] (%)	Min	Max	Average	Median
Region 4	6	46.2	1	77	19.5	6.0
Region 7	66	85.7	1	91	18.5	14.0
Region 9	29	76.3	1	50	12.6	11.0
AET Total	**101**	**78.9**	**1**	**91**	**16.8**	**13.0**

[1] The denominator includes cases responding to the survey that accept the ICO, accept MI Health Link, and accept new patients. Use caution when interpreting rates with denominators that include fewer than 10 cases.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: ICO-specific strengths have not been identified because, although appointments were generally available, a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICOs' provider data files.

Weaknesses

Weakness: Over 60 percent of sampled dental provider locations were unable to be reached, did not accept **Aetna Better Health of Michigan**, did not accept and/or recognize the MI Health Link program, or were not accepting new patients enrolled in the MI Health Link program.

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of **Aetna Better Health of Michigan**'s dental provider data may have contributed to cases with invalid telephone contact information or inaccurate

information on the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

Performance Results

Table 3-12 presents **Aetna Better Health of Michigan**'s 2020 CAHPS top-box scores for the MI Health Link population.

Table 3-12—Summary of 2020 CAHPS Top-Box Scores for AET

	2020 Top-Box Score
Global Ratings	
Rating of Health Plan	64.0%
Rating of All Health Care	56.2%
Rating of Personal Doctor	71.2%
Rating of Specialist Seen Most Often	71.0%
Composite Measures	
Getting Needed Care	85.4%
Getting Care Quickly	85.5%
How Well Doctors Communicate	91.3%
Customer Service	90.1%
Individual Item Measure	
Coordination of Care	88.7% ↑
Effectiveness of Care**	
Advising Smokers and Tobacco Users to Quit	88.7% ↑
Discussing Cessation Medications	66.9% ↑
Discussing Cessation Strategies	55.0% ↑

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
** These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2020 score is at least 5 percentage points greater than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points less than the 2019 national average.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Adult members enrolled in **Aetna Better Health of Michigan** had more positive experiences with their coordination of care, since the score for this measure was at least 5 percentage points greater than the 2019 NCQA adult Medicaid national average. In addition, the Effectiveness of Care scores were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages.
Weaknesses	**Weakness:** HSAG did not identify any weaknesses for **Aetna Better Health of Michigan** for the CAHPS 5.0H Adult Medicaid Health Plan Survey.

HCBS CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **Aetna Better Health of Michigan**; however, due to the low number of respondents to the survey, individual plan results are unable to be presented. Please see Section 5 for statewide results (i.e., MI Health Link program).

AmeriHealth Caritas

Validation of Quality Improvement Projects

Performance Results

Table 3-13 displays the overall validation status, and the baseline and Remeasurement 1 results for the QIP topic. **AmeriHealth Caritas** did not select a plan-specific goal for the study indicator, as this was not a requirement for the QIP.

Table 3-13—Overall Validation Rating for AMI

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	The percentage of discharges for members 21 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses on or between January 1 and December 1 and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	35.1%	46.8% ⇔		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 3-14 displays the interventions implemented to address the barriers identified by the ICO using quality improvement and causal/barrier analysis processes.

Table 3-14—Remeasurement 1 Interventions for AMI

Intervention Descriptions	
Established a process to provide timely notification to care coordinators of behavioral health inpatient care and set the expectation that members are included in the transition of care process.	Created and implemented a process to improve notification and acknowledgement of information from the PIHPs.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: AmeriHealth Caritas designed a methodologically sound QIP.

Strength: AmeriHealth Caritas used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.

Weaknesses

Weakness: Although **AmeriHealth Caritas** demonstrated improvement in the study indicator outcomes for the first remeasurement, the goal of significant improvement was not achieved.

Why the weakness exists: AmeriHealth Caritas had a relatively small eligible population, which decreased during the first remeasurement period. A larger increase in the number of members that are numerator compliant must occur to achieve the desired goal.

Recommendation: As **AmeriHealth Caritas** progresses to the second remeasurement, HSAG recommends the ICO implement interventions that have the greatest impact to the study indicator outcomes. The ICO should also reassess the identified barriers to determine if new barriers exist requiring the development of interventions.

Performance Measures

Performance Results

Performance Measure Validation

HSAG evaluated **AmeriHealth Caritas**' data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system, medical services data system (e.g., claims and encounters), care coordination system, enrollee protections system (e.g., critical incident and abuse reporting), data integration, and readiness to generate data to report Core Measure 9.3—*Minimizing Institutional Length of Stay*.

AmeriHealth Caritas received a measure designation of *Reportable (R)* for all measures (other than the new measure for SFY 2020 in which data were not available and received a designation of *Not Applicable*), signifying that **AmeriHealth Caritas** had reported the measures in compliance with Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-15—Measure-Specific Validation Designation for AMI

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in compliance with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**NOT APPLICABLE (N/A)** The ICO demonstrated sufficient evidence of readiness to report this measure in compliance with MMP Core Reporting Requirements.

Performance Measure	Validation Designation
MI2.3: *Members With Documented Discussion of Care Goals*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI3.1: *Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-16 shows each of **AmeriHealth Caritas**' audited HEDIS measures, rates for HEDIS 2018 and HEDIS 2019 to demonstrate year-over-year performance, and the HEDIS 2019 MI Health Link statewide average performance rates. HEDIS 2019 measure rates performing better than the statewide average are notated by green font.

Table 3-16—Measure-Specific Percentage Rates for AMI

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Prevention and Screening			
ABA—Adult BMI Assessment[1]	87.35	89.05	92.70
BCS—Breast Cancer Screening[1]	47.13	47.51	58.79
COL—Colorectal Cancer Screening[1]	31.87	37.23	50.88
COA—Care for Older Adults—Advance Care Planning	14.11	18.98	47.24
COA—Care for Older Adults—Medication Review	44.04	47.93	73.75
COA—Care for Older Adults—Functional Status Assessment	34.06	39.90	64.24
COA—Care for Older Adults—Pain Assessment	47.93	43.07	73.71
Respiratory Conditions			
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]	50.00	25.81	26.46
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	79.17	59.22	70.19
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	80.21	79.61	88.90
Cardiovascular Conditions			
CBP—Controlling High Blood Pressure[2]	—	52.31	63.90
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack[1]	83.33	81.82	92.35
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	77.22	80.65	78.14
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	80.33	77.33	74.77

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Diabetes			
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	85.40	85.89	88.73
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**[1]	42.09	51.82	39.12
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	48.42	38.93	51.40
CDC—Comprehensive Diabetes Care—Eye Exams[1]	58.15	62.04	64.20
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	90.51	90.51	93.21
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90[1]	53.28	48.18	60.41
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	66.84	73.64	72.48
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	82.44	71.05	75.38
Musculoskeletal Conditions			
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[1]	54.17	63.33	70.18
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	0.00	25.00	14.94
Behavioral Health			
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	48.15	56.04	61.55
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	35.19	43.96	46.28
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	3.45	10.81	24.42
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	27.59	35.14	48.69
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[2]	—	15.09	21.02
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[2]	—	32.08	41.36
Medication Management and Care Coordination			
MRP—Medication Reconciliation Post-Discharge	12.41	13.14	42.40
Overuse/Appropriateness			
*PSA—Non-Recommended PSA-Based Screening of Older Men**	18.91	15.74	21.68
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	44.83	36.14	42.87
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	12.95	14.93	19.39
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	9.08	10.33	12.76
Access/Availability of Care			
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years[1]	76.76	80.75	85.00
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years[1]	89.47	90.36	94.39

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older[1]	83.42	85.73	91.46
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total[1]	84.09	86.29	91.25
IET—Initiation of Alcohol and Other Drug Dependence Treatment	41.98	42.86	33.75
IET—Engagement of Alcohol and Other Drug Dependence Treatment	5.56	5.29	4.26
Risk-Adjusted Utilization			
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[1]	0.86	0.82	0.66
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[1]	0.98	0.69	0.68

*Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1]Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2018 and HEDIS 2019 be considered with caution.
[2]Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2018 and HEDIS 2019; therefore, HEDIS 2018 rates are not displayed and comparisons to benchmarks are not performed for this measure.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: AmeriHealth Caritas demonstrated overall strengths in the accuracy and consistency of its data related to reporting performance measures Core Measure 9.1, MI2.3, and MI3.1, and its readiness to report Core Measure 9.3.

Weaknesses

Weakness: AmeriHealth Caritas fell below the statewide average in 33 of the 43 reported HEDIS measures (77 percent), demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization.

Why the weakness exists: Over half of the measures included in the Prevention and Screening, Respiratory Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization domains fell below the statewide average, indicating **AmeriHealth Caritas** was not performing as well as other ICOs in some measures within these domains.

Recommendation: HSAG recommends **AmeriHealth Caritas** focus on improving upon the performance for measures included in these domains.

Weakness: AmeriHealth Caritas' rate for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator significantly dropped by nearly 25 percent from 2018 to 2019, indicating that some adults 40 years of age and older are not always receiving spirometry testing to confirm their diagnosis of COPD, which may decrease the chances of early detection of COPD for members. Earlier diagnosis using

spirometry testing supports a treatment plan that may protect against worsening symptoms and decrease the number of exacerbations.[3-7]

Why the weakness exists: The rate for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator fell between 2018 and 2019, and although trending of this measure has been cautioned by NCQA, the results could potentially indicate barriers to receiving spirometry testing exist for some adults 40 years of age and older.

Recommendation: HSAG recommends **AmeriHealth Caritas** conduct a root cause analysis or focused study to determine why some adults 40 years of age and older are not always receiving spirometry testing. Upon identification of a root cause, **AmeriHealth Caritas** should implement appropriate interventions to improve the performance related to the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator.

Weakness: AmeriHealth Caritas' rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator significantly dropped by nearly 20 percent from 2018 to 2019, indicating that some adults 40 years of age and older are not always receiving appropriate medication therapy following COPD exacerbations, which may increase costs associated with COPD. COPD exacerbations or "flare-ups" make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication.[3-8]

Why the weakness exists: The rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator fell between 2018 and 2019, suggesting barriers to receiving appropriate medication therapy following COPD exacerbations exist for some adults 40 years of age and older.

Recommendation: HSAG recommends **AmeriHealth Caritas** conduct a root cause analysis or focused study to determine why some adults 40 years of age and older are not always receiving appropriate medication therapy following COPD exacerbations. Upon identification of a root cause, **AmeriHealth Caritas** should implement appropriate interventions to improve the performance related to the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator.

Compliance Review

Performance Results

Table 3-17 presents an overview of the combined results of the prior and current years' compliance reviews for **AmeriHealth Caritas**. The table shows the number of elements for each of the 11 standards that received a score of *Met* in the prior year's (SFY 2019) compliance review. Table 3-17 also presents

[3-7] National Committee for Quality Assurance. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)*. Available at: https://www.ncqa.org/hedis/measures/use-of-spirometry-testing-in-the-assessment-and-diagnosis-of-copd/. Accessed on: Feb 25, 2021.

[3-8] National Committee for Quality Assurance. *Pharmacotherapy Management of COPD Exacerbation (PCE)*. Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-management-of-copd-exacerbation/. Accessed on: Feb 25, 2021.

the number of elements that required a CAP during the prior year's compliance review and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

Table 3-17—Summary of Results for the Prior and Current Years' Compliance Reviews for AMI

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	Availability of Services	11	9	2	2	0	**100%**
II	Assurance of Adequate Capacity and Services	6	4	2	2	0	**100%**
III	Coordination and Continuity of Care	17	12	5	4	1	**94%**
IV	Coverage and Authorization of Services	19	13	6	5	1	**95%**
V	Provider Selection	10	8	2	1	1	**90%**
VI	Confidentiality	7	7	0	-	-	**100%**
VII	Grievance and Appeal Systems	33	24	9	8	1	**97%**
VIII	Subcontractual Relationships and Delegation	5	4	1	1	0	**100%**
IX	Practice Guidelines	4	3	1	1	0	**100%**
X	Health Information Systems	8	7	1	1	0	**100%**
XI	Quality Assessment and Performance Improvement Program	11	9	2	2	0	**100%**
	Total	**131**	**100**	**31**	**27**	**4**	**97%**

M = *Met*; ***NM*** = *Not Met*

Dash (–) = Standard received full compliance in the SFY 2019 review; and therefore, a CAP review was not required during the SFY 2020 review.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Prior Year: The total number of elements within each standard that achieved a score of *Met* or required a CAP in the SFY 2019 review.

Number of Elements: The number of elements that required a CAP in the SFY 2019 review that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

Total Compliance Score: Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in the SFY 2019 review were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength: AmeriHealth Caritas**' plans of correction remedied 27 of 31 identified deficiencies noted during the compliance reviews, indicating that the ICO had demonstrated sufficient strategies to bring the ICO into compliance with most elements.
	Strength: AmeriHealth Caritas received a score of 100 percent in seven of the 11 standards reviewed, indicating **AmeriHealth Caritas** developed the necessary policies, procedures, plans, and systems to operationalize most of the managed care regulations under 42 CFR §438 and the aligned state-specific contract requirements, and has the capability to provide quality and accessible services to its members.
Weaknesses	**Weakness:** While **AmeriHealth Caritas** had four continued deficiencies after the CAP review, no trends of weakness were identified in any program areas.
	Recommendation: While no trends of weakness in program areas were identified, HSAG recommends that **AmeriHealth Caritas** prioritize the remediation of the remaining four deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **AmeriHealth Caritas** should focus on the development of a report to track staff compliance with member contact requirements and take action as necessary to improve individual staff performance; proceed with its plan to automate adverse benefit determinations for the denial of payment and ensure that the notices are sent at the time of the action affecting the claims (i.e., when payment is denied); include a review, and subsequently document the review, of provider-specific quality indicators (e.g., appeal data, quality review results, utilization management [UM] information, and member satisfaction surveys) when determining providers' recredentialing status; and update relevant process and procedure documentation to ensure that appeals are resolved as expeditiously as the member's health condition requires and no later than the date the time frame extension expires (44 days).

Network Adequacy Validation

Provider Network Data Structure and Processes

Performance Results

AmeriHealth Caritas participated in the questionnaire process and responded to HSAG's email requests for clarification. However, **AmeriHealth Caritas** opted not to include supplemental documentation that may have more fully supported its questionnaire responses. Because of the qualitative nature of the provider data structure questionnaire in supporting future NAVs, a determination of performance was not applicable in SFY 2020. HSAG will report on the NAV performance results beginning in SFY 2021.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: The SFY 2020 NAV evaluation considered only program-level strengths, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.

Weaknesses

Weakness: The SFY 2020 NAV evaluation considered only program-level weaknesses, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.

Why the weakness exists: Not applicable.

Recommendation: HSAG offers no ICO-specific recommendations for improvement based on the SFY 2020 NAV evaluation.

Secret Shopper Survey

Performance Results

Table 3-18 and Table 3-19 present the SFY 2020 secret shopper survey results for **AmeriHealth Caritas** by contracted MI Health Link region. Overall, HSAG attempted to contact 51 sampled provider locations (i.e., "cases"), with an overall response rate of 84.3 percent (43 cases) among Regions 7 and 9 for **AmeriHealth Caritas**. Of the responsive cases, 72.1 percent (31 cases) accepted **AmeriHealth Caritas**, and 77.4 percent (24 cases) of those cases stated that the office accepted patients enrolled in the MI Health Link program. Moreover, among the survey respondents who accepted **AmeriHealth Caritas** and the MI Health Link program, 91.7 percent (22 cases) reported accepting new patients, with 86.4 percent (19 cases) offering an appointment date to the caller.

Table 3-18—Summary of Secret Shopper Survey Results for AMI by Region

Region	Total Survey Cases[1]	Cases Reached	Accepting ICO	Accepting MI Health Link	Accepting New Patients[2]	Cases Offered an Appointment
Region 7	33	26	19	17	17	16
Region 9	18	17	12	7	5	3
AMI Total[1]	**51**	**43**	**31**	**24**	**22**	**19**

[1] Total survey cases represent unique ICO and location combinations, as one location may have been sampled for more than one region if the ICO indicated that the location was contracted to serve MI Health Link members in multiple regions.

[2] Sampled cases included dental provider locations from each ICO and were not limited to locations with providers that were accepting new patients.

The average appointment wait time was 17.3 calendar days among the 19 cases offering an appointment date for a new patient enrolled in MI Health Link with **AmeriHealth Caritas**.

Table 3-19—Summary of Secret Shopper Survey Appointment Availability Results for AMI by Region

Region	Cases Offered an Appointment		Appointment Wait Time (Calendar Days)			
	Number	Rate[1] (%)	Min	Max	Average	Median
Region 7	16	94.1	2	37	17.8	15.0
Region 9	3	60.0	2	28	15.0	15.0
AMI Total	**19**	**86.4**	**2**	**37**	**17.3**	**15.0**

[1] The denominator includes cases responding to the survey that accept the ICO, accept MI Health Link, and accept new patients. Use caution when interpreting rates with denominators that include fewer than 10 cases.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: ICO-specific strengths have not been identified because, although appointments were generally available, a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICOs' provider data files.

Weaknesses

Weakness: Over 56 percent of sampled dental provider locations were unable to be reached, did not accept **AmeriHealth Caritas**, did not accept and/or recognize the MI Health Link program, or were not accepting new patients enrolled in the MI Health Link program.

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of **AmeriHealth Caritas**' dental provider data may have contributed to cases with invalid telephone contact information or inaccurate information on the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends **AmeriHealth Caritas** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

Performance Results

Table 3-20 presents **AmeriHealth Caritas**' 2020 CAHPS top-box scores for the MI Health Link population.

Table 3-20—Summary of 2020 CAHPS Top-Box Scores for AMI

	2020 Top-Box Score
Global Ratings	
Rating of Health Plan	69.7% ↑
Rating of All Health Care	59.0%
Rating of Personal Doctor	73.7% ↑
Rating of Specialist Seen Most Often	67.2%
Composite Measures	
Getting Needed Care	87.9% ↑
Getting Care Quickly	85.6%
How Well Doctors Communicate	93.8%
Customer Service	93.6%
Individual Item Measure	
Coordination of Care	85.7%
Effectiveness of Care**	
Advising Smokers and Tobacco Users to Quit	83.6% ↑
Discussing Cessation Medications	62.8% ↑
Discussing Cessation Strategies	52.3% ↑

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
** These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2020 score is at least 5 percentage points greater than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points less than the 2019 national average.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Adult members enrolled in **AmeriHealth Caritas** had more positive experiences overall with their health plan, their personal doctor, and getting the care they needed, since the scores for these measures were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages. In addition, the Effectiveness of Care scores were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages.
Weaknesses	**Weakness:** HSAG did not identify any weaknesses for **AmeriHealth Caritas** for the CAHPS 5.0H Adult Medicaid Health Plan Survey.

HCBS CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **AmeriHealth Caritas**; however, due to the low number of respondents to the survey, individual plan results are unable to be presented. Please see Section 5 for statewide results (i.e., MI Health Link program).

HAP Empowered

Validation of Quality Improvement Projects

Performance Results

Table 3-21 displays the overall validation status, the baseline and Remeasurement 1 results, and the ICO-designated goal for the QIP topic.

Table 3-21—Overall Validation Rating for HAP

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	Percentage of members who had a follow-up visit within 30 days of a discharge for selected mental illness or intentional self-harm.	53.8%	38.2% ⇔		56%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 3-22 displays the interventions implemented to address the barriers identified by the ICO using quality improvement and causal/barrier analysis processes.

Table 3-22—Remeasurement 1 Interventions for HAP

Intervention Descriptions	
Established a process for the care coordinator assistant to review hospitalization notifications from the PIHPs weekly and send to the care coordinators.	Clarified the expectation that care coordinators need to follow up with members with a behavioral health hospitalization.
Completed data validation on hospitalization reports from 2019. This process drove the focus of coordination meetings with PIHPs in 2020 to ensure coordinated follow-up with members following receipt of timely admission and discharge information on weekly behavioral health hospitalization reports.	Began developing two desk-level processes focused on data validation of behavioral health hospitalization information received from PIHPs and procedures for care coordinators to conduct follow-up with members with a hospitalization.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HAP Empowered designed a methodologically sound QIP.

Strength: HAP Empowered used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.

Weaknesses

Weakness: HAP Empowered demonstrated a non-statistically significant decline in performance for the percentage of members receiving follow-up care within 30 days of a hospital discharge for mental illness.

Why the weakness exists: HAP Empowered had a relatively small eligible population, which decreased during the first remeasurement period. A larger increase in the number of members that are numerator compliant must occur to achieve the desired goal.

Recommendation: As **HAP Empowered** progresses to the second remeasurement, HSAG recommends the ICO implement interventions that have the greatest impact to the study indicator outcomes. **HAP Empowered** should also reassess the identified barriers to determine if new barriers exist requiring the development of interventions.

Performance Measures

Performance Results

Performance Measure Validation

HSAG evaluated **HAP Empowered**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no major concerns with the ICO's eligibility and enrollment data system, medical services data system (e.g., claims and encounters), enrollee protections system (e.g., critical incident and abuse reporting), data integration and readiness to generate data to report Core Measure 9.3—*Minimizing Institutional Length of Stay*.

HAP Empowered received a measure designation of *Reportable (R)* for all measures (other than the new measure for SFY 2020 in which data were not available and received a designation of *Not Applicable*), signifying that **HAP Empowered** had reported the measures in compliance with Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-23—Measure-Specific Validation Designation for HAP

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in compliance with the MMP Core Reporting Requirements.

Performance Measure	Validation Designation
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**NOT APPLICABLE (N/A)** The ICO demonstrated sufficient evidence of readiness to report this measure in compliance with MMP Core Reporting Requirements.
MI2.3: *Members With Documented Discussion of Care Goals*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI3.1: *Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-24 shows each of **HAP Empowered**'s audited HEDIS measures, rates for HEDIS 2018 and HEDIS 2019 to demonstrate year-over-year performance, and the HEDIS 2019 MI Health Link statewide average performance rates. HEDIS 2019 measure rates performing better than the statewide average are notated by green font.

Table 3-24—Measure-Specific Percentage Rates for HAP

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Prevention and Screening			
ABA—Adult BMI Assessment[1]	65.19	66.46	92.70
BCS—Breast Cancer Screening[1]	55.53	57.61	58.79
COL—Colorectal Cancer Screening[1]	48.40	50.12	50.88
COA—Care for Older Adults—Advance Care Planning	10.95	25.06	47.24
COA—Care for Older Adults—Medication Review	52.07	61.31	73.75
COA—Care for Older Adults—Functional Status Assessment	17.03	45.26	64.24
COA—Care for Older Adults—Pain Assessment	27.25	55.23	73.71
Respiratory Conditions			
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]	40.00	32.71	26.46
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	59.48	70.49	70.19
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	87.93	90.98	88.90
Cardiovascular Conditions			
CBP—Controlling High Blood Pressure[2]	—	52.31	63.90
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack[1]	91.30	88.89	92.35

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	78.48	79.65	78.14
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	68.82	73.37	74.77
Diabetes			
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	79.83	78.28	88.73
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**[1]	79.16	80.17	39.12
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	16.18	15.84	51.40
CDC—Comprehensive Diabetes Care—Eye Exams[1]	52.14	52.47	64.20
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	91.72	91.61	93.21
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90[1]	17.51	19.41	60.41
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	76.78	76.01	72.48
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	66.76	70.36	75.38
Musculoskeletal Conditions			
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[1]	64.44	59.52	70.18
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	0.00	22.22	14.94
Behavioral Health			
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	51.43	52.38	61.55
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	32.38	40.00	46.28
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	20.22	22.50	24.42
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	57.30	53.75	48.69
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[2]	—	12.07	21.02
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[2]	—	32.76	41.36
Medication Management and Care Coordination			
MRP—Medication Reconciliation Post-Discharge	30.90	43.31	42.40
Overuse/Appropriateness			
*PSA—Non-Recommended PSA-Based Screening of Older Men**	20.15	21.16	21.68
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	37.68	37.05	42.87
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	15.33	12.12	19.39
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	9.92	7.93	12.76

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Access/Availability of Care			
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years[1]	82.00	81.88	85.00
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years[1]	93.24	92.55	94.39
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older[1]	87.73	88.22	91.46
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total[1]	88.44	88.48	91.25
IET—Initiation of Alcohol and Other Drug Dependence Treatment	26.43	30.35	33.75
IET—Engagement of Alcohol and Other Drug Dependence Treatment	2.64	3.89	4.26
Risk-Adjusted Utilization			
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)** [1]	0.65	0.53	0.66
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[1]	0.57	0.74	0.68

*Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1]Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2018 and HEDIS 2019 be considered with caution.
[2]Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2018 and HEDIS 2019; therefore, HEDIS 2018 rates are not displayed and comparisons to benchmarks are not performed for this measure.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HAP Empowered demonstrated overall strengths in the accuracy and consistency of its data related to reporting performance measures Core Measure 9.1 and MI3.1, and its readiness to report Core Measure 9.3.

Strength: HAP Empowered's rate for the *COA—Care for Older Adults—Functional Status Assessment* measure indicator significantly improved by 28 percent from 2018 to 2019, suggesting strength in prevention and treatment, potentially due to strong coordination of care for **HAP Empowered**'s members 66 years and older.

Weaknesses

Weakness: HSAG identified during the PMV Webex review that there were members that did not have a verbal proxy or a physical signature documented within **HAP Empowered**'s care management system for revised IICSPs, demonstrating there is an opportunity for improvement for care coordination system documentation and the reporting of MI2.3.

Why the weakness exists: HAP Empowered's care management system did not contain consistent documentation of a verbal proxy or physical signature from the member for revised IICSPs, resulting in the resubmission of its data for MI2.3.

Recommendation: HSAG recommends **HAP Empowered** implement additional validation checks to ensure that all revised IICSPs that are reported for MI2.3 have a verbal proxy or physical signature documented its care management system.

Weakness: HAP Empowered fell below the statewide average in 30 of the 43 reported HEDIS measures (70 percent), demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Cardiovascular Conditions, Diabetes, Behavioral Health, and Access/Availability of Care.

Why the weakness exists: Over half of the measures included in the Prevention and Screening, Cardiovascular Conditions, Diabetes, Behavioral Health, and Access/Availability of Care domains fell below the statewide average, indicating **HAP Empowered** was not performing as well as other ICOs in some measures within these domains.

Recommendation: HSAG recommends **HAP Empowered** focus on improving upon the performance for measures included in these domains.

Compliance Review

Performance Results

Table 3-25 presents an overview of the combined results of the prior and current years' compliance reviews for **HAP Empowered**. The table shows the number of elements for each of the 11 standards that received a score of *Met* in the prior year's (SFY 2019) compliance review. Table 3-25 also presents the number of elements that required a CAP during the prior year's compliance review and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

Table 3-25—Summary of Results for the Prior and Current Years' Compliance Reviews for HAP

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	Availability of Services	11	8	3	3	0	**100%**
II	Assurance of Adequate Capacity and Services	6	5	1	1	0	**100%**
III	Coordination and Continuity of Care	17	14	3	3	0	**100%**

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
IV	Coverage and Authorization of Services	19	15	4	4	0	**100%**
V	Provider Selection	10	8	2	1	1	**90%**
VI	Confidentiality	7	6	1	1	0	**100%**
VII	Grievance and Appeal Systems	33	22	11	5	6	**82%**
VIII	Subcontractual Relationships and Delegation	5	3	2	2	0	**100%**
IX	Practice Guidelines	4	3	1	1	0	**100%**
X	Health Information Systems	8	8	0	-	-	**100%**
XI	Quality Assessment and Performance Improvement Program	11	8	3	2	1	**91%**
	Total	**131**	**100**	**31**	**23**	**8**	**94%**

M = *Met*; ***NM*** = *Not Met*

Dash (–) = Standard received full compliance in the SFY 2019 review; and therefore, a CAP review was not required during the SFY 2020 review.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Prior Year: The total number of elements within each standard that achieved a score of *Met* or required a CAP in the SFY 2019 review.

Number of Elements: The number of elements that required a CAP in the SFY 2019 review that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

Total Compliance Score: Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in the SFY 2019 review were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HAP Empowered's plans of correction remedied 23 of 31 identified deficiencies noted during the compliance reviews, indicating **HAP Empowered** implemented sufficient strategies to bring most deficiencies into compliance.

Strength: HAP Empowered received a score of 100 percent in eight of the 11 standards reviewed, indicating **HAP Empowered** developed the necessary policies, procedures, plans, and systems to operationalize most of the managed care regulations under 42 CFR §438 and the aligned state-specific contract requirements, and is capable of providing quality and accessible services to its members.

Weaknesses

Weakness: While **HAP Empowered** had eight continued deficiencies after the CAP review, trends of weakness were only identified in the Grievance and Appeal Systems standard.

Why the weakness exists: Six of 11 deficiencies in the Grievance and Appeal Systems standard were not mitigated, indicating **HAP Empowered** did not fully implement the plans of action within its CAP, and/or did not have a comprehensive understanding of the requirements in this program area.

Recommendation: HSAG recommends that **HAP Empowered** prioritize the remediation of the remaining six deficiencies in the Grievance and Appeal Systems standard identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. Specifically, **HAP Empowered** should focus process and document revisions, and training efforts on the following:

- When a provider requests an appeal, files a grievance, or requests a State fair hearing on behalf of a member, **HAP Empowered** requires written consent from the member.
- Any member grievances filed with a provider are forwarded to **HAP Empowered** as required in accordance with the three-way contract with the ICO, MDHHS, and CMS.
- Parties to the appeal and State fair hearing include the member and his or her representative or the legal representative of a deceased member's estate; and, in State fair hearings, the ICO.
- The ICO's process to extend the appeal resolution time frames by up to 14 calendar days when not at the member's request must include informing the member of the right to file a grievance if he or she disagrees with the decision to extend the time frame for resolution.
- If the ICO denies a request for expedited resolution of an appeal, it must transfer the appeal to the time frame for standard resolution; make reasonable efforts to give the member prompt oral notice of the denial; within two calendar days, give the member written notice of the reason for the decision to extend the time frame, and inform the member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the member's health condition requires, and no later than the date the extension expires.
- Accurate and comprehensive information about the grievance and appeal system must be provided to all providers and subcontractors at the time they enter into a contract.

Further, HSAG recommends that **HAP Empowered** prioritize the remediation of the one remaining deficiency in the Provider Selection and Quality Assessment and Performance Improvement Program standards, including obtaining disclosures from all network providers and applicants in accordance with 42 CFR §455 Subpart B and 42 CFR §1002.3 and maintaining such disclosed information in a manner that can be periodically searched by the ICO for exclusions and forwarded to MDHHS as appropriate; and participating in efforts by MDHHS to prevent, detect, and remediate critical incidents by reviewing, analyzing, tracking, and trending critical incident data at the member, provider, and systemic levels.

Network Adequacy Validation

Provider Network Data Structure and Processes

Performance Results

HAP Empowered participated in the questionnaire process and responded to HSAG's email requests for clarification. However, **HAP Empowered** opted not to include supplemental documentation that may have more fully supported its questionnaire responses. Because of the qualitative nature of the provider data structure questionnaire in supporting future NAVs, a determination of performance was not applicable in SFY 2020. HSAG will report on the NAV performance results beginning in SFY 2021.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** The SFY 2020 NAV evaluation considered only program-level strengths, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.
Weaknesses	**Weakness:** The SFY 2020 NAV evaluation considered only program-level weaknesses, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs. **Why the weakness exists:** Not applicable. **Recommendation:** HSAG offers no ICO-specific recommendations for improvement based on the SFY 2020 NAV evaluation.

Secret Shopper Survey

Performance Results

Table 3-26 and Table 3-27 present the SFY 2020 secret shopper survey results for **HAP Empowered** by contracted MI Health Link region. Overall, HSAG attempted to contact 290 sampled provider locations (i.e., "cases"), with an overall response rate of 84.8 percent (246 cases) among Regions 7 and 9 for **HAP Empowered**. Of the responsive cases, 97.2 percent (239 cases) accepted **HAP Empowered**, and 52.7 percent (126 cases) of those cases stated that the office accepted patients enrolled in the MI Health Link program. Moreover, among the survey respondents who accepted **HAP Empowered** and the MI Health Link program, 98.4 percent (124 cases) reported accepting new patients, with 91.9 percent (114 cases) offering an appointment date to the caller.

Table 3-26—Summary of Secret Shopper Survey Results for HAP by Region

Region	Total Survey Cases[1]	Cases Reached	Accepting ICO	Accepting MI Health Link	Accepting New Patients[2]	Cases Offered an Appointment
Region 7	177	143	138	71	71	66
Region 9	113	103	101	55	53	48
HAP Total[1]	**290**	**246**	**239**	**126**	**124**	**114**

[1]Total survey cases represent unique ICO and location combinations, as one location may have been sampled for more than one region if the ICO indicated that the location was contracted to serve MI Health Link members in multiple regions.

[2] Sampled cases included dental provider locations from each ICO and were not limited to locations with providers that were accepting new patients.

The average appointment wait time was 17.2 calendar days among the 114 cases offering an appointment date for a new patient enrolled in MI Health Link with **HAP Empowered**.

Table 3-27—Summary of Secret Shopper Survey Appointment Availability Results for HAP by Region

Region	Cases Offered an Appointment		Appointment Wait Time (Calendar Days)			
	Number	Rate[1] (%)	Min[2]	Max	Average	Median
Region 7	66	93.0	0	74	18.2	12.5
Region 9	48	90.6	0	70	15.8	8.5
HAP Total	**114**	**91.9**	**0**	**74**	**17.2**	**11.0**

[1] The denominator includes cases responding to the survey that accept the ICO, accept MI Health Link, and accept new patients.

[2] A value of "0" indicates that the provider location offered a same-day appointment.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: ICO-specific strengths have not been identified because, although appointments were generally available, a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICOs' provider data files.

Weaknesses

Weakness: Over 57 percent of sampled dental provider locations were unable to be reached, did not accept **HAP Empowered**, did not accept and/or recognize the MI Health Link program, or were not accepting new patients enrolled in the MI Health Link program.

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of **HAP Empowered**'s dental provider data may have contributed to cases with invalid telephone contact information or inaccurate information on the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends **HAP Empowered** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

Performance Results

Table 3-28 presents **HAP Empowered**'s 2020 CAHPS top-box scores for the MI Health Link population.

Table 3-28—Summary of 2020 CAHPS Top-Box Scores for HAP

	2020 Top-Box Score
Global Ratings	
Rating of Health Plan	66.7% ↑
Rating of All Health Care	56.2%
Rating of Personal Doctor	72.3%
Rating of Specialist Seen Most Often	70.0%
Composite Measures	
Getting Needed Care	86.1%
Getting Care Quickly	86.5%
How Well Doctors Communicate	93.2%
Customer Service	91.8%
Individual Item Measure	
Coordination of Care	87.6%
Effectiveness of Care**	
Advising Smokers and Tobacco Users to Quit	84.4% ↑
Discussing Cessation Medications	65.6% ↑
Discussing Cessation Strategies	57.3% ↑

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
** These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2020 score is at least 5 percentage points greater than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points less than the 2019 national average.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Adult members enrolled in **HAP Empowered** had more positive experiences overall with their health plan, since the score for this measure was at least 5 percentage points greater than the 2019 NCQA adult Medicaid national average. In addition, the Effectiveness of Care scores were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages.
Weaknesses	**Weakness:** HSAG did not identify any weaknesses for **HAP Empowered** for the CAHPS 5.0H Adult Medicaid Health Plan Survey.

HCBS CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **HAP Empowered**; however, due to the low number of respondents to the survey, individual plan results are unable to be presented. Please see Section 5 for statewide results (i.e., MI Health Link program).

Meridian Health Plan

Validation of Quality Improvement Projects

Performance Results

Table 3-29 displays the overall validation status, and the baseline and Remeasurement 1 results for the QIP topic. **Meridian Health Plan** did not select a plan-specific goal for the study indicator, as this was not a requirement for the QIP.

Table 3-29—Overall Validation Rating for MER

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Met*	The percentage of discharges for members 21 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses on or between January 1 and December 1 and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	23.1%	67.3% ↑		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 3-30 displays the interventions implemented to address the barriers identified by the ICO using quality improvement and causal/barrier analysis processes.

Table 3-30—Remeasurement 1 Interventions for MER

Intervention Descriptions	
Worked collaboratively with the PIHP to outreach to members with a reported inpatient behavioral health stay to ensure members complete their behavioral health follow-up appointment.	Conducted a weekly teleconference with the PIHP to discuss recently admitted members, status updates, recent discharges, completed transitions of care, and scheduled outpatient behavioral health appointments. Members are followed for 30 days or until the follow-up visit is completed. The discharge notification from the PIHP triggers the transitions of care process.
Established reoccurring meetings with the PIHP to discuss ongoing collaboration, integration, and operational oversight.	Collected data from network providers through an electronic medical record system.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength: Meridian Health Plan** met 100 percent of the requirements for data analysis and implementation of improvement strategies.
	Strength: Meridian Health Plan achieved the goal of statistically significant improvement over the baseline rate for the first remeasurement period.
Weaknesses	**Weakness:** There were no identified weaknesses.
	Recommendation: Although there were no identified weaknesses, HSAG recommends, as **Meridian Health Plan** progresses into the second remeasurement, the ICO revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The ICO should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measures

Performance Results

Performance Measure Validation

HSAG evaluated **Meridian Health Plan**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system, medical services data system (e.g., claims and encounters), care coordination system, enrollee protections system (e.g., critical incident and abuse reporting), data integration, and readiness to generate data to report Core Measure 9.3—*Minimizing Institutional Length of Stay*.

Meridian Health Plan received a measure designation of *Reportable (R)* for all measures (other than the new measure for SFY 2020 in which data were not available and received a designation of *Not Applicable*), signifying that **Meridian Health Plan** had reported the measures in compliance with Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-31—Measure-Specific Validation Designation for MER

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in compliance with the MMP Core Reporting Requirements.

Performance Measure	Validation Designation
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**NOT APPLICABLE (N/A)** The ICO demonstrated sufficient evidence of readiness to report this measure in compliance with MMP Core Reporting Requirements.
MI2.3: *Members With Documented Discussion of Care Goals*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI3.1: *Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-32 shows each of **Meridian Health Plan**'s audited HEDIS measures, rates for HEDIS 2018 and HEDIS 2019 to demonstrate year-over-year performance, and the HEDIS 2019 MI Health Link statewide average performance rates. HEDIS 2019 measure rates performing better than the statewide average are notated by green font.

Table 3-32—Measure-Specific Percentage Rates for MER

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Prevention and Screening			
ABA—Adult BMI Assessment[1]	96.11	94.40	92.70
BCS—Breast Cancer Screening[1]	61.80	64.40	58.79
COL—Colorectal Cancer Screening[1]	63.99	60.86	50.88
COA—Care for Older Adults—Advance Care Planning	32.36	39.66	47.24
COA—Care for Older Adults—Medication Review	80.05	83.45	73.75
COA—Care for Older Adults—Functional Status Assessment	58.39	64.23	64.24
COA—Care for Older Adults—Pain Assessment	69.10	81.75	73.71
Respiratory Conditions			
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]	24.44	18.26	26.46
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	86.32	75.68	70.19
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	91.79	89.53	88.90
Cardiovascular Conditions			
CBP—Controlling High Blood Pressure[2]	—	67.64	63.90
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack[1]	100.00	100.00	92.35

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	75.50	77.43	78.14
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	79.39	78.89	74.77
Diabetes			
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	90.51	92.46	88.73
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**[1]	41.61	35.04	39.12
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	50.36	56.93	51.40
CDC—Comprehensive Diabetes Care—Eye Exams[1]	76.89	79.32	64.20
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	95.86	93.29	93.21
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90[1]	68.37	70.07	60.41
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	69.15	72.50	72.48
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	78.95	76.78	75.38
Musculoskeletal Conditions			
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[1]	78.33	80.39	70.18
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	5.88	33.33	14.94
Behavioral Health			
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	64.45	65.33	61.55
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	51.18	48.00	46.28
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	17.65	3.85	24.42
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	55.88	23.08	48.69
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[2]	—	35.90	21.02
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[2]	—	49.36	41.36
Medication Management and Care Coordination			
MRP—Medication Reconciliation Post-Discharge	51.34	52.55	42.40
Overuse/Appropriateness			
*PSA—Non-Recommended PSA-Based Screening of Older Men**	9.68	21.74	21.68
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	48.33	47.97	42.87
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	23.56	23.06	19.39
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	14.59	15.01	12.76

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Access/Availability of Care			
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years[1]	75.50	88.52	85.00
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years[1]	79.39	96.26	94.39
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older[1]	69.15	95.58	91.46
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total[1]	78.95	94.34	91.25
IET—Initiation of Alcohol and Other Drug Dependence Treatment	28.57	33.80	33.75
IET—Engagement of Alcohol and Other Drug Dependence Treatment	3.42	4.47	4.26
Risk-Adjusted Utilization			
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)** [1]	0.62	0.68	0.66
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[1]	0.67	0.47	0.68

*Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1]Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2018 and HEDIS 2019 be considered with caution.
[2]Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2018 and HEDIS 2019; therefore, HEDIS 2018 rates are not displayed and comparisons to benchmarks are not performed for this measure.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Meridian Health Plan demonstrated overall strengths in the accuracy and consistency of its data related to reporting performance measures Core Measure 9.1, MI2.3, and MI3.1, and its readiness to report Core Measure 9.3.

Strength: Meridian Health Plan's rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator significantly improved by 27 percent from 2018 to 2019 and ranked above the statewide average for 2019; although NCQA cautioned trending in this measure, the results suggest strength in timely treatment for osteoporosis, potentially due to strong coordination of care for **Meridian Health Plan**'s members 65 to 85 years of age.

Weaknesses

Weakness: HSAG identified during the PMV Webex review that there were cases in which initial IICSP and revised IICSP dates did not align between the member-level detail file and the case management system documentation, demonstrating there is an

opportunity for improvement for care coordination system documentation and the reporting of MI2.3.

Why the weakness exists: **Meridian Health Plan**'s initial IICSP and revised IICSP dates contained within the care management system and member-level detail file did not always align.

Recommendation: HSAG recommends **Meridian Health Plan** implement additional validation checks to ensure that accurate initial IICSP and revised IICSP dates are reported for MI2.3.

Compliance Review

Performance Results

Table 3-33 presents an overview of the combined results of the prior and current years' compliance reviews for **Meridian Health Plan**. The table shows the number of elements for each of the 11 standards that received a score of *Met* in the prior year's (SFY 2019) compliance review. Table 3-33 also presents the number of elements that required a CAP during the prior year's compliance review and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

Table 3-33—Summary of Results for the Prior and Current Years' Compliance Reviews for MER

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	Availability of Services	11	8	3	2	1	**91%**
II	Assurance of Adequate Capacity and Services	6	4	2	2	0	**100%**
III	Coordination and Continuity of Care	17	11	6	6	0	**100%**
IV	Coverage and Authorization of Services	19	13	6	4	2	**89%**
V	Provider Selection	10	8	2	1	1	**90%**
VI	Confidentiality	7	7	0	-	-	**100%**
VII	Grievance and Appeal Systems	33	28	5	5	0	**100%**
VIII	Subcontractual Relationships and Delegation	5	4	1	1	0	**100%**

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
IX	Practice Guidelines	4	2	2	2	0	**100%**
X	Health Information Systems	8	7	1	1	0	**100%**
XI	Quality Assessment and Performance Improvement Program	11	7	4	4	0	**100%**
	Total	**131**	**99**	**32**	**28**	**4**	**97%**

M = *Met*; ***NM*** = *Not Met*

Dash (–) = Standard received full compliance in the SFY 2019 review; and therefore, a CAP review was not required during the SFY 2020 review.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Prior Year: The total number of elements within each standard that achieved a score of *Met* or required a CAP in the SFY 2019 review.

Number of Elements: The number of elements that required a CAP in the SFY 2019 review that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

Total Compliance Score: Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in the SFY 2019 review were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Meridian Health Plan's plans of correction remedied 28 of 32 identified deficiencies noted during the compliance reviews, indicating **Meridian Health Plan** implemented sufficient strategies to bring most deficiencies into compliance.

Strength: Meridian Health Plan received a score of 100 percent in eight of the 11 standards reviewed, indicating **Meridian Health Plan** developed the necessary policies, procedures, plans, and systems to operationalize most of the managed care regulations under 42 CFR §438 and the aligned state-specific contract requirements, and is capable of providing quality and accessible services to its members.

Weaknesses

Weakness: While **Meridian Health Plan** had four continued deficiencies after the CAP review, no trends of weakness were identified in any program areas.

Recommendation: While no trends of weakness in program areas were identified, HSAG recommends that **Meridian Health Plan** prioritize the remediation of the remaining four deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **Meridian Health Plan** should focus on revising behavioral health and specialty provider standards for timely access to care and services to comply with contract requirements for urgent and symptomatic office visits; updating policies and procedures on standard and expedited authorization decision time frames extensions; and including provider specific reviews of quality of care events, grievances, appeals, UM, medical records reviews, members satisfaction surveys, and other performance indicators in the recredentialing decision-making process.

Network Adequacy Validation

Provider Network Data Structure and Processes

Performance Results

Meridian Health Plan participated in the questionnaire process and responded to HSAG's email requests for clarification. However, **Meridian Health Plan** opted not to include supplemental documentation that may have more fully supported its questionnaire responses. Because of the qualitative nature of the provider data structure questionnaire in supporting future NAVs, a determination of performance was not applicable in SFY 2020. HSAG will report on the NAV performance results beginning in SFY 2021.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** The SFY 2020 NAV evaluation considered only program-level strengths, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.
Weaknesses	**Weakness:** The SFY 2020 NAV evaluation considered only program-level weaknesses, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs. **Why the weakness exists:** Not applicable. **Recommendation:** HSAG offers no ICO-specific recommendations for improvement based on the SFY 2020 NAV evaluation.

Secret Shopper Survey

Performance Results

Table 3-34 and Table 3-35 present the SFY 2020 secret shopper survey results for **Meridian Health Plan** by contracted MI Health Link region. Overall, HSAG attempted to contact 277 sampled provider locations (i.e., "cases"), with an overall response rate of 80.1 percent (222 cases) in Region 4 for **Meridian Health Plan**. Of the responsive cases, 90.5 percent (201 cases) accepted **Meridian Health Plan**, and 59.7 percent (120 cases) of those cases stated that the office accepted patients enrolled in the MI Health Link program. Moreover, among the survey respondents who accepted **Meridian Health Plan** and the MI Health Link program, 87.5 percent (105 cases) reported accepting new patients, with 84.8 percent (89 cases) offering an appointment date to the caller.

Table 3-34—Summary of Secret Shopper Survey Results for MER by Region

Region	Total Survey Cases	Cases Reached	Accepting ICO	Accepting MI Health Link	Accepting New Patients[1]	Cases Offered an Appointment
Region 4	277	222	201	120	105	89
MER Total	**277**	**222**	**201**	**120**	**105**	**89**

[1] Sampled cases included dental provider locations from each ICO and were not limited to locations with providers that were accepting new patients.

The average appointment wait time was 22.6 calendar days among the 89 cases offering an appointment date for a new patient enrolled in MI Health Link with **Meridian Health Plan**.

Table 3-35—Summary of Secret Shopper Survey Appointment Availability Results for MER by Region

Region	Cases Offered an Appointment		Appointment Wait Time (Calendar Days)			
	Number	Rate[1] (%)	Min[2]	Max	Average	Median
Region 4	89	84.8	0	154	22.6	15.0
MER Total	**89**	**84.8**	**0**	**154**	**22.6**	**15.0**

[1] The denominator includes cases responding to the survey that accept the ICO, accept MI Health Link, and accept new patients.

[2] A value of "0" indicates that the provider location offered a same-day appointment.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: ICO-specific strengths have not been identified because, although appointments were generally available, a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICOs' provider data files.

Weaknesses

Weakness: Over 62 percent of sampled dental provider locations were unable to be reached, did not accept **Meridian Health Plan**, did not accept and/or recognize the MI Health Link program, or were not accepting new patients enrolled in the MI Health Link program.

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of **Meridian Health Plan**'s dental provider data may have contributed to cases with invalid telephone contact information or inaccurate information on the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends **Meridian Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

Performance Results

Table 3-36 presents **Meridian Health Plan**'s 2020 CAHPS top-box scores for the MI Health Link population.

Table 3-36—Summary of 2020 CAHPS Top-Box Scores for MER

	2020 Top-Box Score
Global Ratings	
Rating of Health Plan	71.4% ↑
Rating of All Health Care	59.9% ↑
Rating of Personal Doctor	69.9%
Rating of Specialist Seen Most Often	77.8% ↑
Composite Measures	
Getting Needed Care	89.2% ↑
Getting Care Quickly	87.1% ↑
How Well Doctors Communicate	95.0%
Customer Service	93.1%
Individual Item Measure	
Coordination of Care	90.4% ↑
Effectiveness of Care**	
Advising Smokers and Tobacco Users to Quit	89.2% ↑
Discussing Cessation Medications	66.5% ↑
Discussing Cessation Strategies	55.2% ↑

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
** These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2020 score is at least 5 percentage points greater than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points less than the 2019 national average.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Adult members enrolled in **Meridian Health Plan** had more positive experiences overall with their health plan, the healthcare they received, the specialist they saw most often, getting the care they needed and getting it quickly, and the coordination of their care, since the scores for these measures were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages. In addition, the Effectiveness of Care scores were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages.
Weaknesses	**Weakness:** HSAG did not identify any weaknesses for **Meridian Health Plan** for the CAHPS 5.0H Adult Medicaid Health Plan Survey.

HCBS CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **Meridian Health Plan**; however, due to the low number of respondents to the survey, individual plan results are unable to be presented. Please see Section 5 for statewide results (i.e., MI Health Link program).

Michigan Complete Health

Validation of Quality Improvement Projects

Performance Results

Table 3-37 displays the overall validation status, the baseline and Remeasurement 1 results, and the ICO-designated goal for the QIP topic.

Table 3-37—Overall Validation Rating for MCH

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.	41.5%	40.4% ⇔		56%

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 3-38 displays the interventions implemented to address the barriers identified by the ICO using quality improvement and causal/barrier analysis processes.

Table 3-38—Remeasurement 1 Interventions for MCH

Intervention Descriptions	
The ICO care coordinator used a mental health resource toolkit to outreach to members via telephone to provide education on mental health awareness and the importance of medication and adherence with the follow-up appointment for mental health recovery and stability.	The PIHP care coordinators used a transportation tip sheet containing contact information for the [transportation vendor] medical transportation department to assist members with scheduling transportation to their follow-up appointment.
The ICO care coordinator coordinated the follow-up visit after a hospital discharge with the member by using a checklist that includes the appointment time/location/in-network provider list.	

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Michigan Complete Health designed a methodologically sound QIP.

Strength: Michigan Complete Health used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.

Weaknesses

Weakness: Michigan Complete Health demonstrated a non-statistically significant decline in performance for the percentage of members receiving follow-up care within 30 days of a hospital discharge for mental illness.

Why the weakness exists: While it is unclear what led to the decrease in performance, **Michigan Complete Health** documented lower performance among older age groups as compared to younger age groups.

Recommendation: As **Michigan Complete Health** progresses to the second remeasurement, HSAG recommends the ICO revisit its causal/barrier analysis and develop interventions specific to age groups as appropriate. **Michigan Complete Health** should implement interventions that have the greatest impact to the study indicator outcomes.

Performance Measures

Performance Results

Performance Measure Validation

HSAG evaluated **Michigan Complete Health**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no major concerns with the ICO's eligibility and enrollment data system, medical services data system (e.g., claims and encounters), enrollee protections system (e.g., critical incident and abuse reporting), data integration, and readiness to generate data to report Core Measure 9.3—*Minimizing Institutional Length of Stay*.

Michigan Complete Health received a measure designation of *Reportable (R)* for all measures (other than the new measure for SFY 2020 in which data were not available and received a designation of *Not Applicable*), signifying that **Michigan Complete Health** had reported the measures in compliance with Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-39—Measure-Specific Validation Designation for MCH

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in compliance with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**NOT APPLICABLE (N/A)** The ICO demonstrated sufficient evidence of readiness to report this measure in compliance with MMP Core Reporting Requirements.

Performance Measure	Validation Designation
MI2.3: *Members With Documented Discussion of Care Goals*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI3.1: *Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-40 shows each of **Michigan Complete Health**'s audited HEDIS measures, rates for HEDIS 2018 and HEDIS 2019 to demonstrate year-over-year performance, and the HEDIS 2019 MI Health Link statewide average performance rates. HEDIS 2019 measure rates performing better than the statewide average are notated by green font.

Table 3-40—Measure-Specific Percentage Rates for MCH

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Prevention and Screening			
ABA—Adult BMI Assessment[1]	93.19	95.86	92.70
BCS—Breast Cancer Screening[1]	50.19	53.81	58.79
COL—Colorectal Cancer Screening[1]	36.01	39.66	50.88
COA—Care for Older Adults—Advance Care Planning	44.04	33.82	47.24
COA—Care for Older Adults—Medication Review	68.37	96.35	73.75
COA—Care for Older Adults—Functional Status Assessment	57.91	67.40	64.24
COA—Care for Older Adults—Pain Assessment	61.07	67.88	73.71
Respiratory Conditions			
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]	0.00	23.40	26.46
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	59.14	66.07	70.19
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	78.49	87.50	88.90
Cardiovascular Conditions			
CBP—Controlling High Blood Pressure[2]	—	57.42	63.90
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack[1]	87.50	100.00	92.35
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	73.33	78.46	78.14
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	87.88	74.51	74.77

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Diabetes			
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	92.99	91.26	88.73
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**[1]	34.45	46.72	39.12
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	56.10	45.08	51.40
CDC—Comprehensive Diabetes Care—Eye Exams[1]	64.33	59.02	64.20
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	96.04	91.80	93.21
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90[1]	60.67	60.38	60.41
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	70.05	77.33	72.48
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	83.97	82.76	75.38
Musculoskeletal Conditions			
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[1]	25.00	60.00	70.18
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	0.00	25.00	14.94
Behavioral Health			
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	73.13	83.52	61.55
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	50.75	58.24	46.28
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	6.00	32.08	24.42
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	18.00	41.51	48.69
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[2]	—	21.43	21.02
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[2]	—	35.71	41.36
Medication Management and Care Coordination			
MRP—Medication Reconciliation Post-Discharge	28.22	35.28	42.40
Overuse/Appropriateness			
*PSA—Non-Recommended PSA-Based Screening of Older Men**	16.39	21.67	21.68
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	29.30	31.79	42.87
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	11.45	12.13	19.39
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	9.47	8.16	12.76
Access/Availability of Care			
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years[1]	74.76	74.73	85.00
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years[1]	89.48	90.42	94.39

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older[1]	81.03	82.59	91.46
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total[1]	82.45	83.66	91.25
IET—Initiation of Alcohol and Other Drug Dependence Treatment	18.18	29.53	33.75
IET—Engagement of Alcohol and Other Drug Dependence Treatment	3.74	1.55	4.26
Risk-Adjusted Utilization			
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[1]	0.70	0.50	0.66
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[1]	0.96	0.52	0.68

*Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1]Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2018 and HEDIS 2019 be considered with caution.
[2]Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2018 and HEDIS 2019; therefore, HEDIS 2018 rates are not displayed and comparisons to benchmarks are not performed for this measure.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Michigan Complete Health demonstrated overall strengths in the accuracy and consistency of its data related to reporting performance measures Core Measure 9.1 and MI3.1, and its readiness to report Core Measure 9.3.

Strength: Michigan Complete Health's rate for the *COA—Care for Older Adults—Medication Review* measure indicator significantly improved by nearly 28 percent from 2018 to 2019 and ranked above the statewide average for 2019, suggesting strength in prevention and medication management, potentially due to strong coordination of care for **Michigan Complete Health**'s members 66 years and older.

Weaknesses

Weakness: HSAG identified during the PMV Webex review that there were cases where initial IICSP and revised IICSP dates did not align between the member-level detail file and the case management system documentation. Additionally, some of the initial IICSP and revised IICSP dates were reported in error and needed to be removed, demonstrating there is an opportunity for improvement for care coordination system documentation and the reporting of MI2.3.

Why the weakness exists: Michigan Complete Health's initial IICSP and revised IICSP dates contained within the care management system and member-level detail file did not always align. Additionally, there were data discrepancies within the case management system for some members.

Recommendation: HSAG recommends **Michigan Complete Health** implement additional validation checks to ensure that accurate initial IICSP and revised IICSP dates are reported for MI2.3.

Compliance Review

Performance Results

Table 3-41 presents an overview of the combined results of the prior and current years' compliance reviews for **Michigan Complete Health**. The table shows the number of elements for each of the 11 standards that received a score of *Met* in the prior year's (SFY 2019) compliance review. Table 3-41 also presents the number of elements that required a CAP during the prior year's compliance review and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

Table 3-41—Summary of Results for the Prior and Current Years' Compliance Reviews for MCH

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	Availability of Services	11	10	1	1	0	**100%**
II	Assurance of Adequate Capacity and Services	6	6	0	-	-	**100%**
III	Coordination and Continuity of Care	17	14	3	3	0	**100%**
IV	Coverage and Authorization of Services	19	13	6	4	2	**89%**
V	Provider Selection	10	10	0	-	-	**100%**
VI	Confidentiality	7	7	0	-	-	**100%**
VII	Grievance and Appeal Systems	33	26	7	7	0	**100%**
VIII	Subcontractual Relationships and Delegation	5	4	1	1	0	**100%**
IX	Practice Guidelines	4	4	0	-	-	**100%**
X	Health Information Systems	8	8	0	-	-	**100%**
XI	Quality Assessment and Performance Improvement Program	11	11	0	-	-	**100%**
	Total	**131**	**113**	**18**	**16**	**2**	**98%**

M = *Met*; ***NM*** = *Not Met*

Dash (–) = Standard received full compliance in the SFY 2019 review; and therefore, a CAP review was not required during the SFY 2020 review.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Prior Year: The total number of elements within each standard that achieved a score of *Met* or required a CAP in the SFY 2019 review.

Number of Elements: The number of elements that required a CAP in the SFY 2019 review that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

Total Compliance Score: Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in the SFY 2019 review were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Michigan Complete Health's plans of correction remedied 16 of 18 identified deficiencies noted during the compliance reviews, indicating **Michigan Complete Health** implemented sufficient strategies to bring most deficiencies into compliance.

Strength: Michigan Complete Health received a score of 100 percent in 10 of the 11 standards reviewed, indicating **Michigan Complete Health** developed the necessary policies, procedures, plans, and systems to operationalize most of the managed care regulations under 42 CFR §438 and the aligned state-specific contract requirements, and is capable of providing quality and accessible services to its members.

Weaknesses

Weakness: While **Michigan Complete Health** had two continued deficiencies after the CAP review, no trends of weakness were identified in any program areas.

Recommendation: While no trends of weakness in program areas were identified, HSAG recommends that **Michigan Complete Health** prioritize the remediation of the remaining two deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **Michigan Complete Health** should focus on mailing the termination, suspension, or reduction of previously authorized Medicaid-covered services adverse benefit determination notices at least 10 days before the dates of action, or as indicated by the exceptions; and for the denial of payment, **Michigan Complete Health**'s process must ensure that the adverse benefit determination notice be mailed at the time of the action affecting the claim (e.g., upon the decision to deny payment).

Network Adequacy Validation

Provider Network Data Structure and Processes

Performance Results

Michigan Complete Health participated in the questionnaire process and responded to HSAG's email requests for clarification. Because of the qualitative nature of the provider data structure questionnaire in supporting future NAVs, a determination of performance was not applicable in SFY 2020. HSAG will report on the NAV performance results beginning in SFY 2021.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: The SFY 2020 NAV evaluation considered only program-level strengths, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.

Weaknesses

Weakness: The SFY 2020 NAV evaluation considered only program-level weaknesses, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.

Why the weakness exists: Not applicable.

Recommendation: HSAG offers no ICO-specific recommendations for improvement based on the SFY 2020 NAV evaluation.

Secret Shopper Survey

Performance Results

Table 3-42 and Table 3-43 present the SFY 2020 secret shopper survey results for **Michigan Complete Health** by contracted MI Health Link region. Overall, HSAG attempted to contact 47 sampled provider locations (i.e., "cases"), with an overall response rate of 85.1 percent (40 cases) among Regions 7 and 9 for **Michigan Complete Health**. Of the responsive cases, 70.0 percent (28 cases) accepted **Michigan Complete Health** requested by the caller, and 78.6 percent (22 cases) of those cases stated that the office accepted patients enrolled in the MI Health Link program. Moreover, among the survey respondents who accepted **Michigan Complete Health** and the MI Health Link program, 95.5 percent (21 cases) reported accepting new patients, with 100.0 percent (21 cases) offering an appointment date to the caller.

Table 3-42—Summary of Secret Shopper Survey Results for MCH by Region

Region	Total Survey Cases[1]	Cases Reached	Accepting ICO	Accepting MI Health Link	Accepting New Patients[2]	Cases Offered an Appointment
Region 7	28	21	19	16	16	16
Region 9	19	19	9	6	5	5
MCH Total[1]	**47**	**40**	**28**	**22**	**21**	**21**

[1] Total survey cases represent unique ICO and location combinations, as one location may have been sampled for more than one region if the ICO indicated that the location was contracted to serve MI Health Link members in multiple regions.

[2] Sampled cases included dental provider locations from each ICO and were not limited to locations with providers that were accepting new patients.

The average appointment wait time was 24.6 calendar days among the 21 cases offering an appointment date for a new patient enrolled in MI Health Link with **Michigan Complete Health**.

Table 3-43—Summary of Secret Shopper Survey Appointment Availability Results for MCH by Region

Region	Cases Offered an Appointment		Appointment Wait Time (Calendar Days)			
	Number	Rate[1] (%)	Min	Max	Average	Median
Region 7	16	100.0	1	79	25.4	19.5
Region 9	5	100.0	6	37	22.0	25.0
MCH Total	**21**	**100.0**	**1**	**79**	**24.6**	**20.0**

[1] The denominator includes cases responding to the survey that accept the ICO, accept MI Health Link, and accept new patients. Use caution when interpreting rates with denominators that include fewer than 10 cases.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: ICO-specific strengths have not been identified because, although appointments were generally available, a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICOs' provider data files.

Weaknesses

Weakness: Over 55 percent of sampled dental provider locations were unable to be reached, did not accept **Michigan Complete Health**, did not accept and/or recognize the MI Health Link program, or were not accepting new patients enrolled in the MI Health Link program.

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of **Michigan Complete Health**'s dental provider data may have contributed to cases with invalid telephone contact information or inaccurate information on the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends **Michigan Complete Health** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

Performance Results

Table 3-44 presents **Michigan Complete Health**'s 2020 CAHPS top-box scores for the MI Health Link population.

Table 3-44—Summary of 2020 CAHPS Top-Box Scores for MCH

	2020 Top-Box Score
Global Ratings	
Rating of Health Plan	63.6%
Rating of All Health Care	56.6%
Rating of Personal Doctor	74.2% ↑
Rating of Specialist Seen Most Often	70.1%
Composite Measures	
Getting Needed Care	86.1%
Getting Care Quickly	87.8% ↑
How Well Doctors Communicate	96.5%
Customer Service	93.3%
Individual Item Measure	
Coordination of Care	83.9%
Effectiveness of Care**	
Advising Smokers and Tobacco Users to Quit	83.8% ↑
Discussing Cessation Medications	70.4% ↑
Discussing Cessation Strategies	60.2% ↑

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
** These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2020 score is at least 5 percentage points greater than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points less than the 2019 national average.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Adult members enrolled in **Michigan Complete Health** had more positive experiences overall with their personal doctor and getting their care quickly, since the scores for these measures were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages. In addition, the Effectiveness of Care scores were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages.
Weaknesses	**Weakness:** HSAG did not identify any weaknesses for **Michigan Complete Health** for the CAHPS 5.0H Adult Medicaid Health Plan Survey.

HCBS CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **Michigan Complete Health**; however, due to the low number of respondents to the survey, individual plan results are unable to be presented. Please see Section 5 for statewide results (i.e., MI Health Link program).

Molina Healthcare of Michigan

Validation of Quality Improvement Projects

Performance Results

Table 3-45 displays the overall validation status, and the baseline and Remeasurement 1 results for the QIP topic. **Molina Healthcare of Michigan** did not select a plan-specific goal for the study indicator, as this was not a requirement for the QIP.

Table 3-45—Overall Validation Rating for MOL

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	The percentage of MMP [Medicare-Medicaid plan] member discharges for which the member received follow-up within 30 days of discharge.	55.6%	58.9% ⇔		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 3-46 displays the interventions implemented to address the barriers identified by the ICO using quality improvement and causal/barrier analysis processes.

Table 3-46—Remeasurement 1 Interventions for MOL

Intervention Descriptions	
Executed monthly meetings between the ICO and PIHPs to discuss barriers, interventions, and evaluations.	Developed weekly data sharing reports capturing admission, discharge, and transfer data that is shared between the ICO and PIHP.
Implemented a transition of care program, telepsychiatry program, follow-up appointment reminders for members, and member outreach providing education on importance of follow-up and medication adherence.	Coordinated with hospitals and inpatient facilities to start the discharge coordination planning process early in inpatient stay.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Molina Healthcare of Michigan designed a methodologically sound QIP.

Strength: Molina Healthcare of Michigan used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.

Weaknesses

Weakness: Although **Molina Healthcare of Michigan** demonstrated improvement in the study indicator outcomes for the first remeasurement, the goal of significant improvement was not achieved.

Why the weakness exists: Molina Healthcare of Michigan implemented interventions that may not have a direct impact on the study indicator outcomes.

Recommendation: As **Molina Healthcare of Michigan** progresses to the second remeasurement, HSAG recommends revisiting the causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. **Molina Healthcare of Michigan** should also continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measures

Performance Results

Performance Measure Validation

HSAG evaluated **Molina Healthcare of Michigan**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no major concerns with the ICO's eligibility and enrollment data system, medical services data system (e.g., claims and encounters), care coordination system, enrollee protections systems (e.g., critical incident and abuse reporting), data integration, and readiness to generate data to report Core Measure 9.3—*Minimizing Institutional Length of Stay*.

Molina Healthcare of Michigan received a measure designation of *Reportable (R)* for all measures (other than the new measure for SFY 2020 in which data were not available and received a designation of *Not Applicable*), signifying that **Molina Healthcare of Michigan** had reported the measures in compliance with Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-47—Measure-Specific Validation Designation for MOL

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in compliance with the MMP Core Reporting Requirements.

Performance Measure	Validation Designation
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**NOT APPLICABLE (N/A)** The ICO demonstrated sufficient evidence of readiness to report this measure in compliance with MMP Core Reporting Requirements.
MI2.3: *Members With Documented Discussion of Care Goals*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI3.1: *Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-48 shows each of **Molina Healthcare of Michigan**'s audited HEDIS measures, rates for HEDIS 2018 and HEDIS 2019 to demonstrate year-over-year performance, and the HEDIS 2019 MI Health Link statewide average performance rates. HEDIS 2019 measure rates performing better than the statewide average are notated by green font.

Table 3-48—Measure-Specific Percentage Rates for MOL

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Prevention and Screening			
ABA—Adult BMI Assessment[1]	96.84	97.32	92.70
BCS—Breast Cancer Screening[1]	61.51	60.36	58.79
COL—Colorectal Cancer Screening[1]	64.23	56.20	50.88
COA—Care for Older Adults—Advance Care Planning	37.71	57.66	47.24
COA—Care for Older Adults—Medication Review	75.18	79.08	73.75
COA—Care for Older Adults—Functional Status Assessment	57.91	70.56	64.24
COA—Care for Older Adults—Pain Assessment	80.29	84.91	73.71
Respiratory Conditions			
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]	23.29	29.28	26.46
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	70.34	68.67	70.19
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	92.78	92.70	88.90
Cardiovascular Conditions			
CBP—Controlling High Blood Pressure[2]	—	63.26	63.90
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack[1]	94.55	94.59	92.35

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	75.93	77.01	78.14
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	70.02	75.15	74.77
Diabetes			
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	91.00	91.24	88.73
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**[1]	28.95	33.09	39.12
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	61.31	54.74	51.40
CDC—Comprehensive Diabetes Care—Eye Exams[1]	68.37	67.88	64.20
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	95.38	94.89	93.21
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90[1]	55.47	64.96	60.41
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	71.96	72.00	72.48
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	74.50	75.93	75.38
Musculoskeletal Conditions			
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[1]	57.72	67.77	70.18
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	17.14	4.00	14.94
Behavioral Health			
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	54.96	60.92	61.55
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	44.76	46.84	46.28
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	34.47	28.29	24.42
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	60.00	55.61	48.69
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[2]	—	17.02	21.02
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[2]	—	35.64	41.36
Medication Management and Care Coordination			
MRP—Medication Reconciliation Post-Discharge	37.71	36.01	42.40
Overuse/Appropriateness			
*PSA—Non-Recommended PSA-Based Screening of Older Men**	24.96	29.45	21.68
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	45.45	43.37	42.87
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	18.26	19.26	19.39
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	12.83	13.06	12.76

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Access/Availability of Care			
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years[1]	88.41	87.37	85.00
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years[1]	95.91	96.47	94.39
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older[1]	92.73	94.03	91.46
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total[1]	93.08	93.75	91.25
IET—Initiation of Alcohol and Other Drug Dependence Treatment	32.59	38.15	33.75
IET—Engagement of Alcohol and Other Drug Dependence Treatment	4.05	4.92	4.26
Risk-Adjusted Utilization			
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)** [1]	0.80	0.72	0.66
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[1]	0.87	0.81	0.68

*Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1]Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2018 and HEDIS 2019 be considered with caution.
[2]Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2018 and HEDIS 2019; therefore, HEDIS 2018 rates are not displayed and comparisons to benchmarks are not performed for this measure.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Molina Healthcare of Michigan demonstrated overall strengths in the accuracy and consistency of its data related to reporting performance measures Core Measure 9.1 and MI2.3, and its readiness to report Core Measure 9.3.

Strength: Molina Healthcare of Michigan's rate for the *COA—Care for Older Adults—Advance Care Planning* measure indicator significantly improved by nearly 20 percent from 2018 to 2019 and ranked above the statewide average for 2019, suggesting strength in prevention and medication management, potentially due to strong coordination of care for **Molina Healthcare of Michigan**'s members 66 years and older.

Weaknesses

Weakness: HSAG identified during the PMV Webex review that the MI3.1 member-level detail file submitted by **Molina Healthcare of Michigan** did not align with the preliminary rates submitted. Additionally, during validation of the data, **Molina Healthcare of Michigan** identified that the authorization file was not coded correctly to

verify the members' eligibility status and needed to remove ineligible members from the file, demonstrating there is an opportunity for improvement for eligibility data and the reporting of MI3.1.

Why the weakness exists: **Molina Healthcare of Michigan**'s member-level detail file did not align with the preliminary rates and its authorization file did not include correct coding, impacting the eligibility status of members.

Recommendation: HSAG recommends **Molina Healthcare of Michigan** implement additional validation checks to ensure the accuracy of its member-level detail file and authorization file utilized for reporting of MI3.1.

Weakness: **Molina Healthcare of Michigan**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator significantly dropped by 13 percent from 2018 to 2019, indicating that some women 65 to 85 years of age are not always receiving a bone mineral density test or prescription for a drug to treat osteoporosis within six months after a fracture, which may lead to a decrease in overall quality of life. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.[3-9]

Why the weakness exists: The rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator fell between 2018 and 2019, and although trending of this measure has been cautioned by NCQA, the results could potentially indicate barriers to timely access to treatment after a fracture exist for some women 65 to 85 years of age.

Recommendation: HSAG recommends **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some women 65 to 85 years of age are not receiving treatment within six months after a fracture. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator.

Compliance Review

Performance Results

Table 3-49 presents an overview of the combined results of the prior and current years' compliance reviews for **Molina Healthcare of Michigan**. The table shows the number of elements for each of the 11 standards that received a score of *Met* in the prior year's (SFY 2019) compliance review. Table 3-49 also presents the number of elements that required a CAP during the prior year's compliance review and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review,

[3-9] National Committee for Quality Assurance. *Osteoporosis Testing and Management in Older Women (OMW)*. Available at: https://www.ncqa.org/hedis/measures/osteoporosis-testing-and-management-in-older-women/. Accessed on: Feb 24, 2021.

all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

Table 3-49—Summary of Results for the Prior and Current Years' Compliance Reviews for MOL

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	Availability of Services	11	10	1	1	0	**100%**
II	Assurance of Adequate Capacity and Services	6	5	1	1	0	**100%**
III	Coordination and Continuity of Care	17	14	3	2	1	**94%**
IV	Coverage and Authorization of Services	19	16	3	3	0	**100%**
V	Provider Selection	10	10	0	-	-	**100%**
VI	Confidentiality	7	7	0	-	-	**100%**
VII	Grievance and Appeal Systems	33	19	14	8	6	**82%**
VIII	Subcontractual Relationships and Delegation	5	4	1	1	0	**100%**
IX	Practice Guidelines	4	4	0	-	-	**100%**
X	Health Information Systems	8	8	0	-	-	**100%**
XI	Quality Assessment and Performance Improvement Program	11	8	3	3	0	**100%**
	Total	**131**	**105**	**26**	**19**	**7**	**95%**

M = *Met*; ***NM*** = *Not Met*

Dash (–) = Standard received full compliance in the SFY 2019 review; and therefore, a CAP review was not required during the SFY 2020 review.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Prior Year: The total number of elements within each standard that achieved a score of *Met* or required a CAP in the SFY 2019 review.

Number of Elements: The number of elements that required a CAP in the SFY 2019 review that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

Total Compliance Score: Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in the SFY 2019 review were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: **Molina Healthcare of Michigan**'s plans of correction remedied 19 of 26 identified deficiencies noted during the compliance reviews, indicating **Molina Healthcare of Michigan** implemented sufficient strategies to bring most deficiencies into compliance.

Strength: **Molina Healthcare of Michigan** received a score of 100 percent in nine of the 11 standards reviewed, indicating **Molina Healthcare of Michigan** developed the necessary policies, procedures, plans, and systems to operationalize most of the managed care regulations under 42 CFR §438 and the aligned state-specific contract requirements, and is capable of providing quality and accessible services to its members.

Weaknesses

Weakness: While **Molina Healthcare of Michigan** had seven continued deficiencies after the CAP review, trends of weakness were only identified in the Grievance and Appeal Systems standard.

Why the weakness exists: Six of 14 deficiencies in the Grievance and Appeal Systems standard were not mitigated, indicating **Molina Healthcare of Michigan** did not fully implement the plans of action within its CAP, and/or did not have a comprehensive understanding of the requirements in this program area.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** prioritize the remediation of the remaining six deficiencies in the Grievance and Appeal Systems standard identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. Specifically, **Molina Healthcare of Michigan** should focus process and document revisions, and training efforts on the following:

- When a provider requests an appeal, files a grievance, or requests a State fair hearing on behalf of a member, **Molina Healthcare of Michigan** requires written consent from the member.
- Any member grievances filed with a provider are forwarded to **Molina Healthcare of Michigan** as required in accordance with the three-way contract with the ICO, MDHHS, and CMS.
- When a member makes an oral appeal request, **Molina Healthcare of Michigan**'s process includes acknowledging the details of the appeal, and ensuring the details documented are accurately stated by the ICO. Additionally, **Molina Healthcare of Michigan**'s processes ensure members receive appeal rights for services that are denied, reduced, or terminated, and members must go through the ICO's appeal process prior to accessing the State fair hearing process.
- For notice of an expedited appeal resolution, **Molina Healthcare of Michigan** makes reasonable efforts to provide the member with oral notice of the decision within 72 hours of the request.
- **Molina Healthcare of Michigan** complies with all requirements when it denies a request for an expedited resolution of an appeal.

- Accurate and comprehensive information about the grievance and appeal system must be provided to all providers and subcontractors at the time they enter into a contract.

Further, HSAG recommends that **Molina Healthcare of Michigan** prioritize the remediation of the one remaining deficiency in the Coordination and Continuity of Care standard by developing an audit tool component that pertains to IICSP monitoring and member contact requirements based on risk stratification levels.

Network Adequacy Validation

Provider Network Data Structure and Processes

Performance Results

Molina Healthcare of Michigan participated in the questionnaire process and responded to HSAG's email requests for clarification. Because of the qualitative nature of the provider data structure questionnaire in supporting future NAVs, a determination of performance was not applicable in SFY 2020. HSAG will report on the NAV performance results beginning in SFY 2021.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: The SFY 2020 NAV evaluation considered only program-level strengths, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.

Weaknesses

Weakness: The SFY 2020 NAV evaluation considered only program-level weaknesses, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.

Why the weakness exists: Not applicable.

Recommendation: HSAG offers no ICO-specific recommendations for improvement based on the SFY 2020 NAV evaluation.

Secret Shopper Survey

Performance Results

Table 3-50 and Table 3-51 present the SFY 2020 secret shopper survey results for **Molina Healthcare of Michigan** by contracted MI Health Link region. Overall, HSAG attempted to contact 122 sampled provider locations (i.e., "cases"), with an overall response rate of 89.3 percent (109 cases) among Regions 7 and 9 for **Molina Healthcare of Michigan**. Of the responsive cases, 82.6 percent (90 cases) accepted **Molina Healthcare of Michigan**, and 80.0 percent (72 cases) of those cases stated that the office accepted patients enrolled in the MI Health Link program. Moreover, among the survey respondents who accepted **Molina Healthcare of Michigan** and the MI Health Link program,

94.4 percent (68 cases) reported accepting new patients, with 89.7 percent (61 cases) offering an appointment date to the caller.

Table 3-50—Summary of Secret Shopper Survey Results for MOL by Region

Region	Total Survey Cases[1]	Cases Reached	Accepting ICO	Accepting MI Health Link	Accepting New Patients[2]	Cases Offered an Appointment
Region 7	82	72	61	51	50	44
Region 9	40	37	29	21	18	17
MOL Total[1]	**122**	**109**	**90**	**72**	**68**	**61**

[1] Total survey cases represent unique ICO and location combinations, as one location may have been sampled for more than one region if the ICO indicated that the location was contracted to serve MI Health Link members in multiple regions.

[2] Sampled cases included dental provider locations from each ICO and were not limited to locations with providers that were accepting new patients.

The average appointment wait time was 21.3 calendar days among the 61 cases offering an appointment date for a new patient enrolled in MI Health Link with **Molina Healthcare of Michigan**.

Table 3-51—Summary of Secret Shopper Survey Appointment Availability Results for MOL by Region

Region	Cases Offered an Appointment		Appointment Wait Time (Calendar Days)			
	Number	Rate[1] (%)	Min	Max	Average	Median
Region 7	44	88.0	1	96	23.0	19.0
Region 9	17	94.4	3	54	16.8	13.0
MOL Total	**61**	**89.7**	**1**	**96**	**21.3**	**16.0**

[1] The denominator includes cases responding to the survey that accept the ICO, accept MI Health Link, and accept new patients.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: ICO-specific strengths have not been identified because, although appointments were generally available, a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICOs' provider data files.

Weaknesses

Weakness: Over 44 percent of sampled dental provider locations were unable to be reached, did not accept **Molina Healthcare of Michigan**, did not accept and/or recognize the MI Health Link program, or were not accepting new patients enrolled in the MI Health Link program.

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of **Molina Healthcare of Michigan**'s dental provider data may have contributed to cases with invalid telephone contact information or inaccurate

information on the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends **Molina Healthcare of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

Performance Results

Table 3-52 presents **Molina Healthcare of Michigan**'s 2020 CAHPS top-box scores for the MI Health Link population.

Table 3-52—Summary of 2020 CAHPS Top-Box Scores for MOL

	2020 Top-Box Score
Global Ratings	
Rating of Health Plan	69.6% ↑
Rating of All Health Care	59.7%
Rating of Personal Doctor	76.9% ↑
Rating of Specialist Seen Most Often	78.5% ↑
Composite Measures	
Getting Needed Care	87.3%
Getting Care Quickly	88.1% ↑
How Well Doctors Communicate	95.3%
Customer Service	92.0%
Individual Item Measure	
Coordination of Care	86.6%
Effectiveness of Care**	
Advising Smokers and Tobacco Users to Quit	86.4% ↑
Discussing Cessation Medications	67.3% ↑
Discussing Cessation Strategies	51.2%

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
** These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2020 score is at least 5 percentage points greater than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points less than the 2019 national average.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Adult members enrolled in **Molina Healthcare of Michigan** had more positive experiences overall with their health plan, their personal doctor, the specialist they saw most often, and getting their care quickly, since the scores for these measures were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages. In addition, two of the three Effectiveness of Care scores (*Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*) were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages.
Weaknesses	**Weakness:** HSAG did not identify any weaknesses for **Molina Healthcare of Michigan** for the CAHPS 5.0H Adult Medicaid Health Plan Survey.

HCBS CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **Molina Healthcare of Michigan**; however, due to the low number of respondents to the survey, individual plan results are unable to be presented. Please see Section 5 for statewide results (i.e., MI Health Link program).

Upper Peninsula Health Plan

Validation of Quality Improvement Projects

Performance Results

Table 3-53 displays the overall validation status, and the baseline and Remeasurement 1 results for the QIP topic. **Upper Peninsula Health Plan** did not select a plan-specific goal for the study indicator, as this was not a requirement for the QIP.

Table 3-53—Overall Validation Rating for UPP

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	Follow-up after hospitalization for mental illness within 30 days.	74.2%	76% ⇔		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).

Table 3-54 displays the interventions implemented to address the barriers identified by the ICO using quality improvement and causal/barrier analysis processes.

Table 3-54—Remeasurement 1 Interventions for UPP

Intervention Descriptions	
The PIHP submitted notifications to the ICO on community follow-up appointments through the Integrated Care Bridge record.	Included inpatient mental health admissions/discharges within the standard transitions of care process. ICO care management staff members were educated on the importance of follow-up care due to poor health outcomes.
Conducted community mental health training on discharge planning to include consents.	Developed internal mental health follow-up scripting for staff members conducting outreach to members.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength: Upper Peninsula Health Plan** designed a methodologically sound QIP.
	Strength: Upper Peninsula Health Plan used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers.
Weaknesses	**Weakness:** Although **Upper Peninsula Health Plan** demonstrated some improvement in the study indicator outcomes for the first remeasurement, the goal of significant improvement was not achieved. **Why the weakness exists: Upper Peninsula Health Plan** had a relatively small eligible population. A larger increase in the number of members that are numerator compliant must occur to achieve the desired goal. **Recommendation:** As **Upper Peninsula Health Plan** progresses to the second remeasurement, HSAG recommends revisiting the causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The ICO should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measures

Performance Results

Performance Measure Validation

HSAG evaluated **Upper Peninsula Health Plan**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no major concerns with the ICO's eligibility and enrollment data system, medical services data system (e.g., claims and encounters), enrollee protections system (e.g., critical incident and abuse reporting), data integration, and readiness to generate data to report Core Measure 9.3—*Minimizing Institutional Length of Stay*.

Upper Peninsula Health Plan received a measure designation of *Reportable (R)* for all measures (other than the new measure for SFY 2020 in which data were not available and received a designation of *Not Applicable*), signifying that **Upper Peninsula Health Plan** had reported the measures in compliance with Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-55—Measure-Specific Validation Designation for UPP

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in compliance with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**NOT APPLICABLE (N/A)** The ICO demonstrated sufficient evidence of readiness to report this measure in compliance with MMP Core Reporting Requirements.
MI2.3: *Members With Documented Discussion of Care Goals*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI3.1: *Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-56 shows each of **Upper Peninsula Health Plan**'s audited HEDIS measures, rates for HEDIS 2018 and HEDIS 2019 to demonstrate year-over-year performance, and the HEDIS 2019 MI Health Link statewide average performance rates. HEDIS 2019 measure rates performing better than the statewide average are notated by green font.

Table 3-56—Measure-Specific Percentage Rates for UPP

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Prevention and Screening			
ABA—Adult BMI Assessment[1]	96.11	97.57	92.70
BCS—Breast Cancer Screening[1]	66.10	66.10	58.79
COL—Colorectal Cancer Screening[1]	59.12	57.42	50.88
COA—Care for Older Adults—Advance Care Planning	54.50	68.61	47.24
COA—Care for Older Adults—Medication Review	91.73	90.51	73.75
COA—Care for Older Adults—Functional Status Assessment	78.59	87.83	64.24
COA—Care for Older Adults—Pain Assessment	92.21	92.70	73.71
Respiratory Conditions			
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]	20.00	25.00	26.46
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	70.13	66.67	70.19

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	90.26	87.72	88.90
Cardiovascular Conditions			
CBP—Controlling High Blood Pressure[2]	—	79.32	63.90
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack[1]	78.57	88.24	92.35
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	79.38	82.35	78.14
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	54.33	75.89	74.77
Diabetes			
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	92.15	92.21	88.73
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**[1]	20.07	18.98	39.12
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	68.61	67.15	51.40
CDC—Comprehensive Diabetes Care—Eye Exams[1]	72.08	76.40	64.20
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	91.79	93.19	93.21
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90[1]	80.11	82.73	60.41
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	71.90	72.24	72.48
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	55.63	80.27	75.38
Musculoskeletal Conditions			
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis[1]	68.00	82.05	70.18
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	21.05	11.11	14.94
Behavioral Health			
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	53.17	62.22	61.55
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	49.21	49.63	46.28
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	31.88	54.84	24.42
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	55.07	74.19	48.69
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[2]	—	24.59	21.02
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[2]	—	55.74	41.36
Medication Management and Care Coordination			
MRP—Medication Reconciliation Post-Discharge	67.64	72.02	42.40

HEDIS Measure	HEDIS 2018 (%)	HEDIS 2019 (%)	Statewide Average (%)
Overuse/Appropriateness			
*PSA—Non-Recommended PSA-Based Screening of Older Men**	17.07	13.03	21.68
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	52.98	52.71	42.87
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	23.06	22.15	19.39
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	16.68	16.33	12.76
Access/Availability of Care			
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years[1]	90.60	91.56	85.00
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years[1]	95.21	95.50	94.39
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older[1]	94.99	94.95	91.46
AAP—Adults' Access to Preventative/Ambulatory Health Services—Total[1]	94.28	94.54	91.25
IET—Initiation of Alcohol and Other Drug Dependence Treatment	19.75	17.00	33.75
IET—Engagement of Alcohol and Other Drug Dependence Treatment	2.52	2.37	4.26
Risk-Adjusted Utilization			
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)** [1]	0.70	0.56	0.66
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[1]	0.74	0.67	0.68

*Measures where lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1]Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2018 and HEDIS 2019 be considered with caution.
[2]Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2018 and HEDIS 2019; therefore, HEDIS 2018 rates are not displayed and comparisons to benchmarks are not performed for this measure.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Upper Peninsula Health Plan demonstrated overall strengths in the accuracy and consistency of its data related to reporting performance measures Core Measure 9.1 and MI3.1, and its readiness to report Core Measure 9.3.

Strength: Upper Peninsula Health Plan's rate for the *SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%* measure indicator significantly improved by nearly 25 percent from 2018 to 2019 and ranked above the statewide average for 2019; although trending of this measure has been cautioned by NCQA, results suggest strength in prevention and medication management for patients with diabetes, potentially due to strong coordination of care for **Upper Peninsula Health Plan**'s members 40 to 75 years of age who have diabetes.

Strength: **Upper Peninsula Health Plan**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days* measure indicator significantly improved by nearly 23 percent from 2018 to 2019 and ranked above the statewide average for 2019, suggesting strength in timely access to follow-up care for adults 21 years of age and older, potentially due to strong coordination of care for **Upper Peninsula Health Plan**'s members 6 years of age and older with a diagnosis of mental illness.

Weaknesses

Weakness: HSAG identified during the PMV Webex review one member within the system had an initial IICSP and an existing revision to an IICSP on the same date. Additionally, **Upper Peninsula Health Plan** identified that its source code had been updated and that multiple members would be affected by this change for MI2.3, demonstrating there is an opportunity for care coordination system documentation and the reporting of MI2.3.

Why the weakness exists: HSAG noted that a member had an initial IICSP and revised IICSP reported on the same date, which led to **Upper Peninsula Health Plan** updating their source code as it impacted additional members reported for MI2.3.

Recommendation: HSAG recommends **Upper Peninsula Health Plan** implement additional validation checks to ensure that accurate initial IICSP and revised IICSP dates are reported for MI2.3.

Compliance Review

Performance Results

Table 3-57 presents an overview of the combined results of the prior and current years' compliance reviews for **Upper Peninsula Health Plan**. The table shows the number of elements for each of the 11 standards that received a score of *Met* in the prior year's (SFY 2019) compliance review. Table 3-57 also presents the number of elements that required a CAP during the prior year's compliance review and the corresponding score of *Met* or *Not Met* determined during the current year's (SFY 2020) CAP review. Since only those elements that required a CAP were evaluated during this year's CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

Table 3-57—Summary of Results for the Prior and Current Years' Compliance Reviews for UPP

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	Availability of Services	11	9	2	2	0	**100%**
II	Assurance of Adequate Capacity and Services	6	6	0	-	-	**100%**

Prior Year (SFY 2019) and Current Year (SFY 2020) Scores							
Compliance Review Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Year		Current Year		
			M	*# CAPs*	*M*	*NM*	
III	Coordination and Continuity of Care	17	12	5	5	0	**100%**
IV	Coverage and Authorization of Services	19	16	3	3	0	**100%**
V	Provider Selection	10	9	1	0	1	**90%**
VI	Confidentiality	7	7	0	-	-	**100%**
VII	Grievance and Appeal Systems	33	29	4	4	0	**100%**
VIII	Subcontractual Relationships and Delegation	5	4	1	1	0	**100%**
IX	Practice Guidelines	4	4	0	-	-	**100%**
X	Health Information Systems	8	7	1	1	0	**100%**
XI	Quality Assessment and Performance Improvement Program	11	9	2	2	0	**100%**
	Total	**131**	**112**	**19**	**18**	**1**	**99%**

M = *Met*; ***NM*** = *Not Met*

Dash (–) = Standard received full compliance in the SFY 2019 review; and therefore, a CAP review was not required during the SFY 2020 review.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*.

Prior Year: The total number of elements within each standard that achieved a score of *Met* or required a CAP in the SFY 2019 review.

Number of Elements: The number of elements that required a CAP in the SFY 2019 review that received a score of *Met* or *Not Met* during the SFY 2020 CAP review.

Total Compliance Score: Elements that received a score of *Met* during the SFY 2020 CAP review plus the elements that received a score of *Met* in the SFY 2019 review were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Upper Peninsula Health Plan's plans of correction remedied 18 of 19 identified deficiencies noted during the compliance reviews, indicating **Upper Peninsula Health Plan** implemented sufficient strategies to bring most deficiencies into compliance.

Strength: Upper Peninsula Health Plan received a score of 100 percent in 10 of the 11 standards reviewed, indicating **Upper Peninsula Health Plan** developed the necessary policies, procedures, plans, and systems to operationalize nearly all of the managed care regulations under 42 CFR §438 and the aligned state-specific contract requirements, and is capable of providing quality and accessible services to its members.

Weaknesses

Weakness: While **Upper Peninsula Health Plan** had one continued deficiency after the CAP review, no trends of weakness were identified in any program areas.

Recommendation: While no trends of weakness in program areas were identified, HSAG recommends that **Upper Peninsula Health Plan** prioritize the remediation of the remaining one deficiency identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **Upper Peninsula Health Plan** should focus on the consideration of performance indicators obtained through the quality improvement plan, UM program, grievance and appeals system, member satisfaction surveys, medical record reviews, and quality of care and quality of service events during the recredentialing process.

Network Adequacy Validation

Provider Network Data Structure and Processes

Performance Results

Upper Peninsula Health Plan participated in the questionnaire process and responded to HSAG's email requests for clarification. Because of the qualitative nature of the provider data structure questionnaire in supporting future NAVs, a determination of performance was not applicable in SFY 2020. HSAG will report on the NAV performance results beginning in SFY 2021.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: The SFY 2020 NAV evaluation considered only program-level strengths, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.

Weaknesses

Weakness: The SFY 2020 NAV evaluation considered only program-level weaknesses, as self-reported ICO-specific questionnaire responses reflect the ICO's internal policies, procedures, and systems, rather than uniform metrics across ICOs.

Why the weakness exists: Not applicable.

Recommendation: HSAG offers no ICO-specific recommendations for improvement based on the SFY 2020 NAV evaluation.

Secret Shopper Survey

Performance Results

Table 3-58 and Table 3-59 present the SFY 2020 secret shopper survey results for **Upper Peninsula Health Plan** by contracted MI Health Link region. Overall, HSAG attempted to contact 27 sampled provider locations (i.e., "cases"), with an overall response rate of 77.8 percent (21 cases) in Region 1 for **Upper Peninsula Health Plan.** Of the responsive cases, 90.5 percent (19 cases) accepted **Upper Peninsula Health Plan**, and 78.9 percent (15 cases) of those cases stated that the office accepted patients enrolled in the MI Health Link program. Moreover, among the survey respondents who accepted **Upper Peninsula Health Plan** and the MI Health Link program, 86.7 percent (13 cases) reported accepting new patients, with 84.6 percent (11 cases) offering an appointment date to the caller.

Table 3-58—Summary of Secret Shopper Survey Results for UPP by Region

Region	Total Survey Cases	Cases Reached	Accepting ICO	Accepting MI Health Link	Accepting New Patients[1]	Cases Offered an Appointment
Region 1	27	21	19	15	13	11
UPP Total	**27**	**21**	**19**	**15**	**13**	**11**

[1] Sampled cases included dental provider locations from each ICO and were not limited to locations with providers that were accepting new patients.

The average appointment wait time was 45.8 calendar days among the 11 cases offering an appointment date for a new patient enrolled in MI Health Link with **Upper Peninsula Health Plan**.

Table 3-59—Summary of Secret Shopper Survey Appointment Availability Results for UPP by Region

Region	Cases Offered an Appointment		Appointment Wait Time (Calendar Days)			
	Number	Rate[1] (%)	Min[2]	Max	Average	Median
Region 1	11	84.6	0	121	45.8	41.0
UPP Total	**11**	**84.6**	**0**	**121**	**45.8**	**41.0**

[1] The denominator includes cases responding to the survey that accept the ICO, accept MI Health Link, and accept new patients.

[2] A value of "0" indicates that the provider location offered a same-day appointment.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: ICO-specific strengths have not been identified because, although appointments were generally available, a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICOs' provider data files.

Weaknesses

Weakness: Over 51 percent of sampled dental provider locations were unable to be reached, did not accept **Upper Peninsula Health Plan**, did not accept and/or recognize the MI Health Link program, or were not accepting new patients enrolled in the MI Health Link program.

Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of **Upper Peninsula Health Plan**'s dental provider data may have contributed to cases with invalid telephone contact information or inaccurate information on the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends **Upper Peninsula Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

Performance Results

Table 3-60 presents **Upper Peninsula Health Plan**'s 2020 CAHPS top-box scores for the MI Health Link population.

Table 3-60—Summary of 2020 CAHPS Top-Box Scores for UPP

	2020 Top-Box Score
Global Ratings	
Rating of Health Plan	77.9% ↑
Rating of All Health Care	70.5% ↑
Rating of Personal Doctor	77.7% ↑
Rating of Specialist Seen Most Often	72.8% ↑
Composite Measures	
Getting Needed Care	90.6% ↑

	2020 Top-Box Score
Getting Care Quickly	91.4% ↑
How Well Doctors Communicate	96.5%
Customer Service	95.2% ↑
Individual Item Measure	
Coordination of Care	93.0% ↑
Effectiveness of Care**	
Advising Smokers and Tobacco Users to Quit	85.6% ↑
Discussing Cessation Medications	66.8% ↑
Discussing Cessation Strategies	55.9% ↑

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
** These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2020 score is at least 5 percentage points greater than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points less than the 2019 national average.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Adult members enrolled in **Upper Peninsula Health Plan** had more positive experiences overall with their health plan, the healthcare they received, their personal doctor, the specialist they saw most often, getting the care they needed and getting it quickly, their ICO's customer service, and the coordination of their care, since the scores for these measures were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages. In addition, the Effectiveness of Care scores were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages.

Weaknesses

Weakness: HSAG did not identify any weaknesses for **Upper Peninsula Health Plan** for the CAHPS 5.0H Adult Medicaid Health Plan Survey.

HCBS CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **Upper Peninsula Health Plan**; however, due to the low number of respondents to the survey, individual plan results are unable to be presented. Please see Section 5 for statewide results (i.e., MI Health Link program).

4. Follow-Up on Prior EQR Recommendations for ICOs

From the findings of each ICO's performance for the SFY 2019 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the MI Health Link program. The recommendations provided to each ICO for the EQR activities in the *State Fiscal Year 2018–2019 External Quality Review Technical Report* are summarized in Table 4-1 through Table 4-7. The ICO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-7.

Aetna Better Health of Michigan

Table 4-1—Prior Year Recommendations and Responses for AET

1. Recommendation—Performance Measures
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Aetna Better Health of Michigan** to members, HSAG recommended that **Aetna Better Health of Michigan** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Aetna Better Health of Michigan** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **Aetna Better Health of Michigan**'s quality improvement strategy within its QAPIP: **Domains With Measure Ratings Below the Statewide Average** • **Prevention and Screening** – *BCS—Breast Cancer Screening* – *COL—Colorectal Cancer Screening* • **Respiratory Conditions** – *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* • **Cardiovascular Conditions** – *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* – *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* • **Diabetes** – *CDC—Comprehensive Diabetes Care—HbA1c Testing* – *CDC—Comprehensive Diabetes Care—Eye Exams* – *SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy* – *SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%* • **Musculoskeletal Conditions** – *OMW—Osteoporosis Management in Women Who Had a Fracture*

1. Recommendation—Performance Measures
• **Behavioral Health** – *AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment* – *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* • **Medication Management and Care Coordination** – *MRP—Medication Reconciliation Post-Discharge* • **Overuse/Appropriateness** – *PSA—Non-Recommended PSA-Based Screening of Older Men* – *DAE—Use of High-Risk Medications in the Elderly—One Prescription* • **Access/Availability of Care** – *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total* • **Risk-Adjusted Utilization** – *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Aetna Better Health of Michigan selected the Diabetes subset of measures to incorporate efforts for improvement for performance measures that fell below the statewide average to focus on in 2020. For each measure, we added the statewide rates to the goals we set in the quality improvement workplan with targeted interventions to improve performance and increase the rates. The rates are monitored monthly by our HEDIS Outreach team and progress will be reported to health plan leadership. We have contracted with a vendor that uses the iComply in-home model to make it easier for members to complete diabetic retinal eye exams, microalbumin Testing, hemoglobin A1c testing, and provide member education on diabetes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Due to the COVID-19 pandemic and the restrictions on face to face initiatives, we have not been able to start the in-home screenings. As soon as health care in home face to face restrictions are limited, we will resume.
c. Identify any barriers to implementing initiatives: Due to the COVID-19 pandemic and the restrictions on face to face initiatives, we have not been able to start the in-home screenings. As soon as health care in home face to face restrictions are limited, we will resume.

1. Recommendation—Performance Measures	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** The ICO selected a subset of measures that fell below the statewide average and developed initiatives to improve the performance of those selected measures. The selected measures, initiatives, and interventions were included as part of **Aetna Better Health of Michigan**'s quality improvement workplan. **Recommendation(s):** As **Aetna Better Health of Michigan** continues to perform below the statewide average in several of the Diabetes measures, HSAG recommends the ICO conduct a root cause analysis or focused study to determine why its members are not accessing the services that are required under these performance measures, and implement additional interventions as needed to increase members' access to these services.

2. Recommendation—Compliance Review
Aetna Better Health of Michigan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommended that **Aetna Better Health of Michigan** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include: • Progress on implementation of each plan of action. • Successes or barriers in remediating each deficiency. • Revised actions steps, if necessary. Once all plans of action are fully implemented, HSAG recommended that **Aetna Better Health of Michigan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Aetna submitted our action plan in accordance with the HSAG and MDHHS required timeframe, and implemented all plans of action outlined in our response to the final compliance report. After developing the action plans to address the identified deficiencies, implementation status was evaluated and verified at 30, 60, and 120 days. Policy updates, staff training, and system upgrades were among the actions implemented to address identified deficiencies in program requirements. Additionally, internal daily monitoring and monthly audit processes were developed to provide timely process oversight and staff coaching opportunities to address any concerns identified. Aetna also conducts internal audits of program areas as part of our overall Compliance Plan. These internal audits include review and validation of actions implemented as a result of external quality reviews.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Aetna was engaged in a CMS Program Audit in 2019, shortly after the 2019 HSAG EQR on site review. Many action plans implemented for the 2019 HSAG EQR addressed issues identified in the CMS Program Audit. Remediation following implementation of the action plans is evidenced by Aetna having passed a

2. Recommendation—Compliance Review	
validation audit in August 2020, demonstrating improved performance around the CMS Program Audit issues and corresponding HSAG EQR identified areas of deficiency.	
c. Identify any barriers to implementing initiatives: There were no barriers to implementing the action plans.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** **Aetna Better Health of Michigan** completed plans of action to address each identified deficiency and submitted the CAP timely to MDHHS. **Recommendation(s):** Although **Aetna Better Health of Michigan** demonstrated compliance with all but two of the previously noted deficiencies during the most current CAP compliance review, the ICO should continue to conduct ongoing audits to ensure staff are adhering to the Medicaid managed care requirements and the requirements under the three-way contract with the ICO, MDHHS, and CMS.

3. Recommendation—Performance Improvement Projects

HSAG recommended that **Aetna Better Health of Michigan** take proactive steps to ensure a successful QIP. Specifically, **Aetna Better Health of Michigan** should address all recommendations in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Aetna Better Health of Michigan*, which includes ensuring that all validation feedback is addressed, and necessary corrections are made prior to the next annual submission. HSAG also recommended the following:

- To impact the Remeasurement 1 study indicator rate, **Aetna Better Health of Michigan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.
- **Aetna Better Health of Michigan** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **Aetna Better Health of Michigan** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **Aetna Better Health of Michigan** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
An evaluation of program feedback identified a need to increase frequency of interaction between provider, member, and members of the Integrated Care Team (ICT) to improve communication and coordination of care. We are now scheduling care collaboration meetings more frequently to ensure necessary parties are kept informed, and aware of each participant's role in a member's care. Appropriate follow-up and required care-coordination activities are discussed amongst the members of the ICT to ensure needed services are performed.

3. Recommendation—Performance Improvement Projects
We are getting weekly reports of inpatient admissions from the PIHP behavioral health providers and outreaching to members as soon as notification of inpatient admission has occurred. This is critical to potentially impacting member behavior prior to discharge. A quality improvement team that consisted of representation from Care Management, Pharmacy, Member Services, Provider Relations and Quality Management used brainstorming, cause and effect diagram, and the 5 Why's to identify barriers. Once the barriers were identified, multi-voting was applied to select, rank, and prioritize barriers. The QI process identified unresolved SDoH [Social Determinants of Health] as a barrier to a member prioritizing their health care needs. The care coordinator works with the PIHPs and community-based partners to identify social services eligible and available for the individual member to meet their needs. Behavioral health needs, exacerbated by social isolation created by the COVID-19 pandemic, have pivoted to offer the use of telehealth and BH support line counseling services. Relapse from lack of medication adherence for behavioral health conditions can negatively impact follow up, as well as lead to readmission. All members with a recent hospital discharge are referred from the PIHPs to be contacted by the MCO Care coordinators and provided education regarding medication adherence. Clinical Pharmacy Managers monitor and alert the Care Coordinator when members that are non- adherent to their medication regimen, pharmacy shopping, or potentially when a member is being over or under medicated, to perform medication reconciliations. By monitoring the member's adherence, we are potentially improving their life quality, reducing care costs, and utilizing member's care regimen to the fullest.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): For CY[calendar year]2018 (HEDIS]2019) FUH rate is 47.1% for the 30 day follow up measurement. For CY2019 (HEDIS]2020) FUH rate is 54.9% for the 30 day follow up measurement. The CY2019 rate is just 1.1 percentage point short of the goal of 56%, compared to the prior year rate having been short of our goal by 8.9 percentage points, representing a 7.8 percentage point improvement. We will continue to monitor our performance against the goal to determine effectiveness of interventions.
c. Identify any barriers to implementing initiatives: The following barriers were identified: 1. Impaired information sharing with providers 2. Timely notification of psychiatric discharges 3. Homelessness, hindering ability to maintain contact with member 4. Limited access to Behavioral Health (BH) providers due to Covid-19 5. Lack of medication adherence for members with a BH Diagnosis

HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** **Aetna Better Health of Michigan** identified barriers, implemented interventions, and successfully demonstrated improvement in the study indicator outcomes for the first remeasurement. **Recommendation(s):** N/A

AmeriHealth Caritas

Table 4-2—Prior Year Recommendations and Responses for AMI

1. Recommendation—Performance Measures
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **AmeriHealth Caritas** to members, HSAG recommended that **AmeriHealth Caritas** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **AmeriHealth Caritas** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **AmeriHealth Caritas**' quality improvement strategy within its QAPIP: **Domains With Measure Ratings Below the Statewide Average** • **Prevention and Screening** – *ABA—Adult BMI Assessment* – *BCS—Breast Cancer Screening* – *COL—Colorectal Cancer Screening* – *COA—Care for Older Adults—Advance Care Planning* – *COA—Care for Older Adults—Medication Review* – *COA—Care for Older Adults—Functional Status Assessment* – *COA—Care for Older Adults—Pain Assessment* • **Respiratory Conditions** – *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* • **Cardiovascular Conditions** – *CBP—Controlling High Blood Pressure* – *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* • **Diabetes** – *CDC—Comprehensive Diabetes Care—HbA1c Testing* – *CDC—Comprehensive Diabetes Care—Poor HbA1c Control* – *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* – *CDC—Comprehensive Diabetes Care—Eye Exams* – *CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* – *CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90* – *SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy* • **Musculoskeletal Conditions** – *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* – *OMW—Osteoporosis Management in Women Who Had a Fracture* • **Behavioral Health** – *AMM—Antidepressant Medication Management—Effect Acute Phase Treatment*

1. Recommendation—Performance Measures
– *AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment* – *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days* – *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* – *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* – *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* • **Medication Management and Care Coordination** – *MRP—Medication Reconciliation Post-Discharge* • **Overuse/Appropriateness** – *DDE—Potentially Harmful Drug-Disease Interactions in the Elderly* • **Access/Availability of Care** – *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total* • **Risk-Adjusted Utilization** – *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)* – *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: As a result of the findings related to the quality of, timeliness of, and access to care and services, HSAG recommended that AmeriHealth Caritas incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, AmeriHealth Caritas identified a specific subset of the below measures and developed initiatives to improve the performance of those selected measures. The specific measures were chosen to allow focus on the critical areas of preventive health, chronic disease management, and transitions of care. The selected measures and any subsequent initiatives and interventions are included as part of AmeriHealth Caritas' quality improvement strategy within its Quality Assessment and Performance Improvement (QAPI) program. AmeriHealth Caritas selected the following measures to focus on in 2020: • Breast and colorectal cancer screenings (BCS and COL); Care of older adults (COA); Comprehensive diabetes care (CDC); Follow up after hospitalization for mental illness (FUH); Medication reconciliation post-discharge (MRP); and Plan all-cause readmission (PCR). For each measure, additional interventions were implemented to facilitate submission of and better capture the required information and ensure data abstraction for HEDIS reporting to improve performance. • BCS, COL, CDC: Expanded member and provider outreach and education, including identification of care gaps and reminders of need for care gap closure;

1. Recommendation—Performance Measures
• COA and MRP: Established non-standard supplemental data process (NCQA auditor-approved) for completion and reporting of this data; • Follow up after hospitalization for mental illness – Refer to #3 PIP Update below. • PCR: Revised Transition of Care program to improve use of information received from daily ADT report, enhance ED visit follow up, increase monitoring of members with frequent admissions, daily TOC meetings, implementation of a corporate-wide TOC Workgroup.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Based on HEDIS 2021 interim results through 6/30/2020, all measure rates have improved consistently since January 2020. However, when comparing June year-over-year rates, the following is noted: • BCS: There has been little change to the BCS rate when compared to June 2019 results. This is the result of restrictions of in-person medical care March – May, 2020 per Governor's executive order due to COVID-19 pandemic. • Colorectal cancer screening has increased 6.6% compared to June 2019. This is a hybrid measure with a multi-year lookback period, plus AmeriHealth offers an in-home testing option (FitKit). • COA: Rates are significantly lower than they were in June 2019. This is due to the non-standard supplemental data process on hold since January, due to need to complete HEDIS 2020 hybrid project and system updates to comply with updated HEDIS specifications. Data entry resumed 8/1/20, expect to see rate increases in future interim HEDIS reports. • Comprehensive diabetes care measure rates lower by 1-4% compared to June 2019. This is the result of restrictions of in-person medical care March – May 2020 per Governor's executive order due to COVID-19 pandemic. • FUH: The rate has increased 2% compared to June 2019. This is due to the improvement efforts for the PIP – refer to #3 "PIP Update" below. • MRP: Rate has decreased by 2%. This is due to the non-standard supplemental data process on hold since January, due to need to complete HEDIS 2020 hybrid project and system updates to comply with updated HEDIS specifications. Data entry resumed 8/1/20, expect to see rate increases in future interim HEDIS reports. • PCR: The O/E ratio has more than doubled since June 2019, due to the HEDIS specification change that now requires admission following observation stay to be counted as a readmission for this measure. All improvement interventions will continue.
c. Identify any barriers to implementing initiatives: Barriers include: • The restrictions of in-person medical care March – May 2020 due to COVID-19 per Governor's executive order. • Hold on non-standard supplemental data process for COA and MRP measures due to need to complete HEDIS 2020 hybrid project and system updates to comply with updated HEDIS specifications.

1. Recommendation—Performance Measures	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** The ICO selected a subset of measures that fell below the statewide average and developed initiatives to improve the performance of those selected measures. The selected measures, initiatives, and interventions were included as part of **AmeriHealth Caritas**' quality improvement workplan. **Recommendation(s):** Although **AmeriHealth Caritas** has demonstrated some improvement overall, some measures continue to perform below the statewide average and/or have experienced a decrease. HSAG recommends the ICO continue its efforts to improve performance, which may include conducting a root cause analysis or focused study to determine why its members are not accessing the services that are required under these performance measures, and implement additional interventions as needed to increase members' access to these services.

2. Recommendation—Compliance Review

AmeriHealth Caritas was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommended that **AmeriHealth Caritas** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include:

- Progress on implementation of each plan of action.
- Successes or barriers in remediating each deficiency.
- Revised actions steps, if necessary.

Once all plans of action are fully implemented, HSAG recommended that **AmeriHealth Caritas** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
As of September 30, 2020, twenty-seven deficiencies have been remediated. Four deficiencies remain open as follows:
3.15 IICSP Monitoring – The ICO's monitoring of contact time frames based on member's risk level is being finalized. Target date for implementation is November 1, 2020.
4.12 Denial of Payment Member Letters - Members will receive an integrated denial letter in the limited situation in which both Medicare and Medicaid does not cover a service and the ICO denied the provider payment. ICO is working towards the implementation of the manual denial letter by October 15, 2020.
5.3 - Recredentialing Requirements - The ICO must include the consideration of performance indicators obtained through the quality improvement plan, utilization management program, grievance and appeals system, member satisfaction surveys, medical record reviews, and quality of care and quality of service events during the recredentialing process. The ICO must document the consideration of provider performance at the time of a provider's recredentialing. ICO will review the updated recredentialing

2. Recommendation—Compliance Review	
process and determine if the listed requirements above are being met. Target review date is by October 27, 2020. **7.19 Resolution of Appeals** – As of September 30, 2020, the language regarding "the appeal determination must not be extended beyond 45 calendar days from receipt" has been removed from the job aid.	
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A	
c. Identify any barriers to implementing initiatives: • Implementation of the IICSP monitoring was delayed due to the ICO's need to coordinate the monitoring roll-out internally with other lines of business. • Programming the manual and automated claims denial letter for members has taken longer than expected due to the need to refine the requirements.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** **AmeriHealth Caritas** completed plans of action to address each identified deficiency and submitted the CAP timely to MDHHS. **Recommendation(s):** Although **AmeriHealth Caritas** demonstrated compliance with all but four of the previously noted deficiencies during the most current CAP compliance review, the ICO should continue to prioritize the implementation of these remaining four elements, and conduct ongoing audits to ensure staff are adhering to the Medicaid managed care requirements and the requirements under the three-way contract with the ICO, MDHHS, and CMS.

3. Recommendation—Performance Improvement Projects
HSAG recommended that **AmeriHealth Caritas** take proactive steps to ensure a successful QIP. Specifically, **AmeriHealth Caritas** should address any recommendations in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for AmeriHealth Michigan, Inc.* HSAG also recommended the following: • To impact the Remeasurement 1 study indicator rate, **AmeriHealth Caritas** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate. • **AmeriHealth Caritas** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • **AmeriHealth Caritas** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes. • **AmeriHealth Caritas** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

3. Recommendation—Performance Improvement Projects	
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***	
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Established process to provide timely notification to ICO care coordinators of behavioral health inpatient care and expectation the members be included in TOC process – completed. • Created process to improve rate of Care Coordinator notification and acknowledgement of PIHP information, to include ongoing monitoring and coaching – still underway. • Started review of steps that will be necessary to fully automate data exchange between PIHPs and ICO specific to behavioral health inpatient care and follow up visits, to eliminate current reliance on manual processes – still underway. o Implementation of this activity was delayed due to need to divert AmeriHealth Caritas and PIHP resources to other projects as a result of COVID-19 pandemic.	
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Notification provided to Care Coordinator: o February 2020: 70% compliance rate o June 2020: Improved to 100% compliance rate • Care Coordinator compliance with process after receipt of notification: o February 2020: 38% o June 2020: Improved to 67%	
c. Identify any barriers to implementing initiatives: Barriers include: • Continued reliance on manual processes for data exchange and reporting due to delay in automation resulting from COVID-19 pandemic.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings: AmeriHealth Caritas** identified barriers, implemented interventions, and successfully demonstrated improvement in the study indicator outcomes for the first remeasurement. **Recommendation(s):** N/A

HAP Empowered

Table 4-3—Prior Year Recommendations and Responses for HAP

1. Recommendation—Performance Measures
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **HAP Empowered** to members, HSAG recommended that **HAP Empowered** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **HAP Empowered** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **HAP Empowered**'s quality improvement strategy within its QAPIP: **Domains With Measure Ratings Below the Statewide Average** • **Prevention and Screening** – *ABA—Adult BMI Assessment* – *BCS—Breast Cancer Screening* – *COL—Colorectal Cancer Screening* – *COA—Care for Older Adults—Advance Care Planning* – *COA—Care for Older Adults—Medication Review* – *COA—Care for Older Adults—Functional Status Assessment* – *COA—Care for Older Adults—Pain Assessment* • **Respiratory Conditions** – *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* – *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* • **Cardiovascular Conditions** – *CBP—Controlling High Blood Pressure* – *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* • **Diabetes** – *CDC—Comprehensive Diabetes Care—HbA1c Testing* – *CDC—Comprehensive Diabetes Care—Poor HbA1c Control* – *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* – *CDC—Comprehensive Diabetes Care—Eye Exams* – *CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* – *CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90* – *SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%* • **Musculoskeletal Conditions** – *OMW—Osteoporosis Management in Women Who Had a Fracture* • **Behavioral Health** – *AMM—Antidepressant Medication Management—Effect Acute Phase Treatment*

1. Recommendation—Performance Measures
– *AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment* – *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days* • **Medication Management and Care Coordination** – *MRP—Medication Reconciliation Post-Discharge* • **Overuse/Appropriateness** – *PSA—Non-Recommended PSA-Based Screening of Older Men* • **Access/Availability of Care** – *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total* – *IET—Initiation of Alcohol and Other Drug Dependence Treatment* – *IET—Engagement of Alcohol and Other Drug Dependence Treatment*
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: To address the low performing measures, HAP Empowered implemented several new initiatives and modified improvement efforts in 2020. The following is an overview of the strategy employed to impact all the performance measures. **Improved the structure of the Medicaid/MMP improvement efforts** • Implemented a new interdepartmental team in 2020 to focus on Medicaid and MMP initiatives aimed at increasing HEDIS/CAHPS and performance measure rates. This team is in addition to the HAP MMP workgroup that meets routinely. • Developed a comprehensive Medicaid/MMP dashboard to monitor monthly HEDIS rates and progress toward goals. • Developed a Medicaid/MMP Initiative work plan focused on activities to improve performance measures. • Completed an inventory of data improvements/gaps needed to effectively and efficiently meet improvement goals • HAP Empowered is partnering with Carrot Health to design additional initiatives to improve MMP Program quality measure outcomes and rates. **Additional Improvement Efforts** • Coordinated efforts to revise a 'gaps in care' tool. Trained case managers, pharmacists and Customer Service on use of the tool that includes members' gaps that can be addressed when members call-in or during pharmacy and case management calls. • Developed a template for member gaps in care outreach to include all the necessary demographics

1. Recommendation—Performance Measures
• Pharmacy is implementing new and continuing initiatives to address the pharmacologic measures (diabetes, asthma, etc.) • New member mailing with an incentive for OMW (Osteoporosis Management in Women) is being developed in 2020. • Collaborating with Provider Network to develop a revised Best Practice Program (P4P) with measures that include adult preventive services along with improvements in diabetic care. • Developing a process with the MMP Care Coordinators that includes addressing a member's gap in care when coordinating member care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): HAP monitors all MMP performance measures on a monthly basis. As we are still evaluating our efforts with the initiatives we have implemented, initial analysis has yielded improved awareness with our A1C testing and controlling blood pressure. As a result, we are further partnering with our Care Management and Pharmacy departments in the development of proactive interventions.
c. Identify any barriers to implementing initiatives: The COVID pandemic has been a barrier to the initiatives. Several provider offices and testing sites (mammography centers) were closed for months in 2020 limiting members access to services. As a result of COVID's impact on HAP members, an intervention to address member needs was implemented. The following is an overview of the methodology and efforts. HAP, using the vendor Carrot's *MarketView Health module*, utilized Carrot Health's COVID index and Social Risk Grouper (SRG) scores to identify members most at risk (SRG is a Social Determinants of Health taxonomy that uses consumer data and predictive analytics to assign risk to every US adult.) Once vulnerable members were identified HAP implemented a program with four key objectives: • Proactively identify the top 10% of members with SDoH (Social Determinants of Health) related concerns • Prioritize outreach to those members using care coordinators • Educate members on relevant personalized topics, including hygiene practices and available plan benefits • Fulfill immediate human needs that impact a member's health risk and utilization HAP proactively identified the top 10% of members with SDoH-related concerns. HAP is aware that it is important to reach the most at-risk members first, therefore, Carrot Health scored and ranked each of the individuals in HAP's member population to identify the top 10% of members who would most likely benefit from targeted outreach. Those higher-risk members were then further segmented into four categories of risk, and outreach was customized for each subgroup. The higher the risk, the higher the level of outreach and engagement from the appropriate staff. Carrot Health generated a list of individuals in each category, and HAP assigned lists to Care Teams, which consisted of community outreach staff, healthcare management staff, care coordinators, and behavioral

1. Recommendation—Performance Measures	
health specialists. Care Teams were structured to consist of multi-disciplinary resources. Outreach to members, via telephone, began on April 14, 2020.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** The ICO focused on measures that fell below the statewide average and developed initiatives to improve the performance of those selected measures. The selected measures, initiatives, and interventions were included as part of **HAP Empowered**'s quality improvement program. **Recommendation(s):** As **HAP Empowered** continues to perform below the statewide average in many of the performance measures, HSAG recommends the ICO continue with its current initiatives and conduct additional root cause analyses or focused studies to determine why its members are not accessing the services that are required under these performance measures. The ICO should implement additional interventions as needed to increase members' access to these services.

2. Recommendation—Compliance Review
HAP Empowered was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommended that **HAP Empowered** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include: • Progress on implementation of each plan of action. • Successes or barriers in remediating each deficiency. • Revised actions steps, if necessary. Once all plans of action are fully implemented, HSAG recommended that **HAP Empowered** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
HAP Empowered ICO Compliance Review yielded a total of 31 CAPs of which 29 were deemed *Completed* with 2 identified as *On Track for Completion* as of the April 28, 2020 summary review. The two remaining CAPs *On Track* are Standard 8 Element 5 and Standard 11 Element 4. We are pleased to report that both Standard 8 Element 5 and Standard 11 Element 4 are complete. a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Standard 8 Element 4- HAP Empowered ICO examined the government program contractual amendment templates to eliminate conflicting information regarding record retention timelines, and to ensure that each template detailed the pertinent language per legal review and recommendation. For existing vendors, each template was reviewed and replaced with the revised amendment template. All

2. Recommendation—Compliance Review
Medicare, Medicaid and MI Health Link amendments were updated and signed by all vendors in July 2020. • Standard 11 Element 4- HAP Empowered ICO stakeholders from Quality Management, Provider Network, HEDIS and Finance continue to identify, monitor and report out on the Under and Over Utilization of services. HAP network performance reports are distributed quarterly to each IPA [Individual Practice Association]. Provider Network is also developing a business plan with the IPAs with quarterly review. Reports are to be sent monthly. HEDIS panel reports are shared with providers via the provider portal and are automatically updated monthly. All is indicated and tracked via the 2020 QM Workplan • Standard 3 Element 14- HAP Empowered under new care management leadership, examined the DLP (Desk Level Procedure) and knowledge base of the care coordination team as it relates to ensuring follow up occurs with interventions related to the IISCP. As emphasis was placed on all member centric goals and objectives, emphasis was placed on follow up related to member needs relative to pharmacy requests, hearing and vision. Bi-Monthly meetings are held routinely with leadership, management and staff to provide reinforcement of care coordinator responsibilities. In addition, review audits are in place monthly to evaluate the performance and follow up of each care coordinator. These are completed by the assigned manager.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Standard 8 Element 4- All amendment templates were reviewed and updated as recommended and no longer contain conflicting information related to record retention timelines. The new templates now contain appropriate language for all successive FDR [First Tier, Downstream, and Related Entities] contracts which will assist in minimizing any future conflict or confusion. All existing vendors have signed the updated contract template. • Standard 11 Element 4-. With the completion and inclusion of the MMP membership within the Network Performance reports, this value add has enhanced our data sharing capabilities and collaboration with our providers. • Standard 3 Element 14- Monthly manager IICSP audits to ensure appropriate follow up has occurred, coupled with regular training and reinforcement has yielded a continued trending decline in identified member needs being missed related to care coordination activities. Individual Audit results have also provided the manager with the opportunity to identify and solicit care coordination feedback related to the desk level procedure. HAP's new Care Management Leader is highly engaged with the care coordination team and acts as a reference to ensure compliance to policy is adhered to.
c. Identify any barriers to implementing initiatives: • Standard 8 Element 4- Though no associative barriers related to the CAP were identified, Covid-19 did have an impact on operational priorities. • Standard 11 Element 4- No barriers identified. QM continues to track progress quarterly via the workplan. • Standard 3 Element 14- As new care management leadership was present Q4 of 2019, no barriers were identified as new process improvement initiatives immediately commenced.

2. Recommendation—Compliance Review	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** **HAP Empowered** completed plans of action to address each identified deficiency and submitted the CAP timely to MDHHS. **Recommendation(s):** Although **HAP Empowered** demonstrated compliance with all but eight of the previously noted deficiencies during the most current CAP compliance review, the ICO should continue to prioritize implementation of any outstanding plans of action, and conduct ongoing audits of all program areas to ensure staff are adhering to the Medicaid managed care requirements and the requirements under the three-way contract with the ICO, MDHHS, and CMS.

3. Recommendation—Performance Improvement Projects

HSAG recommended that **HAP Empowered** take proactive steps to ensure a successful QIP. Specifically, **HAP Empowered** should address any recommendations in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for HAP Empowered*. HSAG also recommended the following:

- To impact the Remeasurement 1 study indicator rate, **HAP Empowered** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.
- **HAP Empowered** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- **HAP Empowered** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.
- **HAP Empowered** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

HAP Empowered continued working with a quality improvement workgroup that was established in 2017 consisting of representatives from the Quality Management, Performance Improvement/HEDIS, Outreach, and Care Management departments. This workgroup meets bimonthly to discuss ongoing barriers, interventions, and strategies to improve metrics and increase members' health outcomes. To identify initial barriers, the workgroup created and used a fishbone diagram as a QI tool. This helped to document barriers and initiate discussions for improvement. The workgroup completed the following activities throughout 2019-early 2020

- Reviewing HEDIS performance data
- Identifying key drivers and areas in need of improvement utilizing the initial fishbone diagram
- Identifying evidence-based interventions/change concepts to implement
- Developing action and work plans
- Monitoring intervention performance and outcomes

3. Recommendation—Performance Improvement Projects
• Revise or discontinue interventions when necessary The quality team continued the use of a fishbone diagram to identify barriers for the follow up after hospitalization measure during workgroup sessions. Many barriers remained the same and the fishbone diagram was utilized and updated based on feedback from workgroup discussions. Priority was then assigned to each barrier and combined into focus areas where the team strategized to identify interventions that would impact measurement. The two main areas are PIHP collaboration and Case Management follow up interventions. The fishbone diagram helped to document barriers and initiate discussions for improvement. **PIHP Collaboration:** • HAP Empowered continues to reach out to the PIHPs to schedule ongoing care coordination and planning meetings. • HAP Empowered continues to validate the information received from the PIHPs regarding BH hospitalizations. **Care Coordination Follow up** • HAP Empowered is in the process of creating desk level processes (DLP) for validating the information received from the PIHPs. • HAP Empowered is developing a DLP to standardize the way care coordinators follow up with members who had a BH hospitalization HAP Empowered evaluates each intervention by reviewing HEDIS results and comparing baseline to remeasurement periods. All interventions are tracked to determine if the intervention had an impact on the rate. A tracking log is maintained of the interventions to compare rates each year. HEDIS results are also utilized to measure the effectiveness of interventions and to identify additional opportunities for improvement. The data used to support the project comes from the HEDIS software that includes claims and encounter data. HEDIS rates are compared to established benchmarks on an annual basis. The team reviews and evaluates annual rates in comparison to NCQA benchmarks, as well as the performance of other health plans to determine HAP Empowered's ranking against their peers. Intervention success is evaluated by improvement in annual rates, as well as feedback from providers, members, and internal staff. Interventions not deemed to be effective are terminated. HAP Empowered continues to develop and implement additional interventions as needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Data validation was completed on hospitalization reports from 2019. This data validation process helped HAP Empowered to determine where gaps in interventions were, develop improved interventions for the members, and to drive the focus of the coordination meetings with the PIHPs in 2020. To ensure coordinated follow up with the members, ongoing discussions are held to ensure timely admission and discharge information is updated on the weekly BH hospitalization reports. For HEDIS 2020 (CY 2019), there were 63 admissions, or 93% of total admissions, that were received on the PIHP file. Out of the members who were received on the PIHP file, 20 members (32%) were scheduled for a follow up visit, and from those scheduled, 6 members (30%) completed a follow up visit. Even though the

3. Recommendation—Performance Improvement Projects	
HEDIS score went down for HEDIS 2020, the fact that four out of seven members (57%) who were contacted after a BH hospitalization did attend their follow up visit shows that contacting members after a BH hospitalization can have a positive impact on this outcome	
c. Identify any barriers to implementing initiatives: No known barriers; the workgroup continues to meet on a regular basis and discuss progress on interventions	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** Although **HAP Empowered** experienced a decline from its baseline rate, the ICO analyzed data, identified barriers, and implemented interventions that should improve future performance. **Recommendation(s): HAP Empowered** should continue its efforts to improve rates associated with member follow-up after hospitalization and should continue conducting ongoing evaluations of its interventions to ensure they are effective.

Meridian Health Plan

Table 4-4—Prior Year Recommendations and Responses for MER

1. Recommendation—Performance Measures
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Meridian Health Plan** to members, HSAG recommended that **Meridian Health Plan** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Meridian Health Plan** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **Meridian Health Plan**'s quality improvement strategy within its QAPIP: **Domains With Measure Ratings Below the Statewide Average** • **Prevention and Screening** – *COA—Care for Older Adults—Advance Care Planning* • **Respiratory Conditions** – *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* • **Cardiovascular Conditions** – *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* • **Diabetes** – *CDC—Comprehensive Diabetes Care—Poor HbA1c Control* – *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* – *SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy* • **Musculoskeletal Conditions** – *OMW—Osteoporosis Management in Women Who Had a Fracture* • **Behavioral Health** – *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days* • **Overuse/Appropriateness** – *DDE—Potentially Harmful Drug-Disease Interactions in the Elderly* – *DAE—Use of High-Risk Medications in the Elderly—One Prescription* – *DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions* • **Access/Availability of Care** – *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total* – *IET—Initiation of Alcohol and Other Drug Dependence Treatment* – *IET—Engagement of Alcohol and Other Drug Dependence Treatment*

1. Recommendation—Performance Measures
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Meridian Health Plan conducted a year over year analysis using data from measurement years 2018 and 2019 to identify a subset of measures that fell below the MMP State Average in both years. Please note that DAE – One Prescription was retired after HEDIS® 2019 and was not included in this analysis. The measures identified for Performance Improvement Plans (PIPs) were DAE – Two Prescriptions, SPR and COA – Advance Care Planning due to not meeting the MMP State Average in 2018 or 2019. Meridian is in the process of conducting root cause and data analysis for the three measures to determine interventions. Meridian has modified its previous PIP template to meet the requirements outlined by HSAG and will use this for all PIPs moving forward. The goal for these measures will be that their 2020 measurement results meet or exceed the MMP State Average for 2019 due to a lag in receipt of MMP State Average data for evaluation. • For the DAE – Two Prescriptions measure, Meridian plans to improve the rate by educating providers on the importance of reconciling medications at every single visit. Provider education will be distributed before the end of the year in 2020. • For the COA – Advance Care Planning measure, Meridian plans to improve the rate by completing medical record abstraction, collecting COA attestation forms and educating providers on the importance/components of the measure. Members are provided with a reminder to complete this measure with their provider when they call the health plan and by Meridian's Care Coordination team. Additionally, providers who are performing poorly in this measure will receive targeted education. Provider education will be completed before the end of the year in 2020. • For the SPR measure, Meridian plans to improve the rate by collecting supplemental data, educating members on the importance of completing the spirometry test and educating providers on the timeframes associated with the measure as well as the importance of the spirometry test. Members are provided with a reminder to complete this measure with their provider when they call the health plan. These initiatives will be completed before the end of the year in 2020.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance improvement for DAE – Two Prescriptions, SPR and COA – Advance Care Planning will be evaluated in 2021 for the 2020 measurement year. • Meridian identified through analysis that since HSAG's audit in 2018, for measures that did not meet the 2018 state average, 12 of the measures met the 2019 state average for HEDIS® 2019 and seven of the measures met the 2019 state average for HEDIS® 2020.
c. Identify any barriers to implementing initiatives: • COVID-19 has created unforeseen barriers for implementing initiatives including Stay at Home orders halting preventative care in early 2020 and increased fear for members to be in public places like the doctor's office. To alleviate these barriers, Meridian encourages use of telehealth. • Unfamiliarity/uncomfortability with use of telehealth by members and providers may cause barriers with accessing care. Meridian has a member in the September Consumer Advisory Committee meetings report that they preferred seeing their provider in person. • Additional barriers to implementing member initiatives include:

1. Recommendation—Performance Measures	
- Unable to reach members due to inability to establish updated and correct contact information - With the focus measures being provider-driven, based on clinical practice guidelines, it is mostly up to the provider to ensure the measures are completed for the member - Lack of motivation and follow through to complete annual provider visit based on these measures being provider-driven - Additional barriers to implementing provider initiatives include: - Potential lack of provider engagement - Competing prioritization of measures across lines of business; potential for provider communication fatigue - Provider's compliance with clinical practice guidelines addressing DAE, COA and SPR	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** The ICO selected a subset of measures that fell below the statewide average and developed initiatives to improve the performance of those selected measures. The selected measures, initiatives, and interventions were included as part of **Meridian Health Plan**'s quality improvement activities. **Recommendation(s):** As **Meridian Health Plan** continues to perform below the statewide average in several of the identified measures, HSAG recommends the ICO continue its efforts to remove the identified barriers to performance and improvement, which may include conducting additional root cause analyses or focused studies to determine why its members are not accessing the services that are required under these performance measures.
2. Recommendation—Compliance Review	
Meridian Health Plan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommended that **Meridian Health Plan** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include: - Progress on implementation of each plan of action. - Successes or barriers in remediating each deficiency. - Revised actions steps, if necessary. Once all plans of action are fully implemented, HSAG recommended that **Meridian Health Plan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.	
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*	
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: - Standard I Element 3- Meridian is in the processes of updating all materials for 2021, including the member handbook. - Standard I, Element 7 – The following activities are underway and due by the end of 2020:	

2. Recommendation—Compliance Review

- Process for follow-up with failing providers to be updated as appropriate following audit results/response rates
- A more comprehensive process for requesting CAPs of providers who fail to meet access standards will be created. This will be updated in the Meridian Member Appointment Access and Availability Audit policy.

- Standard I Element 11 – As Meridian further integrates into Centene's structure, our ADA [Americans with Disabilities Act] workplan will become consistent with that of our parent organization.
- Standard III Element 11 – Prior to the pandemic, all Meridian members were offered an in-person assessment and care plan review, regardless of stratification level. As Meridian further integrates into Centene's structure and works to move our Care Coordination team back into the market, these recommendations will be considered while building our "in-house" care management program.
- Standard III Element 12 – Meridian's current Care Plan documentation under H3 Management includes concerns, goals, preferences, and strengths identified by the member, measurable member-specific goals, details of all supports and services received by the member, as well as an assessment of all risks to the member and any back-up plans or strategies. Additionally, as Meridian further integrates into Centene's structure and works to move our Care Coordination team back into the market, these recommendations will also be considered while building out our "in-house" care management program.
- Standard III Element 13 - As Meridian further integrates into Centene's structure and works to move our Care Coordination team back into the market, we will begin partnering with Specialty Medical Management to assist with waiver submissions. This partnership will allow for better oversight and monitoring for the LTSS membership at Meridian.
- Standard IV Element 7 – As Meridian further integrates into Centene's structure and works to move our Utilization Management team back to be managed by the market, these recommendations will be considered while building the after-hours processes.
- Standard IV Element 9 – Meridian's IDNs were updated for 2020 to correctly reflect the 10 calendar day time frame for requesting continuation of benefits
- Standard IV Element 15 – Policy "Referral Process Medicare Advantage Pre-Service Expedited" accurately depicts the process of both oral and written notification to the member within 72 hours.
- Standard V Element 9 – Meridian's credentialing policies have been updated to include the following Nondiscriminatory Statement:
  MHP does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or patients in which the practitioner specializes in. MHP does not discriminate against providers based on reimbursement, or indemnification, against any health care professionals who are acting within the scope of his/her license, solely on the basis of license or certification. However, MHP may exclude a provider if the network already has a sufficient number of the specific type of provider to meet the needs of its members, the providers reimbursement amount is in excess of other similar providers, and/or based on the quality of care and cost control consistent with the health plan's responsibilities. All credentialing exception files are presented to the Credentialing Committee as "blind files" removing the provider's name. MHP uses the provider's identification number to protect their identity. All terminated providers are presented to the Quality Improvement Committee to track any discrimination in the credentialing and recredentialing process quarterly.
- Standard VII Element 14 – Meridian's *MI MMP Enrollee Grievance Administration* policy has been updated to reflect the correct language that grievances are resolved within 30 calendar days.

2. Recommendation—Compliance Review

- Standard VII Element 26 – Meridian's *MI Enrollee Appeal of Adverse Determinations* policy has been updated to include language stating that Meridian will not take any punitive actions towards a Provider who requests or supports an Expedited Appeal Request.
- Standard VIII Element 4 – Meridian's contact with SWMBH is currently under review and revision. This addition will be considered during this revision.
- Standard IX Element 2 - Meridian is updating Policy 5.70 – Clinical Practice Guidelines (CPGs) to support that CPGs are reviewed by committee members, including the Medical Director and network providers, prior to adoption. The policy will go to the next QIC for approval on 11/25.
- Standard IX, Element 3 - Meridian has completed all actions that were submitted in the corrective action plan for this requirement. Actions included:
    - Update provider manual language to notify providers that CPGs are available on website (include link to website location)
    - Update language surrounding obtaining clinical guidelines to be consistent among provider manuals, provider orientations, and Meridian provider website
    - Ensure language in Member handbooks state that CPGs are available on website and upon request
    - Update language on website to remove NCQA developed language and replace with MQIC, or other CPG creator
    - Add language to Provider Newsletter stating CPGs are updated and direct to Meridian website CPG location. Other distribution strategies, such as email, fax or other correspondence, will be utilized if timing does not align with newsletter distribution
    - Update Website to indicate most recently updated/retired CPGs, at least quarterly
- Standard XI, Element 10 – Meridian has completed all actions that were submitted in the corrective action plan for this requirement. Actions included:
    - Future Work Plans will include the following elements:
        - Include specific interventions and actions to meet each measurable goal
        - Clearly identify BH and LTSS sections
    - Future Annual Evaluations will incorporate the following elements:
        - Include specific sections for behavioral health and LTSS interventions and outcomes
        - Ensure that effectiveness is analyzed related to the interventions and activities meeting established goals and benchmarks
        - If goals or benchmarks were met or sustained, establish new goals or benchmarks that in an effort to strive for continued performance improvement.
        - If goals or benchmarks are not met, conduct a barrier analysis and identify new initiatives or activities for the subsequent year to achieve the goal
        - Add new initiatives or actions to the subsequent year's annual work plan
    - Meridian will continue to employ qualified staff who meet the employment minimum standards and requirements for employees who will be responsible for Quality, increase frequency in communication to all staff who are responsible for Quality including internal stakeholders who are involved in initiatives or activities that impact Quality and continue ongoing meetings with Care Coordination delegate to ensure communication of initiatives and activities. In addition to this, Meridian's Quality Improvement team is now overseen by a Registered Nurse with a background in Epidemiology.
- Standard XI, Element 11: Meridian has completed most of the actions that were submitted in the corrective action plan for this requirement. One action item, discussion of the Annual Evaluation at

2. Recommendation—Compliance Review	
Regional Provider meetings, will be slightly altered due to barriers cause by COVID-19. Actions that have been completed include: o Create an overview with the key highlights from the MI Health Link Quality Improvement Annual Evaluation and share the overview with providers annually ▪ Publish overview to website's "Bulletins" page ▪ Include hyperlink and information for the overview in provider emails; this will allow Meridian to monitor how many providers open the link ▪ Upload the full MI Health Link Quality Annual Evaluation to Meridian's Provider Portal	
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian has completed most of the corrective action items outlined thus ensuring compliance with contract requirements; Meridian has implemented ongoing actions to reduce findings in future audits.	
c. Identify any barriers to implementing initiatives: • Meridian is not able to discuss overview of the Annual Evaluation at Regional Provider meetings because they were cancelled due to COVID-19. To ensure network providers still receive this information, Meridian will send a notification in the monthly Provider Notification fax blast with instructions on where to access to the full Annual Evaluation for their review.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** **Meridian Health Plan** completed plans of action to address each identified deficiency and submitted the CAP timely to MDHHS. **Recommendation(s):** Although **Meridian Health Plan** demonstrated compliance with all but four of the previously noted deficiencies during the most current CAP compliance review, the ICO should continue to prioritize implementation of the plans of actions for these four program areas, and conduct ongoing audits of all program areas to ensure staff are adhering to the Medicaid managed care requirements and the requirements under the three-way contract with the ICO, MDHHS, and CMS.

3. Recommendation—Performance Improvement Projects
HSAG recommended that **Meridian Health Plan** should take proactive steps to ensure a successful QIP. Specifically, **Meridian Health Plan** should address any recommendations in the *2018–2019 QIP Validation Report Addressing Follow-Up After Hospitalization for Mental Illness for Meridian Health Plan*. HSAG also recommended the following: • To impact the Remeasurement 1 study indicator rate, **Meridian Health Plan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate. • **Meridian Health Plan** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • **Meridian Health Plan** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.

3. Recommendation—Performance Improvement Projects
• **Meridian Health Plan** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • To ensure a successful QIP, Meridian's Quality Improvement team collaborated closely with the PIHP and Meridian Care Coordination team to complete a causal/barrier analysis to identify barriers to desired outcomes and implemented interventions to address those in a timely manner. In Meridian's most recent QIP submission, five interventions have been implemented in 2019 with four continuing into 2020 and one intervention has yet to be implemented. The intervention pending is a provider education flyer that encourages providers to notify the PIHP when a member is inpatient and work with their case managers, schedule a follow-up appointment for the member and address social determinants of health. This education piece will be distributed in Q3 or Q4 of 2020. Interventions continuing into Remeasurement 2 (2020 measurement year) include: o The Care Coordination team works collaboratively with SWMBH [Southwest Michigan Behavioral Health] to outreach to all members that have been reported as having a recent inpatient behavioral health (IPBH) stay. The Care Coordination team reaches out to the members once notified of the IPBH discharge and works with the member to make sure they complete their behavioral health (BH) follow-up appointment. o Weekly teleconference between Care Coordination team and SWMBH to discuss recently admitted members, status updates, recent discharges, completed TOCs, and scheduled outpatient behavioral health appointments. The Care Management team follows each member during the weekly SWMBH meetings for 30 days or until confirmation of BH follow-up has been completed, whichever comes first. The discharge notification from SWMBH triggers the TOC process, where receiving the data from facilities is often not timely. o Recurring meetings with the PIHP to discuss ongoing collaboration, integration, and operational oversight. o Data collection from network providers through Electronic Medical Record (EMR) system access. • In Meridian's most recent QIP submission, Meridian documented the process/steps used to determine barriers to improvement and attached complete quality improvement tools, meeting minutes and data analysis results used for the causal/barrier analysis. • Meridian shows in the most recent QIP submission that improvement strategies have directly impacted the study indicator outcomes and improved the FUH rate with statistical significance by 44.2% year over year. • In Meridian's most recent QIP submission, Meridian outlined the evaluation process and outcomes to determine effectiveness of each intervention. Decisions to continue, revise or discontinue each intervention were made using data.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of initiatives implemented, the FUH rate improved by 44.2% from 2018 to 2019.

3. Recommendation—Performance Improvement Projects	
c. Identify any barriers to implementing initiatives: • COVID-19 has created unforeseen barriers for implementing initiatives including Stay at Home orders halting preventative care in early 2020 and increased fear for members to be in public places like the doctor's office. To alleviate these barriers, Meridian encourages use of telehealth. • One of the interventions implemented for the QIP was investigation for alternate contact information for members who couldn't be reached. Difficulties were experienced when gathering data for this intervention because for some members, the investigation for new demographics occurred prior to FUH intervention for reasons like assessment completion or contractual member contact. Due to the nature of this intervention occurring for many reasons and not just transition of care, this intervention will no longer be considered FUH-specific and considered discontinued.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings: Meridian Health Plan** identified barriers, implemented interventions, and successfully demonstrated statistically significant improvement in the study indicator outcomes for the first remeasurement. **Recommendation(s):** N/A

Michigan Complete Health

Table 4-5—Prior Year Recommendations and Responses for MCH

1. Recommendation—Performance Measures
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Michigan Complete Health** to members, HSAG recommended that **Michigan Complete Health** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Michigan Complete Health** identified a subset of the measures listed below and developed initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, are included as part of **Michigan Complete Health**'s quality improvement strategy within its QAPIP. Results are also reported to the Quality Improvement Committee, Compliance Committee and the Board of Directors. Domains With Measure Ratings Below the Statewide Average: • **Prevention and Screening** – *BCS—Breast Cancer Screening* – *COL—Colorectal Cancer Screening* – *COA—Care for Older Adults—Medication Review* – *COA—Care for Older Adults—Pain Assessment* • **Respiratory Conditions** – *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* – *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* – *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* • **Cardiovascular Conditions** – *CBP—Controlling High Blood Pressure* – *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* – *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* • **Diabetes** – *SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy* • **Musculoskeletal Conditions** – *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* – *OMW—Osteoporosis Management in Women Who Had a Fracture* • **Behavioral Health** – *FUH—Follow-Up After Hospitalization for Mental Illness–7 Days* – *FUH—Follow-Up After Hospitalization for Mental Illness–30 Days* • **Medication Management and Care Coordination** – *MRP—Medication Reconciliation Post-Discharge* • **Access/Availability of Care** – *AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years*

1. Recommendation—Performance Measures
– *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—Total* – *IET—Initiation of Alcohol and Other Drug Dependence Treatment* – *IET—Engagement of Alcohol and Other Drug Dependence Treatment* • **Risk-Adjusted Utilization** *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
Michigan Complete Health evaluated the findings of the HSAG report and determined that the focus areas would include the following measures within Prevention and Screening, Behavioral Health and Access to Preventative and Ambulatory Health Services. **Michigan Complete Health** selected the measures listed below to focus on in 2020. For each measure, goals were added to the quality improvement work plan with targeted interventions directed toward improving performance. These goals are being monitored and reported quarterly by the Quality Committee and results are reported to the Board of Directors. • **Prevention and Screening** – *BCS—Breast Cancer Screening* – *COA—Care for Older Adults—Medication Review* • **Behavioral Health** – *FUH—Follow-Up After Hospitalization for Mental Illness–30 Days* • **Access/Availability of Care** – *AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years* – *AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older* a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Prevention and Screening BCS—Breast Cancer Screening – Breast cancer screening was identified as an aspect of care in which member rewards might offer an incentive for the member to obtain a mammogram. Member rewards for mammogram have been in place for the 2019 and 2020 calendar year along with postcard reminders, automated calls, and member outreach activities to encourage Mammogram screening to address members' gaps in care. A 'Member Passport' is under development to send in 4Q 2020. Provider gaps in care data, including mammogram service, are available as part of Interpreta gaps in care data to primary care providers. COA—Care for Older Adults—Medication Review – During the latter half of 2018, MCH moved the pharmacy benefit management to Envolve Pharmacy which includes program of annual medication review of

1. Recommendation—Performance Measures
all members. Since that time, MCH has experienced a steady improvement in the Care for Older Adults – Medication Review measure. Behavioral Health - FUH—Follow-Up After Hospitalization for Mental Illness–30 Days. MCH has had a Quality Improvement Project underway for the last two years addressing the FUH measure. The approach has included developing relationships with the key staff at two PIHPs that service the MCH population, addressing educational initiatives to support the community mental providers through the PIHPs, identifying barriers to receiving the appropriate follow-up care, data sharing and the identification of new initiatives with each of the PIHPs that work with the MCH population. Access/Availability of Care – MCH has a multi-year Performance Improvement project to address access to care through the improvement of non-clinical services and barriers to care. Two barriers that have been addressed include member motivation to access care and services and transportation barriers to obtaining services. 1. Member rewards for annual well visits, print materials such as the Medicare Health Guide and reminders for services 2. Addressing the barriers to transportation by working with the Transportation vendor to provide 'ride recovery' through the use of Lyft services, the identification of preferred providers for members that have had poor experiences, limiting drivers at the members request as well as ongoing improvements activities with the vendor. • AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years • AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

The table below indicates the performance for each measure from calendar year 2017 to 2018 and 2019.

HEDIS Measure	*HEDIS 2018*	*HEDIS 2019*	*HEDIS 2020**	*Initiatives*
Prevention and Screening				
BCS—Breast Cancer Screening	*50.19%*	*53.81%*	*54.42%*	*Member Reward, Targeted*
COA—Care for Older Adults—	*68.37%*	*96.35%*	*95.13%*	*New PBM* [b]
Behavioral Health				
FUH—Follow-Up After	*18.00%*	*41.51%*	*40.35%*	*Collaboration with the PIHPs*
Access/Availability of Care				
AAP—Adults' Access to Preventative/Ambulatory Health Services— 45–64 Years	*89.48%*	*90.42%*	*87.66%*	*Member rewards, Medicare Health Guide and reminders for services, Transportation vendor initiatives*

1. Recommendation—Performance Measures				
AAP—Adults' Access to Preventative/Ambulatory Health Services— 65 and Older	*81.03*	*82.59%*	*84.20%*	*Member rewards, Medicare Health Guide and reminders for services, Transportation vendor initiatives*

**HEDIS 2020 was not submitted to CMS due to the COVID 19 pandemic*

c. Identify any barriers to implementing initiatives:

Prevention and Screening

- BCS—Breast Cancer Screening – there has been a delay in implementing the Member Postcard and targeted member outreach due to COVID 19 in 2020.
- COA—Care for Older Adults—Medication Review – no barriers have been identified.

Behavioral Health

- FUH—Follow-Up After Hospitalization for Mental Illness–30 Days – one barrier has been the staff turnover and changes in key contact personnel at both PIHPs in 2019 and 2020. This resulted in slower progress and the need to re-engage with the PIHPs and review the same information during multiple meetings over the last 18 months.

Access/Availability of Care

- AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years and AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older – one barrier that continues to be a challenge is obtaining accurate member contact information to promote access to services.

HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** The ICO selected a subset of measures that fell below the statewide average and developed initiatives to improve the performance of those selected measures. The selected measures, initiatives, and interventions were included as part of **Michigan Complete Health**'s quality improvement workplan. **Recommendation(s):** As **Michigan Complete Health** continues to perform below the statewide average in several measures, HSAG recommends the ICO continue with its performance improvement efforts, which may include conducting additional root cause analyses or focused studies to determine why its members are not accessing the services that are required under these performance measures. The ICO should evaluate its current improvement efforts, and implement additional interventions as needed to increase members' access to these services.

2. Recommendation—Compliance Review
Michigan Complete Health was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommended that **Michigan Complete Health** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include: • Progress on implementation of each plan of action. • Successes or barriers in remediating each deficiency. • Revised actions steps, if necessary. Once all plans of action are fully implemented, HSAG recommended that **Michigan Complete Health** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Based on the findings from the Compliance Review, a Corrective Action Plan was submitted to HASG to address all the areas of deficiencies. The action plans for the 18 of the elements that did not pass (out of a total 131 elements) was submitted. All 18 action plans have been implemented and are completed. All the actions of implementing policies, changing processes, training on the updates and changes, updating oversight plans, and developing and conducting access surveys has been implemented. Since all the actions have been implemented, they are being monitored on monthly basis to ensure continued compliance with reports on performance reviewed at the Quality Improvement Committee or Compliance Committee.
• The lowest performing standards, Coverage and Authorization of Services and Grievances and Appeals, had a common issue of ensuring appropriate timeframes were in place in our grievance and appeal policies and procedures. HSAG recommended that **Michigan Complete Health** conduct a thorough review of its grievance and appeal program policies and procedures against federal and contract requirements. The actions taken are as follows:
  • A thorough review of the grievance and appeal program policies and procedures and the UM Program against federal and contract requirements was conducted.
  • Revision of both the Grievance and Appeal policy and procedures and the UM Program to accurately the federal and contract requirements for the administration of a Grievance and Appeals program and UM decision and notification timelines occurred.
  • The development of Appeals and Grievances Re-Training Materials for all member-facing staff, especially customer service and care coordination staff.
  • Updating of letters for Appeals and Grievances.
  • Retraining of all the Quality staff on policy changes occurred.
  • Retraining the UM staff on the updates and changes to the UM program, including decision timeframes occurred.
  • Implemented tracking and complete documentation, process flow for UM decisions.
  • Monthly auditing and tracking of UM metrics including all TAT's, CR review, and determinations. This is all tracked in a UM Dashboard.

2. Recommendation—Compliance Review	
• Ongoing monitoring to ensure compliance occurs through monthly review and reporting of metrics to Leadership, the Compliance Committee and the Quality Improvement Committee. In addition, Provider Services Department implemented a secret shopper survey for appointment access and availability. The actions taken are as follows: • Developed the survey in Q4 2019. • Provider Representatives were in-serviced on the process and the calls were made to offices. • The survey was completed and results were presented to the Quality Improvement Committee. • Providers who did not meet the required performance metrics were educated on the contractually required timeframes for appointments.	
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Ongoing tracking and complete documentation, process flow for Appeals is occurring. • Correction of timeliness standard for addressing Appeals is in place and is being monitored each month. • Process for Oral Appeals has been implemented. • Grievance and Appeals tracking log shows continued compliance to timelines. Monthly Executive report shows 100% compliance since January 2020. • Monthly submission and review of the SARAG (UM timeliness) universes occurs. MMP Dashboard metrics shows 99-100% compliance since January 2020. • Metrics on complaints and UM turnaround times are included in the monthly executive report that is reviewed at the Compliance Committee and BOD [Board of Directors]. Monthly Executive Report for Member Appeals report shows 100% compliance since January 2020. Monthly Executive Report for Provider Appeals shows compliance ranging from 94%-100% since May 2020. • The Provider Secret Shopper Survey was revised to include a more comprehensive tracking tool with updated performance metrics so Provider Representatives could easily identify areas of noncompliance and conduct immediate education. • Provider Representatives were in-serviced on revised survey and processes for remediation with Providers.	
c. Identify any barriers to implementing initiatives: • Provider Secret Shopper Surveys have been on hold due to the COVID-19 pandemic. They will be reinstated once providers return to their offices.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings: Michigan Complete Health** completed plans of action to address each identified deficiency and submitted the CAP timely to MDHHS. **Recommendation(s):** Although **Michigan Complete Health** demonstrated compliance with all but two of the previously noted deficiencies during the most current CAP compliance review, the ICO should continue to conduct ongoing audits in all program areas to ensure staff are adhering to the Medicaid managed care requirements and the requirements under the three-way contract with the ICO, MDHHS, and CMS.

3. Recommendation—Performance Improvement Projects
HSAG recommended that **Michigan Complete Health** take proactive steps to ensure a successful QIP. Specifically, **Michigan Complete Health** should address any recommendations in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Michigan Complete Health*. HSAG also recommended the following: • To impact the Remeasurement 1 study indicator rate, **Michigan Complete Health** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate. • **Michigan Complete Health** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • **Michigan Complete Health** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes. • **Michigan Complete Health** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.
MCE's Response (Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Michigan Complete Health continues to take proactive steps to ensure a successful QIP and to evaluate and implement recommendations in the 2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Michigan Complete Health. HSAG recommended the following: **Recommendation 1:** To impact the Remeasurement 1 study indicator rate, Michigan Complete Health (MCH) should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate. During 2019 MCH conducted a barrier analysis to evaluate the outcomes and better understand PIHP and ICO operational and clinical initiatives that impact the FUH measures. MCH received weekly reports from both PIHPs containing detailed information related to follow-up appointment made and kept, discharge records sent to the next outpatient care provider, and complaints related to transportation events. Monthly meetings continued to allow review of the data, discussions with the PIHPs, reinforcement of the implemented initiatives and strengthening of the communications between the ICO and the PIHP **Recommendation 2:** Michigan Complete Health should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.

3. Recommendation—Performance Improvement Projects
During 2019, MCH documented processes used to determine barriers to improvement, including quality improvement tools, meeting minutes and data analysis. These materials were included in the remeasurement 1 report submitted in mid- 2020. **Recommendation 3:** Michigan Complete Health should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes. During 2019 MCH, through coordination with the delegated behavioral health vendors (the PIHPs), implemented new strategies to directly impact the outcome. These initiatives included PIHP care coordinator post-hospital visits and checklists, the development of a Mental Health Resource Toolkit for members, and the development of a transportation tip sheet for the care coordinators. **Recommendation 4:** Michigan Complete Health should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven. During 2019, MCH developed leading indicators to evaluate month to month performance to evaluate the performance of the initiatives.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): A. PIHP Care Coordinator (CC) to utilize a Checklist for Post-Hospital Follow-Up Visits: 96% of members (51 out of 56 members) scheduled a follow up visit for Wayne County and 100% (27 members) scheduled a DC [discharge] after care appointment for Macomb. B. PIHP CC to utilize a Mental Health Resource Toolkit to educate members on mental health awareness and the Importance of Medication/Follow-Up Aftercare adherence to appointment for mental health recovery and stability. 1. Macomb County members were more compliant with keeping their initial follow up appointment at 41% versus Wayne County member at 12%. That is to say the health plan's overall 17 members kept their Follow-up appointment resulting in a 22% rate in 2019. 2. Wayne county members' Community Mental Health (CMH) provider received 24 hour notification of member's discharge 83% of the time and Macomb County members' CMH provider was notified 67% of the time. Overall compliancy with 24 hour notification to CMH providers was 78% (62 providers out of 80 providers received timely notification in 2019. C. MCH provided a useful transportation tip sheet to the PIHP's care coordinators (CC). The transportation tip sheet contained important contact information for Logisticare [transportation vendor]. Tip sheet contained phone numbers for LogistiCare's Medical Transportation Department and 'Where's My Ride'. The 57 hospitalization events represented 44 members. Of the 44 members, there were 113 trips scheduled January-June, 68 of which were completed. There were 154 trips scheduled July-December, 117 of which were completed. From a macro-level, the utilization of the transportation benefit increased for the members with behavioral health related hospitalizations, once transportation tip sheet was made available in the second half of the year. The transportation tip sheet and use by the PIHPs, may have contributed to the increased use of the transportation benefit.

3. Recommendation—Performance Improvement Projects	
c. Identify any barriers to implementing initiatives: MCH has worked closely with the PIHPs to improve follow-up care after hospitalization for mental illness for the MMP population. The communication between the ICO and the PIHPs has helped the organization to understand the barriers to care and service for the membership. The monthly meetings have served to better understand the requirements of each organization. One identified barrier is the requirement of the PIHPs to have a PIHP Care Coordinator meet with the member post-hospitalization. This 'care coordinator visit' does not meet the HEDIS definition of an outpatient visit for follow-up after hospitalization for a serious mental illness. The visit with the care coordinator may be interpreted by the member as an outpatient visit after the hospitalization. The ICO and PIHP continue to evaluate this potential barrier to care.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** Although **Michigan Complete Health** demonstrated a slight decline over the baseline rate, the ICO analyzed data, identified barriers, and implemented interventions to support performance improvement. **Recommendation(s): Michigan Complete Health** should continue to evaluate interventions to determine if they are successful at improving the prevalence of members accessing care timely after a hospitalization. Additionally, the ICO should continue to work with the PIHPs to eliminate any noted barriers.

Molina Healthcare of Michigan

Table 4-6—Prior Year Recommendations and Responses for MOL

1. Recommendation—Performance Measures
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Molina Healthcare of Michigan** to members, HSAG recommended that **Molina Healthcare of Michigan** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Molina Healthcare of Michigan** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **Molina Healthcare of Michigan**'s quality improvement strategy within its QAPIP: **Domains With Measure Ratings Below the Statewide Average** • **Respiratory Conditions** – *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* – *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* • **Cardiovascular Conditions** – *CBP—Controlling High Blood Pressure* – *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* – *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* • **Diabetes** – *CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90* • **Musculoskeletal Conditions** – *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* • **Behavioral Health** – *AMM—Antidepressant Medication Management—Effect Acute Phase Treatment* – *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* – *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* • **Medication Management and Care Coordination** – *MRP—Medication Reconciliation Post-Discharge* • **Overuse/Appropriateness** – *PSA—Non-Recommended PSA-Based Screening of Older Men* – *DDE—Potentially Harmful Drug-Disease Interactions in the Elderly* – *DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions* • **Risk-Adjusted Utilization** – *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)* – *PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*

1. Recommendation—Performance Measures
MCE's Response (Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Molina Healthcare selected two measures CBP-Controlling High Blood Pressure and CDC-Comprehensive Diabetes Care-Blood Pressure Control <140/90 which fell below the Statewide Average and also below the NCQA 50th percentile, to work on in 2020. For each measure at least one goal was added to the quality improvement work plan with targeted interventions directed toward improved performance. The goals are monitored quarterly by the Quality Committee and the Quality Improvement Workgroup. • Ongoing Quality Improvement initiatives include: o The Provider Service and Provider Intervention teams provide medical sites with HEDIS Tip Sheet (electronically and hardcopy) and discussed during meeting with site staff, which includes steps to take to improve the blood pressure performance rates which include: ▪ Use CPT II codes to submit BP results. ▪ Take second BP reading if the first reading is high. Analysis of medical record review indicates about 86% of non-compliance BP reading did not include a second reading. ▪ Refer patients for Health Management and intervention coaching, especially those who are non-compliant with diet and medication. o Educate members regarding the Health Management program and how they can self-refer to the program.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The performance rates for the CBP-Controlling High Blood Pressure and CDC-Comprehensive Diabetes Care-Blood Pressure Control <140/90 have both improved during the HEDIS 2019 and HEDIS 2020 reporting years exceeding the NCQA 50th percentile. o The performance rate for the Controlling Blood Pressure improved from the HEDIS 2018 rate of 52.31% to the HEDIS 2019 rate of 63.26%, exceeding the 50th percentile (58.46%) by 4.8 percentage points and to the HEDIS 2020 rate of 63.02%, exceeding the 50th percentile (61.04%) by 1.97 percentage points. o The performance rate for CDC-Blood Pressure Control <140/90 improved from the HEDIS 2018 of 55.47% to the HEDIS 2019 rate of 64.96%, exceeding the NCQA 50th percentile (63.02%) by 1.94 percentage points and to the HEDIS 2020 rate of 66.26%, exceeding the 50th percentile (63.72%) by 2.54 percentage points.
c. Identify any barriers to implementing initiatives: • Barriers include: o Various billing software limit the number of codes that are allowed on a claim, so the providers often exclude the CPT II codes for the blood pressure reading. o The second blood pressure reading is not recorded for patients with a high first reading.

1. Recommendation—Performance Measures	
o Multiple reminders and discussions with clinic staff, regarding taking the second blood pressure, are needed because of the high staff turnover.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** The ICO selected a subset of measures that fell below the statewide average and developed initiatives to improve the performance of those selected measures. The selected measures, initiatives, and interventions were included as part of **Molina Healthcare of Michigan**'s quality improvement workplan. **Recommendation(s):** Although **Molina Healthcare of Michigan** demonstrated improvement in both selected measures, the *CBP-Controlling High Blood Pressure* measure continues to perform below the statewide average. HSAG recommends the ICO continue its improvement efforts, which may include conducting additional root cause analyses or focused studies to determine why its members are not accessing the services that are required under this performance measure. The ICO should implement additional interventions as needed to increase these services, or the reporting of these services.

2. Recommendation—Compliance Review
Molina Healthcare of Michigan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommended that **Molina Healthcare of Michigan** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include: • Progress on implementation of each plan of action. • Successes or barriers in remediating each deficiency. • Revised actions steps, if necessary. Once all plans of action are fully implemented, HSAG recommended that **Molina Healthcare of Michigan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.
MCE's Response (Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: According to the Compliance Review conducted by Health Services Advisory Group ("HSAG"), Molina Healthcare of Michigan ("Molina") met 105 elements and received 26 corrective action plans for remediation. Over the course of the review period, Molina updated policies and procedures, created auditing and monitoring tools, updated member and provider communications to include but not limited to member handbooks, provider manuals, and member materials to correct the 26 identified deficiencies. To date, Molina has achieved full compliance in 9 of the 11 standards or 95% total compliance score, demonstrating most program areas have the necessary policies, procedures, and initiatives in place to carry

2. Recommendation—Compliance Review	
out most required functions of the contract. The remaining two standards (i.e. Standard III-Coordination and Continuity of Care and Standard VII- Grievance and Appeals Systems) have continued opportunities for improvement. Molina continues to improve the elements of Standard III-Coordination and Continuity of Care. To date, Molina has corrected all deficiencies except for revising an audit tool to more clearly reflect the scoring pertaining to IICSP monitoring and member contact requirements based on risk stratification level. The revision and implementation of the audit tool is in progress. Molina also continues to improve the elements of Standard VII- Grievance and Appeals Systems. To date, Molina has corrected 8 of the 14 identified deficiencies notated in the report. Molina is committed to improving the handling of Appeals and Grievances. Over the past year, Molina has engaged in a standardization project to improve operations related to member Appeals and Grievances. In addition, Molina is in the process of implementing a new Appeals and Grievances software to improve tracking, reporting, and day-to-day handling of Appeals and Grievances. These efforts, in addition to the remediation of the findings and recommendations by HSAG, continues to be a priority for Molina.	
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): In summary, Molina has noted general performance improvement in the areas identified in the HSAG Compliance Review. These improvements include but is not limited to increased availability and adequacy of services, improved care coordination and authorization of services, strengthened oversight of delegated entities and more visible quality improvement program performance. In addition, Molina has noted performance improvement in its grievance and appeals systems. To date, key performance indicators that reflect the requirements of the MI Health Link program have improved and continue to show progress as corrective actions are completed.	
c. Identify any barriers to implementing initiatives: Molina has not identified any material barriers to implementing initiatives. As mentioned above for Standard VII- Grievance and Appeals Systems, Molina is in the process of standardizing and updating its system for tracking, reporting, and day-to-day handling of Appeals and Grievances. This implementation has caused a minor delay to the timeliness of completing all corrective actions.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings: Molina Healthcare of Michigan** completed plans of action to address each identified deficiency and submitted the CAP timely to MDHHS. **Recommendation(s):** Although **Molina Healthcare of Michigan** demonstrated compliance with all but seven of the previously noted deficiencies during the most current CAP compliance review, the ICO should continue to prioritize efforts around the Grievance and Appeals Systems standard, and conduct ongoing audits in all program areas to ensure staff are adhering to the Medicaid managed care requirements and the requirements under the three-way contract with the ICO, MDHHS, and CMS.

3. Recommendation—Performance Improvement Projects
HSAG recommended that **Molina Healthcare of Michigan** take proactive steps to ensure a successful QIP. Specifically, **Molina Healthcare of Michigan** should address any recommendations in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Molina Healthcare of Michigan*. HSAG also recommended the following: • **Molina Healthcare of Michigan** must ensure that all validation feedback is addressed, and necessary corrections are made prior to the next annual submission. • To impact the Remeasurement 1 study indicator rate, **Molina Healthcare of Michigan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate. • **Molina Healthcare of Michigan** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • **Molina Healthcare of Michigan** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes. • **Molina Healthcare of Michigan** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.
MCE's Response (Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **Molina Healthcare of Michigan** must ensure that all validation feedback is addressed, and necessary corrections are made prior to the next annual submission. Molina ensured that all validation feedback and recommendations within the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Molina Healthcare of Michigan* were corrected and addressed in the next annual submission to HSAG on 8/15/2020. The following is the summary of the information that was addressed: • Included language "with a mental health practitioner" in the study question. • Revised the enrollment requirement to include "*enrollment on date of discharge* through 30 days after discharge." • Updated all diagnosis and/or procedure codes needed to identify the study population. • Updated denominator description, following HEDIS specifications for discharges occurring between January 1 and December 1 of the measurement period. Clarified that members must be enrolled on the date of discharge through 30 days after discharge. • Submitted the Final Audit Report demonstrating a passing audit score for the FUH measure. To impact the Remeasurement 1 study indicator rate, **Molina Healthcare of Michigan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.

3. Recommendation—Performance Improvement Projects

Molina completed and submitted a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner.

- Molina utilized the process of identifying barriers through a fishbone diagram (i.e., Ishikawa) and brainstorming conducted within a collaborative Quality Improvement workgroup as well as internal team sessions. Through this collaborative workgroup, we worked on high-priority barriers which were to: develop a common format for data-sharing of inpatient hospital admissions for follow-up care; and coordination between the health plan and the Pre-paid Inpatient Health Plans (PIHPs) after a member's hospitalization.

Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate.

- Molina's first order of business was to determine high-priority barriers and interventions that could be impactful within 2019. As behavioral health hospitalizations are managed by the local PIHPs, it was determined that there was a lack of collaborative care coordination and clearly defined responsibilities for post-discharge coordination between Molina Care Coordinators and PIHP Support Coordinators, as well as timely data sharing. Early on, a joint workgroup for collaboration and data sharing was established to: monitor the measure, brainstorm the related barriers to goal achievement and propose and implement associated interventions. Collaboratively with the PIHPs, we developed an ongoing workgroup that contributed interventions to positively impact the measure. By convening a workgroup of key internal and external stakeholders, Molina was able to bring a spotlight to the importance of the FUH measure, to study the issue and inform the tactics and interventions. Through the workgroup, we were also successful in obtaining member discharge data through data sharing with the PIHPs on a weekly basis.

Molina Healthcare of Michigan should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.

- Molina utilized the process of identifying barriers through a fishbone diagram (i.e., Ishikawa) and brainstorming conducted within a collaborative QIP workgroup as well as internal team sessions. Within the workgroup we addressed care coordination barriers during the transition of care period and examined processes related to best practices for follow-up care. Molina supplied the Ishikawa diagram, as well as workgroup meeting minutes as part of the casual/barrier analysis.

Molina Healthcare of Michigan should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes.

Health plan interventions to improve outcomes were formed by:

- The ongoing engagement and effective communication with PIHP partners
- The need to develop interventions early on in the program
- Setting realistic timeframes for selected strategies to have an effect
- The need to enforce contracted delegation requirements with PIHPs
- Adding a financial incentive for PIHPs to improve performance
- Assessing workflow processes to determine entry points to care and to ensure adequate clinical resources are available to support the transition of care
- Members lack of understanding on how to address physical barriers to health (e.g., transportation available through health plan)

3. Recommendation—Performance Improvement Projects

- The need to educate providers, hospitals/facilities and related agencies on the importance of follow-up after discharge standards of care
- The need to consider a deeper dive into data (if feasible with available data) to determine differences between PIHP performance with possible individualized interventions for each respective entity

Through a collaborative process with the associated PIHPs, Molina developed the following interventions:

- Joint meetings instituted among key health plan and PIHP representatives, occurring monthly to discuss barriers, intervention and evaluation.
- Report prototypes developed to accommodate admission, discharge and transfer data information from PIHP stakeholders and shared with Molina. Reports are received on a weekly basis.
- Assessed workflow processes to ensure adequate clinical resources to address timely discharge planning.
  - Through a Transition of Care (ToC) Program, developed and implemented member outreach activities to promote healthy behaviors, improve members' self-management of their behavioral health illness and ensure members take an active role in their aftercare planning upon discharge
  - Telepsychiatry options were offered to members and reinforced for follow-up after hospitalization, as an alternative to the traditional 'face-to-face' model of care. As a result of COVID-19, additional emphasis was placed on the availability of telepsychiatry visits for post-discharge follow-up.
- Coordinated aftercare planning between the facility, PIHP and Health Plan Care Coordinator upon inpatient mental health admission or upon concurrent notification of the admission, to ensure members have an outpatient appointment with an appropriate behavioral health provider upon discharge from a facility and within 30 days of discharge.
- Revised delegated contract requirements by incorporating a withhold associated with the FUH measure in PIHP contract language to support FUH goal achievement.
- Engage Molina and PIHP senior leadership (e.g., CEO, CFO, CIO, Medical Directors, etc.) and key clinical leadership to discuss the importance of the FUH measure at a peer-to-peer level and develop initiatives to continue to improve the measure.

Molina Healthcare of Michigan should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.

- Exploring joint work processes and interventions was discussed and evaluated at monthly joint meetings. Modifications to the programs are also discussed during these monthly meetings. This allowed for consensus gathering of joint processes and interventions to continue, to be revised or to be discontinued.
- Molina HEDIS Operations develops and delivers a dashboard of the FUH rate. This rate is used to track progress throughout the measurement year. The dashboards tracks the FUH measure on a monthly basis and includes the current rate, the current rate compared to the same time in the prior year, a projected forecast of the final rate and a comparison of current rate to an established 'internal' goal. This data is shared with key internal and external stakeholders to measure progress towards goal. This allows all stake holders to see a 'snapshot' to determine if we are showing overall improvement with the rate and making appropriate progress.
- An internal workgroup within Molina meets and analyzes this data on a quarterly basis. This group includes key staff from functional areas within Molina including Quality, Medicare Administrative, Finance staff, Healthcare Services, as well as the Michigan Plan President.

3. Recommendation—Performance Improvement Projects
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Molina did not experience a statistically significant improvement in the study indicator of improving access to and utilization of a mental health practitioner for appropriate follow-up care. Although we implemented interventions, they did not yield the outcomes we were expecting, most likely due to the contractually required bifurcated system of medical and behavioral health care between Molina and the PIHPs. However, the measure did move in the right direction and we experienced an increase from the baseline by 3.27 percentage points (5.88% increase) and met Molina's internal goal of 56% which is the standard set forth in the *Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes (DY 2 – 5)*. While we did not experience a statistically significant improvement from our baseline, our current FUH rate of 58.88% is approximating the NCQA 2019 Quality Compass 66.67th percentile and nearing the 75th national percentile. Additionally, we were successful in addressing the two high priority system barriers identified in 2019. By convening a workgroup of key internal and external stakeholders, Molina was able to bring a spotlight to the importance of the FUH measure. Through the workgroup, we were successful in obtaining member discharge data through data sharing with the PIHPs on a weekly basis. We were successful in addressing two major high-priority barriers: • The bifurcated medical and behavioral health model of care with behavioral health services managed through the PIHPs leading to a disjointed processes and barriers to communication. • Lack of standard protocol for care coordination and communication of member behavioral health admission between associated entities and the Health Plan not receiving timely inpatient or discharge information.
c. Identify any barriers to implementing initiatives: There are systemic barriers to improving the FUH rate: • Sharing of behavioral health information is critical and is the 'backbone' to success. Behavioral health information is not complete in the current Health Information Exchanges, lacks a standard report protocol for data sharing for care coordination and suffers from behavioral health information gaps that the health plan cannot influence. • Federal and state laws protecting behavioral health information hinder information sharing. Regardless of State guidance, providers' misinterpretation of laws impedes information sharing for care coordination. • The bifurcated nature of the physical and behavioral model of care set forth in the MMP contractual guidelines for which the health plan has little influence. In order to bolster this rate and associated processes, Molina began additional intervention planning early-on. Molina re-evaluated barriers initially identified. Unfortunately, in the first and second quarters of 2020, the unforeseen COVID-19 pandemic did prevent or postpone some planned and ongoing interventions. • Some interventions were postponed, others were paused and resources were reallocated to other pressing initiatives such as crisis intervention/stabilization, the distribution of personal protective equipment, residential housing/recovery placement and support services • The inability of staff to perform follow-up due to both the furlough of staff and the lack of access to facilities • Members unwillingness/anxiety/apprehension in seeking follow-up care due to COVID-19 concerns As we meet monthly with our PIHP partners, we have recently addressed COVID-19 concerns and related changes to service delivery. We are monitoring PIHP call center volume to crises lines, inpatient volumes and

3. Recommendation—Performance Improvement Projects	
related encounters and are determining barriers encountered by providers and members, as well as providing COVID-19 specific resources during this pandemic. Transitions of Care (ToC) Programs were modified to be telephonic versus face-to-face. Molina educational material (on the importance of follow-up after hospitalization and Molina resources available) dissemination to the member by the PIHP ToC staff and facility discharge planning staff was interrupted. We expect these programs above to continue once COVID-19 restrictions are lifted at hospitals and related facilities. In the interim, to meet the needs of members and providers telepsychiatry options were offered to members and reinforced for follow-up after hospitalization, as an alternative to the traditional 'face-to-face' model of care.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings: Molina Healthcare of Michigan** analyzed data, identified barriers, implemented interventions, and successfully demonstrated slight improvement in the study indicator outcomes for the first remeasurement. **Recommendation(s): Molina Healthcare of Michigan** should continue its efforts to more closely work with the PIHPs and MDHHS, as applicable, to reduce barriers caused by the bifurcated medical and behavioral health model of care.

Upper Peninsula Health Plan

Table 4-7—Prior Year Recommendations and Responses for UPP

1. Recommendation—Performance Measures
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Upper Peninsula Health Plan** to members, HSAG recommended that **Upper Peninsula Health Plan** incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, **Upper Peninsula Health Plan** should identify a specific subset of the below measures and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of **Upper Peninsula Health Plan**'s quality improvement strategy within its QAPIP: **Domains With Measure Ratings Below the Statewide Average** • **Respiratory Conditions** – *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* – *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* • **Cardiovascular Conditions** – *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* – *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* • **Diabetes** – *CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* – *SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%* • **Behavioral Health** – *AMM—Antidepressant Medication Management—Effect Acute Phase Treatment* • **Overuse/Appropriateness** – *DDE—Potentially Harmful Drug-Disease Interactions in the Elderly* – *DAE—Use of High-Risk Medications in the Elderly—One Prescription* – *DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions* • **Access/Availability of Care** – *IET—Initiation of Alcohol and Other Drug Dependence Treatment* – *IET—Engagement of Alcohol and Other Drug Dependence Treatment*
MCE's Response (Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: *Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)* – UPHP focuses on improving spirometry testing rates in newly diagnosed members mutually served with Northcare Network, the Regional Prepaid Inpatient Health Plan (PIHP) as part of its Population Health Management (PHM) strategy. UPHP includes MHL members in the provider and member interventions and outreach for this measure. *Antidepressant Medication Management (AMM)* – UPHP

1. Recommendation—Performance Measures	
focuses on AMM as part of its PHM strategy. Interventions include MHL members as part of the target population. *Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)* – In July 2020 UPHP began targeted provider letters to prescribers. *Use of High-Risk Medications in the Elderly (DAE)* – In July 2020 UPHP began targeted provider letters to prescribers.	
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): SPR – No improvement in performance was noted in CY2019 for the SPR measure. AMM – too early to evaluate effectiveness. DDE/DAE – too early to evaluate effectiveness.	
c. Identify any barriers to implementing initiatives: UPHP noted COVID-19 as a barrier for continued provider and member outreach in CY2020, as provider practices were closed or restricted for a period of time under executive orders.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** The ICO selected a subset of measures that fell below the statewide average and developed initiatives to improve the performance of those selected measures. It was not clear based on **Upper Peninsula Health Plan**'s response, however, if the selected measures, initiatives, and interventions were included as part of the quality improvement workplan. **Recommendation(s):** As **Upper Peninsula Health Plan** continues to perform below the statewide average in several of the selected measure domains, HSAG recommends the ICO continue its current efforts to improve performance, which may include conducting additional root cause analyses or focused studies to determine why its members are not accessing the services that are required under these performance measures. The ICO should also continually evaluate its implemented interventions to ensure they are improving performance as expected. Finally, **Upper Peninsula Health Plan** should ensure its quality improvement work plan contains the selected measures, set goals, initiatives, and interventions implemented to improve performance in these areas.

2. Recommendation—Compliance Review
Upper Peninsula Health Plan was required to complete plans of action to address each deficiency and submit to MDHHS within 30 days of receipt of the final compliance report. HSAG recommended that **Upper Peninsula Health Plan** implement internal processes to periodically review the status of each plan of action; for example, completing a progress update every 45 business days. This periodic review should include: • Progress on implementation of each plan of action. • Successes or barriers in remediating each deficiency. • Revised actions steps, if necessary. Once all plans of action are fully implemented, HSAG recommended that **Upper Peninsula Health Plan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency.

2. Recommendation—Compliance Review
MCE's Response (Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*** UPHP revised and implemented policies as recommended by HSAG to ensure contractual compliance, including: Primary Care Provider Access Policy, Care Management and Coordination Policy, Utilization Management Policy, and Member Appeals policy. Staff were trained and educated on the new policies, procedures, and documentation expectations. Many staff were involved in the original audit process and exit interview to ensure consistent communication and expectations. UPHP has made changes to our provider contracts and provider manual as recommended by HSAG. We have updated our provider auditing checklist to ensure offices are monitored for all compliance elements and to ensure a thorough site visit. A PCP Secret Shopper Survey was conducted to understand our member experience when attempting to secure an appointment. A formal review schedule is being developed to include all first tier, downstream and related entities. A separate QAPIP has been developed for the MI Health Link program and this QAPIP summary is now shared with our providers. We have also changed workflows to more accurately stratify MI Health Link members and ensure documentation captures member preferences and meets all requirements of the care plan. Risk areas and corrective action plans developed in response to this audit will be added to our auditing and monitoring work plan and/or brought to the Compliance Committee for updates to ensure each deficiency has been resolved. Some initiatives are pending as a result of the COVID-19 pandemic, including onsite provider audits and meeting members face-to-face.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): The initiatives implemented as a result of the HSAG audit are projected to have more long term effects than immediate results. There were no findings immediately adversely impacting our enrollees and providers. This audit has improved our operations and we predict an increase in member engagement in their care plan, closer monitoring of our provider network and first tier, downstream and related (FDR) entities, and more appropriate stratification of our membership helping us prioritize and determine care coordination needs and resources for each member. Some of the initiatives that may have shown more immediate results have been pending due to the COVID-19 pandemic as cited above.
c. Identify any barriers to implementing initiatives: Many of the initiatives have been successfully implemented, but for those that are pending, the COVID-19 pandemic has been the biggest barrier. In general, we had to shift our resources to respond to the pandemic and keep our members, providers and employees safe. Therefore, we have not yet been able to fully implement the additional provider site visits, the in-person visits, and FDR monitoring. One barrier, non-COVID related, we

2. Recommendation—Compliance Review	
are working through is the addition of quality metrics to our recredentialed provider reports. We have included compliance findings-audit results, SIU and data analysis findings-but we continue to research and identify a way to incorporate our quality metrics into our recredentialed provider reports.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings: Upper Peninsula Health Plan** completed plans of action to address each identified deficiency and submitted the CAP timely to MDHHS. **Recommendation(s):** Although **Upper Peninsula Health Plan** demonstrated compliance with all but one of the previously noted deficiencies during the most current CAP compliance review, the ICO should continue to conduct ongoing audits of all program areas to ensure staff are adhering to the Medicaid managed care requirements and the requirements under the three-way contract with the ICO, MDHHS, and CMS.

3. Recommendation—Performance Improvement Projects
HSAG recommended that **Upper Peninsula Health Plan** take proactive steps to ensure a successful QIP. Specifically, **Upper Peninsula Health Plan** should address any recommendations in the *2018–2019 QIP Validation Report Follow-Up After Hospitalization for Mental Illness for Upper Peninsula Health Plan*. HSAG also recommended the following: • **Upper Peninsula Health Plan** must ensure that all validation feedback is addressed, and necessary corrections are made prior to the next annual submission. • To impact the Remeasurement 1 study indicator rate, **Upper Peninsula Health Plan** should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period may not have the time to impact the study indicator rate. • **Upper Peninsula Health Plan** should document the process/steps used to determine barriers to improvement and attach completed quality improvement tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • **Upper Peninsula Health Plan** should implement active, innovative improvement strategies that have the potential to directly impact study indicator outcomes. • **Upper Peninsula Health Plan** should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data-driven.
MCE's Response (Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: UPHP continues to perform well for the measure "*Follow-Up After Hospitalization for Mental Illness.*" While not significantly significant, rates increased from 74.2% to 76% for 30 day follow-up rates, despite small denominators, and surpassed Medicare-Medicaid Plan National Average CY2019 rate of 54.2%. UPHP has addressed all feedback provided in the "Points of Clarification" section for *partial met* [scores].

3. Recommendation—Performance Improvement Projects	
UPHP has conducted a causal/barrier analysis, prioritized barriers, identified and implemented interventions and continues to evaluate the effectiveness of each intervention.	
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): UPHP noted notification rates of only 74% of discharges in 2019 by NorthCare to UPHP for member follow up. Data was analyzed to determine breakdowns in notifications, which quickly resulted in process changes for 2020 to allow for more consistent notifications. UPHP and NorthCare continue to monitor notifications and will continue to measure notifications and staff outreach to identify barriers.	
c. Identify any barriers to implementing initiatives: Staff follow up and evaluation in March 2020 on training initiatives performed late in 2019 for follow up after hospitalization indicated that while the training was easy and understandable, staff are not able to use the training in their daily work due to the low volume of members that are discharged from the hospital for mental illness. An outreach script was developed for use in March 2020 to provide uniform messages to UPHP and support care management staff when making calls to members discharged from the hospital after hospitalization for mental illness. As noted above, volume of scripts run will be measured in 2020 and evaluated.	
HSAG's Assessment of Follow-Up to Prior Recommendations	
ICO adequately addressed HSAG's recommendations: ☒ Yes ☐ No	**Findings:** **Upper Peninsula Health Plan** analyzed data, identified barriers, implemented interventions, and successfully demonstrated slight improvement in the study indicator outcomes for the first remeasurement. **Recommendation(s):** N/A

5. ICO Comparative Information

In addition to performing a comprehensive assessment of the performance of each ICO, HSAG compared the findings and conclusions established for each ICO to assess the MI Health Link program. The overall findings of the seven ICOs were used to identify the overall strengths and weaknesses of the MI Health Link program and to identify areas in which MDHHS could leverage or modify the MDHHS CQS to promote improvement.

ICO EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the ICOs.

Validation of Quality Improvement Projects

For the SFY 2020 validation, the ICOs submitted Remeasurement 1 data for their ongoing state-mandated QIP topic: *Follow-Up After Hospitalization for Mental Illness*. Table 5-1 provides a comparison of the validation scores by ICO.

Table 5-1—Comparison of Validation by ICO

Overall QIP Validation Status, by ICO		Design, Implementation, and Outcomes Scores		
		Met	Partially Met	Not Met
AET	*Not Met*	*95%*	*0%*	*5%*
AMI	*Not Met*	*95%*	*0%*	*5%*
HAP	*Not Met*	*95%*	*0%*	*5%*
MER	*Met*	*100%*	*0%*	*0%*
MCH	*Not Met*	*95%*	*0%*	*5%*
MOL	*Not Met*	*95%*	*0%*	*5%*
UPP	*Not Met*	*95%*	*0%*	*5%*

The validation statuses for the ICOs that received an overall *Not Met* validation score are related to one or more critical elements not receiving a *Met* score, which impacted the overall validation status. For the SFY 2020 QIP, achieving statistically significant improvement was an MDHHS-approved critical element. Only one ICO, **Meridian Health Plan**, achieved this high level of performance improvement. However, **Aetna Better Health of Michigan**, **AmeriHealth Caritas**, **Molina Healthcare of Michigan**, and **Upper Peninsula Health Plan** all demonstrated some improvement over the baseline rate.

Performance Measures

Performance Measure Validation

The SFY 2020 PMV of Core Measure 9.1, *Emergency Department (ED) Behavioral Health Services Utilization*, MI2.3—*Members With Documented Discussion of Care Goals*, and MI3.1—*Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)* resulted in all ICOs receiving validation designations of *Reportable (R)* for all measures, indicating the measure data were compliant with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements. Additionally, HSAG assessed the ICOs' readiness to report Core Measure 9.3 and noted that there were no readiness review-related corrective actions required of the ICOs.

Table 5-2 provides the validation designations for the MI Health Link program PMV of Core Measure 9.1, MI2.3, and MI3.1.

Table 5-2—Comparison of Overall Validation Designations

ICO	Core Measure 9.1	MI2.3	MI3.1
AET	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
AMI	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
HAP	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
MER	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
MCH	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
MOL	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
UPP	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*

Performance Measure Rates

Table 5-3 provides an ICO to ICO comparison with the statewide average in 10 HEDIS measure domains. Green represents best ICO performance in comparison to the statewide average. Red represents worst ICO performance in comparison to the statewide average.

The HEDIS performance data are from RY 2018 (HEDIS 2019) and, therefore, the rates are not reflective of the MI Health Link program's current performance. Due to COVID-19, reporting of HEDIS measurement year 2020 data was not required per CMS guidance.

Table 5-3—ICO to ICO Comparison and Statewide Average

HEDIS Measure	Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MCH (%)	MOL (%)	UPP (%)
Prevention and Screening								
ABA—Adult BMI Assessment	92.70	99.03	89.05	66.46	94.40	95.86	97.32	97.57
BCS—Breast Cancer Screening	58.79	54.82	47.51	57.61	64.40	53.81	60.36	66.10
COL—Colorectal Cancer Screening	50.88	41.12	37.23	50.12	60.86	39.66	56.20	57.42
COA—Care for Older Adults—Advance Care Planning	47.24	54.99	18.98	25.06	39.66	33.82	57.66	68.61
COA—Care for Older Adults—Medication Review	73.75	59.12	47.93	61.31	83.45	96.35	79.08	90.51
COA—Care for Older Adults—Functional Status Assessment	64.24	61.80	39.90	45.26	64.23	67.40	70.56	87.83
COA—Care for Older Adults—Pain Assessment	73.71	65.69	43.07	55.23	81.75	67.88	84.91	92.70
Respiratory Conditions								
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.46	26.45	25.81	32.71	18.26	23.40	29.28	25.00
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	70.19	76.12	59.22	70.49	75.68	66.07	68.67	66.67
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	88.90	86.16	79.61	90.98	89.53	87.50	92.70	87.72
Cardiovascular Conditions								
CBP—Controlling High Blood Pressure	63.90	67.40	52.31	52.31	67.64	57.42	63.26	79.32
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	92.35	89.47	81.82	88.89	100.00	100.00	94.59	88.24
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	78.14	75.79	80.65	79.65	77.43	78.46	77.01	82.35
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[2]	74.77	70.37	77.33	73.37	78.89	74.51	75.15	75.89
Diabetes								
CDC—Comprehensive Diabetes Care—HbA1c Testing	88.73	87.10	85.89	78.28	92.46	91.26	91.24	92.21
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control**	39.12	28.71	51.82	80.17	35.04	46.72	33.09	18.98
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	51.40	63.26	38.93	15.84	56.93	45.08	54.74	67.15

HEDIS Measure	Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MCH (%)	MOL (%)	UPP (%)
CDC—Comprehensive Diabetes Care—Eye Exams	64.20	50.12	62.04	52.47	79.32	59.02	67.88	76.40
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	93.21	93.19	90.51	91.61	93.29	91.80	94.89	93.19
CDC—Comprehensive Diabetes Care—Blood Pressure Cont. <140/90	60.41	64.72	48.18	19.41	70.07	60.38	64.96	82.73
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	72.48	68.91	73.64	76.01	72.50	77.33	72.00	72.24
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[2]	75.38	73.11	71.05	70.36	76.78	82.76	75.93	80.27
Musculoskeletal Conditions								
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	70.18	72.31	63.33	59.52	80.39	60.00	67.77	82.05
OMW—Osteoporosis Management in Women Who Had a Fracture[2]	14.94	7.69	25.00	22.22	33.33	25.00	4.00	11.11
Behavioral Health								
AMM—Antidepressant Medication Management—Effect Acute Phase Treatment	61.55	60.00	56.04	52.38	65.33	83.52	60.92	62.22
AMM—Antidepressant Medication Management—Effect Continuation Phase Treatment	46.28	43.08	43.96	40.00	48.00	58.24	46.84	49.63
FUH—Follow-Up After Hospitalization for Mental Illness–7 Days	24.42	20.26	10.81	22.50	3.85	32.08	28.29	54.84
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	48.69	47.06	35.14	53.75	23.08	41.51	55.61	74.19
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	21.02	21.88	15.09	12.07	35.90	21.43	17.02	24.59
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	41.36	46.88	32.08	32.76	49.36	35.71	35.64	55.74
Medication Management and Care Coordination								
MRP—Medication Reconciliation Post-Discharge	42.40	40.63	13.14	43.31	52.55	35.28	36.01	72.02
Overuse/Appropriateness								
*PSA—Non-Recommended PSA-Based Screening of Older Men**[,2]	21.68	17.61	15.74	21.16	21.74	21.67	29.45	13.03

HEDIS Measure	Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MCH (%)	MOL (%)	UPP (%)
*DDE—Potentially Harmful Drug-Disease Interactions in the Elderly**	42.87	42.70	36.14	37.05	47.97	31.79	43.37	52.71
*DAE—Use of High-Risk Medications in the Elderly—One Prescription**	19.39	24.25	14.93	12.12	23.06	12.13	19.26	22.15
*DAE—Use of High-Risk Medications in the Elderly—At Least Two Prescriptions**	12.76	14.20	10.33	7.93	15.01	8.16	13.06	16.33
Access/Availability of Care								
AAP—Adults' Access to Preventative/Ambulatory Health Services—20–44 Years	85.00	82.06	80.75	81.88	88.52	74.73	87.37	91.56
AAP—Adults' Access to Preventative/Ambulatory Health Services—45–64 Years	94.39	93.29	90.36	92.55	96.26	90.42	96.47	95.50
AAP—Adults' Access to Preventative/Ambulatory Health Services—65 and Older	91.46	89.80	85.73	88.22	95.58	82.59	94.03	94.95
AAP—Adult' Access to Preventative/Ambulatory Health Services—Total	91.25	89.55	86.29	88.48	94.34	83.66	93.75	94.54
IET—Initiation of Alcohol and Other Drug Dependence Treatment	33.75	36.85	42.86	30.35	33.80	29.53	38.15	17.00
IET—Engagement of Alcohol and Other Drug Dependence Treatment	4.26	4.94	5.29	3.89	4.47	1.55	4.92	2.37
Risk-Adjusted Utilization								
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[1]	0.66	0.69	0.82	0.53	0.68	0.50	0.72	0.56
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[1]	0.68	0.65	0.69	0.74	0.47	0.52	0.81	0.67

*Measures where lower rates indicate better performance.

Note: Green represents best ICO performance in comparison to the statewide average. Red represents worst ICO performance in comparison to the statewide average.

Based on the ICOs' performance in the 43 measure rates within the identified domains of care, **Upper Peninsula Health Plan** demonstrated the best overall performance (highest performing ICO in 17 measure rates), while **AmeriHealth Caritas** demonstrated the worst overall performance (lowest performing ICO in 15 measure rates).

Compliance Review

HSAG calculated the MI Health Link program's overall performance in each of the 11 performance areas. Table 5-4 compares the MI Health Link program average compliance score (combined results of the SFY 2019 and SFY 2020 reviews) in each of the 11 performance areas with the compliance score achieved by each ICO. The percentages of requirements met for each of the 11 standards reviewed are provided.

Table 5-4—Summary of Combined SFY 2019 and SFY 2020 Compliance Review Results

Standard	AET	AMI	HAP	MER	MCH	MOL	UPP	MI Health Link Program
Standard I—Availability of Services	100%	100%	100%	91%	100%	100%	100%	99%
Standard II—Assurance of Adequate Capacity and Services	100%	100%	100%	100%	100%	100%	100%	100%
Standard III—Coordination and Continuity of Care	94%	94%	100%	100%	100%	94%	100%	97%
Standard IV—Coverage and Authorization of Services	100%	95%	100%	89%	89%	100%	100%	96%
Standard V—Provider Selection	90%	90%	90%	90%	100%	100%	90%	93%
Standard VI—Confidentiality	100%	100%	100%	100%	100%	100%	100%	100%
Standard VII—Grievance and Appeal Systems	100%	97%	82%	100%	100%	82%	100%	94%
Standard VIII—Subcontractual Relationships and Delegation	100%	100%	100%	100%	100%	100%	100%	100%
Standard IX—Practice Guidelines	100%	100%	100%	100%	100%	100%	100%	100%
Standard X—Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%
Standard XI—Quality Assessment and Performance Improvement Program	100%	100%	91%	100%	100%	100%	100%	99%
Total Compliance Score	**98%**	**97%**	**94%**	**97%**	**98%**	**95%**	**99%**	**97%**

Total Compliance Score—Elements scored *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each ICO's standards and for the MI Health Link program.

Indicates standards in which ICOs did not achieve full compliance.

Network Adequacy Validation

Provider Network Data Structure and Processes

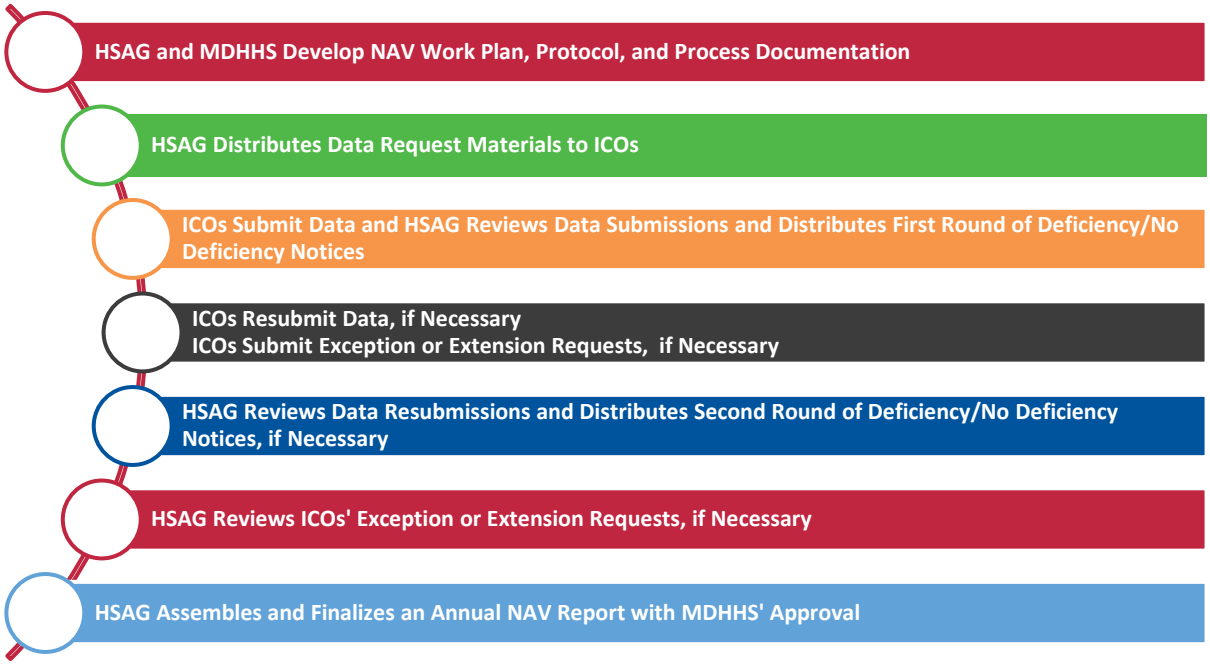
HSAG's SFY 2020 NAV activities sought to prepare for the anticipated SFY 2021 NAV activities scheduled to begin with the ICOs' October 1, 2020, network data submissions. All ICOs participated in the questionnaire process and responded to HSAG's email requests for clarification. However, **AmeriHealth Caritas**, **HAP Empowered**, and **Meridian Health Plan** opted not to include selected supplemental documentation that may have more fully supported their questionnaire responses. Among the notable questionnaire responses, the ICOs reported various strategies for documenting region-specific networks to ensure a choice of at least two providers for specific at-home services. Most of the ICOs rely on outside entities or vendors to analyze and validate ICO compliance with the two-provider minimum standard. Additionally, although the ICOs display provider information in online provider directories, members are often encouraged to use their care coordinator to find appropriate providers for behavioral health, disability, SUD, and waiver services.

In addition to implementing the provider data structure questionnaire, HSAG collaborated with MDHHS to streamline and enhance the existing data submission template and documentation. HSAG used findings from its review of the existing MDHHS NAV process documentation to inform the development of a suite of updated NAV process documentation, including the following:

- NAV data request materials, including two files for distribution to the ICOs in advance of their October 1, 2020, network data submissions.
- Eleven documents supporting HSAG's future implementation of the SFY 2021 NAV, including a work plan, NAV protocol, and sample communications that HSAG will use to notify the ICOs of their NAV results.

HSAG incorporated MDHHS' feedback into the final version for the ICOs' SFY 2021 NAV data submissions. The suite of documents aligns with HSAG's SFY 2021 NAV process for ICOs' MI Health Link Medicaid and LTSS providers, depicted in Figure 5-1.

Figure 5-1—SFY 2021 NAV Process for ICOs' MI Health Link Medicaid and LTSS Providers



Because of the qualitative and preparatory nature of the provider data structure questionnaire and the NAV process documentation enhancements, comparative performance among the ICOs was not applicable in SFY 2020. HSAG will report on the ICOs' NAV performance results beginning in SFY 2021.

Secret Shopper Survey

During September and October 2020,[5-1] HSAG completed a secret shopper telephone survey of dental providers' offices contracted with one or more ICO under the MI Health Link program to collect information on MI Health Link members' access to general dental services.

HSAG's callers attempted to contact 1,140 sampled provider locations (i.e., "cases"), with an overall response rate of 82.1 percent (936 cases) among the ICOs. Of the responsive cases, 88.6 percent (829 cases) accepted the ICO requested by the caller. Among the cases that reported accepting the ICO, 62.1 percent (515 cases) stated that the office accepted patients enrolled in the MI Health Link program. Moreover, among the survey respondents who accepted the ICO and the MI Health Link program, 93.4 percent (481 cases) reported accepting new patients, with 86.5 percent (416 cases) offering an

[5-1] Survey calls for the MI Health Link dental provider secret shopper survey were originally scheduled to take place beginning in March 2020; however, MDHHS instructed HSAG to postpone the survey due to the COVID-19 public health emergency. MDHHS approved HSAG to begin survey calls on September 9, 2020, after receiving the ICOs' confirmation that routine dental services were available.

appointment date to the caller. Additionally, survey results most affected by the COVID-19 public health emergency were related to new patient acceptance and availability, rather than dental providers' office closures.

Table 5-5 summarizes the number of survey cases and outcomes by region and ICO.

Table 5-5—Summary of Secret Shopper Survey Case Outcomes by Region and ICO

ICO	Total Survey Cases[1]	Cases Reached	Accepting ICO	Accepting MI Health Link	Accepting New Patients[2]	Cases Offered an Appointment
Region 1						
UPP	27	21	19	15	13	11
Region 1 Total	**27**	**21**	**19**	**15**	**13**	**11**
Region 4						
AET	49	36	32	20	13	6
MER	277	222	201	120	105	89
Region 4 Total	**326**	**258**	**233**	**140**	**118**	**95**
Region 7						
AET	173	133	118	77	77	66
AMI	33	26	19	17	17	16
HAP	177	143	138	71	71	66
MCH	28	21	19	16	16	16
MOL	82	72	61	51	50	44
Region 7 Total	**493**	**395**	**355**	**232**	**231**	**208**
Region 9						
AET	104	86	71	39	38	29
AMI	18	17	12	7	5	3
HAP	113	103	101	55	53	48
MCH	19	19	9	6	5	5
MOL	40	37	29	21	18	17
Region 9 Total	**294**	**262**	**222**	**128**	**119**	**102**
ICO Total[1]	**1,140**	**936**	**829**	**515**	**481**	**416**

[1]Total survey cases represent unique ICO and location combinations, as one location may have been sampled for more than one ICO in regions contracted with multiple ICOs.

[2] Sampled cases included dental provider locations from each ICO and were not limited to locations with providers that were accepting new patients.

Among cases that could be reached, were accepting the specified ICO, and accepting MI Health Link members, a relatively high percentage of cases were accepting new MI Health Link members and able to offer a preventive dental appointment within 30 calendar days. However, 63.5 percent (n=724) of overall cases were unable to be reached, did not accept the requested ICO, did not accept and/or recognize the MI Health Link program, were not accepting new patients, or were unable to offer an appointment date.

Appointment availability was reported for 86.5 percent of all cases in which the survey respondent reported that the provider location accepted the ICO, the MI Health Link program, and was accepting new patients. Table 5-6 displays the number and percentage of cases in which the survey respondent reported that the provider location offered an appointment date to new MI Health Link patients with the specified ICO for routine dental care (i.e., a dental cleaning). Appointments may have been offered with any practitioner at the sampled location.

Table 5-6—Summary of Secret Shopper Appointment Availability Results by Region and ICO

ICO	Cases Offered an Appointment		Appointment Wait Time (Calendar Days)			
	Number	Rate[1] (%)	Min[2]	Max	Average	Median
Region 1						
UPP	11	84.6	0	121	45.8	41.0
Region 1 Total	**11**	**84.6**	**0**	**121**	**45.8**	**41.0**
Region 4						
AET	6	46.2	1	77	19.5	6.0
MER	89	84.8	0	154	22.6	15.0
Region 4 Total	**95**	**80.5**	**0**	**154**	**22.4**	**15.0**
Region 7						
AET	66	85.7	1	91	18.5	14.0
AMH	16	94.1	2	37	17.8	15.0
HAP	66	93.0	0	74	18.2	12.5
MCH	16	100.0	1	79	25.4	19.5
MOL	44	88.0	1	96	23.0	19.0
Region 7 Total	**208**	**90.0**	**0**	**96**	**19.8**	**15.0**
Region 9						
AET	29	76.3	1	50	12.6	11.0
AMH	3	60.0	2	28	15.0	15.0
HAP	48	90.6	0	70	15.8	8.5
MCH	5	100.0	6	37	22.0	25.0
MOL	17	94.4	3	54	16.8	13.0
Region 9 Total	**102**	**85.7**	**0**	**70**	**15.3**	**11.0**
ICO Total	**416**	**86.5**	**0**	**154**	**20.0**	**14.0**

[1]The denominator includes cases responding to the survey that accept the ICO, accept MI Health Link, and accept new patients. Use caution when interpreting rates with denominators that include less than 10 cases.'

[2]A value of "0" indicates that the provider location offered a same-day appointment.

Based on the survey findings, MDHHS required the ICOs to develop and implement remediations for all cases in which HSAG was unable to reach the provider or no appointment date was offered. The ICOs were also expected to extend all training and oversight activities implemented for the purpose of the CAP to dental providers not included in the survey's sample.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

A comparative analysis identified whether the MI Health Link ICOs performed statistically significantly higher or lower on each measure compared to the MI Health Link program. Table 5-7 through Table 5-9 shows a summary of the statistically significant findings (noted with arrows) from the plan comparisons.

Table 5-7—Statewide Comparisons: Statistically Significant Results for Composite Measures

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
MI Health Link Program	**87.4%**	**87.5%**	**94.3%**	**92.3%**
AET	85.4%	85.5%	91.3% ↓	90.1%
AMI	87.9%	85.6%	93.8%	93.6%
HAP	86.1%	86.5%	93.2%	91.8%
MER	89.2%	87.1%	95.0%	93.1%
MCH	86.1%	87.8%	96.5% ↑	93.3%
MOL	87.3%	88.1%	95.3%	92.0%
UPP	90.6%	91.4%	96.5% ↑	95.2%

↑ *Statistically significantly above the MI Health Link Program.*
↓ *Statistically significantly below the MI Health Link Program.*

Table 5-8—Statewide Comparisons: Statistically Significant Results for Global Ratings

	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
MI Health Link Program	**69.0%**	**59.6%**	**74.0%**	**73.9%**
AET	64.0% ↓	56.2%	71.2%	71.0%
AMI	69.7%	59.0%	73.7%	67.2%
HAP	66.7%	56.2%	72.3%	70.0%
MER	71.4%	59.9%	69.9% ↓	77.8%
MCH	63.6% ↓	56.6%	74.2%	70.1%
MOL	69.6%	59.7%	76.9%	78.5%
UPP	77.9% ↑	70.5% ↑	77.7% ↑	72.8%

↑ *Statistically significantly above the MI Health Link Program.*
↓ *Statistically significantly below the MI Health Link Program.*

Table 5-9—Statewide Comparisons: Statistically Significant Results for the Individual Item Measure and Effectiveness of Care Measures

	Coordination of Care	*Advising Smokers and Tobacco Users to Quit*	*Discussing Cessation Medications*	*Discussing Cessation Strategies*
MI Health Link Program	**88.1%**	**86.5%**	**66.7%**	**54.4%**
AET	88.7%	88.7%	66.9%	55.0%
AMI	85.7%	83.6%	62.8%	52.3%
HAP	87.6%	84.4%	65.6%	57.3%
MER	90.4%	89.2%	66.5%	55.2%
MCH	83.9%	83.8%	70.4%	60.2%
MOL	86.6%	86.4%	67.3%	51.2%
UPP	93.0% ↑	85.6%	66.8%	55.9%

↑ *Statistically significantly above the MI Health Link Program.*
↓ *Statistically significantly below the MI Health Link Program.*

HCBS CAHPS Survey

Table 5-10 presents the 2020 HCBS CAHPS mean scores for the MI Health Link program using a scale from 0 to 100. A higher mean score indicates a positive response (i.e., no unmet need) and a lower mean score indicates a negative response. Higher scores indicate that members reported more positive health care experiences.

Table 5-10—Summary of 2020 HCBS CAHPS Mean Scores for the MI Health Link Program

	2020 Mean Score
Global Ratings	
Rating of Personal Assistance and Behavioral Health Staff	95.9
Rating of Homemaker	95.5*
Rating of Case Manager	96.1
Composite Measures	
Reliable and Helpful Staff	90.0
Staff Listen and Communicate Well	92.7
Helpful Case Manager	96.5
Choosing the Services that Matter to You	93.4
Transportation to Medical Appointments	87.3
Personal Safety and Respect	94.7

	2020 Mean Score
Planning Your Time and Activities	73.9
Recommendation Measures	
Recommend Personal Assistance/Behavioral Health Staff	95.9
Recommend Homemaker	90.9*
Recommend Case Manager	92.2
Unmet Need Measures	
Unmet Need in Dressing/Bathing	S
Unmet Need in Meal Preparation/Eating	S
Unmet Need in Medication Administration	S
Unmet Need in Toileting	100.0*
Unmet Need with Household Tasks	S
Physical Safety Measure	
Hit or Hurt by Staff	100.0

** Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

"S" indicates that there were fewer than 11 respondents for a measure; therefore, results were suppressed.

Statewide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of each ICO and of the overall strengths and weaknesses of the MI Health Link program related to the provision of healthcare services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise the MI Health Link program.

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified several areas of strength in the program.

- Through their participation in the state-mandated QIP, *Follow-Up After Hospitalization for Mental Illness,* the ICOs focused their efforts on specific quality outcomes—particularly timeliness and access to care and services—which should ultimately result in better health outcomes for MI Health Link program members diagnosed with, and hospitalized for, mental illness. MDHHS elected to extend the QIP to continue its focus on ensuring members receive timely follow-up care after hospitalization for mental illness. Regular evaluation and subsequent implementation of effective improvement strategies implemented over time should continue to improve the mental health and overall wellness of the ICOs' members. Overall, the ICOs designed methodologically sound QIPs supported by the use of key research principals. The ICOs also reported appropriate data collection methods, data analysis results, and implemented timely improvement strategies. Although only one ICO, **Meridian Health Plan**, has demonstrated statistically significant improvement to date, four additional ICOs (**Aetna Better Health of Michigan**, **AmeriHealth Caritas**, **Molina Healthcare of Michigan**, and **Upper Peninsula Health Plan)** demonstrated an increase in the rate of members accessing timely follow-up care with a mental health practitioner after inpatient discharge. Follow-up after inpatient discharge is important in continuity of care between treatment settings and in ensuring that members receive appropriate care and services to manage their illness. Members receiving appropriate and timely follow-up care with a mental health practitioner after discharge promotes recovery, while reducing the risk of suicide,[6-1] repeat hospitalization, and the overall cost of healthcare.
- As determined through the PMV activity, the ICOs were able to consistently and accurately report on the total number of members who visited the ED and had a primary diagnosis related to behavioral health; the total number of members with a completed care plan who also had at least one documented discussion of care plan goals; and the number of members receiving LTSS who had a

[6-1] National Action Alliance for Suicide Prevention. *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care*, November 2019. Available at: https://www.samhsa.gov/sites/default/files/suicide-risk-practices-in-care-transitions-11192019.pdf. Accessed on: Feb 24, 2021.

critical incident or abuse report. Additionally, the ICOs successfully demonstrated their readiness to report on the *Minimizing Institutional Length of Stay* measure. Accurate and meaningful information on healthcare quality is useful for the ICOs and MDHHS to identify and implement initiatives that will lead to overall improvement in the quality of care being provided to MI Health Link members.

  - All seven ICOs received validation designations of *Reportable (R)* for all measures, indicating the measure data were compliant with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements.

- Through MDHHS' annual compliance review activities, the ICOs demonstrated areas of strength in conforming to and abiding by federal Medicaid managed care and MDHHS-specific monitoring standards, which support quality, timely, and accessible care for members enrolled in the MI Health Link program. At the conclusion of the CAP review, the MI Health Link program average compliance score was 97 percent, with one ICO (**Upper Peninsula Health Plan**) receiving an overall score of 99 percent, while two additional ICOs (**Aetna Better Health of Michigan** and **Michigan Complete Health**) each scored 98 percent overall. The lowest performing ICO received an overall score of 94 percent.
  - All seven ICOs received 100 percent compliance in the Assurance of Adequate Capacity and Services, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, and Health Information Systems standards, indicating the ICOs had the systems, staff knowledge, processes, and procedures in place to effectively support full implementation of all reviewed managed care requirements in these program areas.
  - The MI Health Link average score in the Quality Assessment and Performance Improvement Program standard was 99 percent, with six ICOs receiving full compliance, suggesting most ICOs had effective quality programs in place that included quality improvement and UM policies and procedures to ensure consistency in processes, clinical practice guidelines to support decisions related to medical necessity, quality improvement evaluations and workplans to evaluate and track quality improvement initiatives and progress, QIPs to target improvement in clinical and/or nonclinical performance areas, and reporting to monitor performance with MDHHS and CMS-established performance measures.
- Through the NAV activity, MDHHS is able to more effectively discern potential areas of opportunities in the ICOs' provider networks that could not be obtained through the limited time-distance and provider count analyses activities.
  - MDHHS has more insight into the ICOs' vendor oversight processes and can use this knowledge to target additional reviews through the compliance activities.
  - MDHHS can take different approaches and/or use additional data sources for assessing network adequacy (rather than the limited time-distance and provider count analyses).
- The HCBS CAHPS Survey identified that members receiving LTSS have positive experiences with their personal assistance and behavioral health staff, homemakers, and case managers as demonstrated by the three global ratings (Rating of Personal Assistance and Behavioral Health Staff, Rating of Homemaker, and Rating of Case Manager) all receiving mean scores above 95 on a rating scale of 0 to 100.

Weaknesses

HSAG's comprehensive assessment of the ICOs and the MI Health Link program also identified areas of focus that represent significant opportunities for improvement within the program. Based on HSAG's assessment of the QIP performance and identified barriers, ICO-level PMV findings, HEDIS rates, compliance review results from SFY 2019 and SFY 2020, secret shopper survey outcomes, and CAHPS responses, as well as information obtained from the ICOs through the follow-up to EQR recommendations information, members diagnosed with mental illness may be experiencing barriers to care that deter them from accessing follow-up behavioral health services and the MI Health Link program has opportunities to improve care planning, care coordination efforts, and reporting and tracking of critical incidents.

- **Behavioral Health Services and Integration—**Although MDHHS has a vision for care integration that will bring together physical and specialty behavioral health services to better meet the whole-person needs of the members they serve, mild-to-moderate behavioral health needs are currently managed by the ICOs and MHPs, while specialty behavioral health services are provided through the PIHPs. Although the ICOs are required to contract directly with PIHPs for delivery of Medicare-covered behavioral health services, the separation of systems and responsibilities create challenges that may contribute to poor health outcomes,[6-2] especially for members with mental illness, while also posing challenges to the MI Health Link program when implementing efforts to improve program performance related to behavioral health.
  - Although the ICOs developed methodologically sound *Follow-Up After Hospitalization for Mental Illness* QIPs, the goal of demonstrating significant improvement was not achieved for six of the seven ICOs during the first remeasurement, with a decrease in performance for two of the ICOs' QIPs. The statewide performance across the QIPs indicate the quality improvement strategies do not appear to be targeting the appropriate barriers, or areas in need of improvement, to achieve the desired outcomes, and/or there may be barriers across the MI Health Link program that are inhibiting the ICOs from seeing real improvement in the prevalence of members accessing timely follow-up care after a hospitalization for mental illness.
  - While not presented within this EQR, MDHHS compared ICO statewide average results to HEDIS 2019 MMP national averages, and the statewide average for the ICOs' rates fell below the MMP national average for all measures included in the Behavioral Health domain, suggesting room for improvement in the HEDIS Behavioral Health domain. Additionally, four of the seven ICOs failed to achieve the MI Health Link program average for *FUH—Follow-Up After Hospitalization for Mental Illness–7 Days*, *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days*, and *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator rates; while three of the seven ICOs failed to meet the statewide average for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measure indicator rate.

[6-2] Michigan Department of Health and Human Services. *Michigan's Public Behavioral Health System: Proposed New Approach* (Virtual Forum), February 6, 2020. Available at: https://www.michigan.gov/documents/mdhhs/2020.02.06_Future_of_BH_680766_7.pdf. Accessed on: Feb 24, 2021.

  - As reported by the ICOs through the follow-up to EQR recommendations and QIP activity, delays in timely data sharing, lack of collaborative care coordination and clearly defined responsibilities for member management with the PIHPs could be impeding timely member follow-up and negatively impacting timely access to behavioral health services.

- **Care Management and Coordination of Care—**Care coordination is a foundation of the MI Health Link program. Every MI Health Link member has a care coordinator to assist in accessing services; provide support through care transitions; and coordinate care with existing providers and coordinating agencies, including the PIHPs. In alignment with the expectations set by MDHHS,[6-3] the ICOs' care coordinators are responsible for supporting an ongoing person-centered planning process, which includes developing a care plan that is specific to the member's needs and preferences; facilitating timely access to services and medications, and supporting transitions of care; and engaging the member in other activities or services as needed to optimize his or her health status. Additionally, ICO staff members are required by contract and Minimum Operating Standards for the MI Health Link program and MI Health Link HCBS waiver[6-4] to have procedures for identifying, preventing, and reporting member neglect, abuse, exploitation, and critical incidents. The ICOs are responsible for tracking and responding to individual critical incidents using the MI Health Link Critical Incident Reporting System. Although these robust measures have been implemented by MDHHS to ensure members in the MI Health Link program maintain optimal health, results from the EQR identified potential gaps that may lead to poor experiences of care, reduced health outcomes, and increased costs of care.
  - Although all of the ICOs received a *Reportable (R)* designation for Michigan-specific measures, MI2.3 and MI3.1, five of the ICOs had findings that resulted in resubmission of data for either MI2.3—*Members With Documented Discussion of Care Goals* or MI3.1—*Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*, indicating opportunities exist for improving care coordination system documentation and accurate reporting of measures.
  - From the SFY 2019 compliance review of all program standards, three areas required significant opportunities for statewide improvement, including the standards related to coordination and continuity of care and coverage and authorization of services. In the SFY 2020 CAP review, three ICOs continued to have deficiencies in these program areas, requiring additional remediation to ensure members were being care managed in accordance with their person-centered care and supports plan.
  - While the ICOs' remediation plans from the SFY 2020 CAP reviews supported appropriate actions and interventions to correct the previously identified deficiencies in the Subcontractual Relationships and Delegation standard, some of the ICOs' remediation plans had not been fully implemented at the time of the review. This demonstrated an overall opportunity for continued

[6-3] MI Health Link. Care Coordinator Responsibilities and Expectations. Available at: https://www.michigan.gov/documents/mdch/MI_Health_Link_Care_Coordinator_RE-FINAL_488265_7.pdf. Accessed on: Feb 25, 2021.

[6-4] Michigan Department of Health and Human Services, Medical Services Administration. *Minimum Operating Standards For MI Health Link Program and MI Health Link HCBS Waiver*, Version 8, July 22, 2019. Available at: https://www.michigan.gov/documents/mdhhs/Minimum_Operating_Standards_for_MI_Health_Link_March_2017_557197_7.pdf. Accessed on: Feb 25, 2021.

focus on the comprehensive monitoring and oversight of the ICOs' delegates, including the PIHPs and other agencies providing member-facing services. Additionally, conversations during technical assistance sessions with the ICOs and information provided in the follow-up to EQR recommendations process confirmed that enhanced collaboration, data-sharing, and timely communication are necessary to support safe and effective care for MI Health Link members, while also ensuring ICOs are meeting their obligations under their contract with MDHHS and CMS (e.g., critical incident and abuse reports, utilization data, joint care planning).

Quality Strategy Recommendations for the MI Health Link Program

The MDHHS CQS was designed to improve the health and welfare of the people of the State of Michigan and address the challenges facing the State. Through its CQS, MDHHS is focusing on population health improvement on behalf of all of the Medicaid members it serves, while accomplishing its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs. MDHHS uses three foundational principles to guide implementation of the CQS to improve the quality of care and services. The principles include:

- A focus on health equity and decreasing racial and ethnic disparities.
- Addressing social determinants of health.
- Using an integrated data-driven approach to identify opportunities and improve outcomes.

In consideration of the goals of the CQS and the comparative review of findings for all activities related to quality, timely, and accessible care and services, HSAG recommends the following quality improvement initiatives, which focus on behavioral health services and integration and care management and coordination of care, and target goals #1, #2, #3, and #4 within the MDHHS CQS.

Goal #1: Ensure high quality and high levels of access to care.

Goal #2: Strengthen person and family-centered approaches.

Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).

Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes.

- MDHHS could consider conducting a program-wide survey/interview of members who have recently received inpatient or emergency services for a behavioral health condition to determine potential barriers members have to accessing timely care.
  - Each ICO could identify and outreach to members who have received a specific set of psychiatric/behavioral health services within a designated time period (e.g., within three months).
  - MDHHS and/or the ICOs could offer an incentive for members to complete the telephonic or in-person survey.

  - MDHHS and/or MDHHS and the ICOs could develop and ask a predefined set of questions that focus on member experience while obtaining a specific set of behavioral health services, including experiences with obtaining timely behavioral services (pre- and post-visit), barriers to receiving care (e.g., lack of behavioral health providers, transportation issues, behavioral health stigma), perception of member/provider relationship (e.g., primary care provider [PCP], therapist, psychiatrist), perception of member/ICO relationship, and perception of collaboration efforts prior to/after discharge.
  - The ICOs could consider working with the PIHPs to administer the survey.
  - MDHHS and/or the ICOs could stratify survey respondents' demographics to identify any health disparities (e.g., race, ethnicity, ZIP Code).
  - MDHHS and/or the ICOs could leverage the information gained from the surveys to identify potential barriers members are experiencing when seeking specific behavioral health services and develop interventions to eliminate those barriers and support program improvement.
  - The ICOs should analyze the results of the surveys/interviews and revisit their QIPs and associated quality improvement processes to determine why significant improvement was not achieved, or a decline in performance occurred. The ICOs should make necessary changes to interventions and strategies, as applicable, to achieve the desired outcomes.
- Based on the SFY 2019 EQR findings and technical report recommendations, MDHHS elected to conduct a targeted compliance review of specific program areas in SFY 2021, including a comprehensive review of the ICOs' implementation of processes and procedures for monitoring and overseeing their delegated entities. HSAG recommends MDHHS use the SFY 2021 targeted compliance review results to develop interventions and initiatives to improve program performance, including performance related to delegation oversight processes and overall performance of the ICOs' delegates.
  - MDHHS could make contract revisions or enhancements to enforce accountability of the ICOs and their relationships with the delegates.
  - MDHHS could continue to use the MI Health Link Quality Sub-Workgroup Meeting to facilitate collaborative quality improvement discussions between the ICOs and the PIHPs, and develop subsequent initiatives or projects to improve performance related to behavioral health services (e.g., HEDIS results, utilization, member satisfaction), physical health and behavioral health integration (e.g., care planning, data-sharing, critical incident tracking and trending data, communication mechanisms), and care coordination services (e.g., responsibility grid, discharge follow-up) for the MI Health Link members.
- While MDHHS is monitoring ICO performance and statewide averages in comparison to national averages, MDHHS could consider developing a concentrated effort and focus for ICOs to align improvement efforts based on this monitoring. HSAG recommends that MDHHS focus on improvement in domains that include a significant number of measures that fall below the national average to consistently improve ICO performance overall.
  - Since the statewide average for the MI Health Link program fell below the MMP national average for all HEDIS measures included in the Behavioral Health domain, MDHHS could consider requiring the ICOs to prioritize efforts in this area to ensure the best possible overall health of its members with behavioral health conditions.

- MDHHS could consider requesting each ICO provide results of any quality improvement programs or interventions in place to address performance in the Behavioral Health domain and track any individual ICO successes for future consideration for statewide implementation.
- MDHHS could also request the results of any root cause analyses the ICOs conduct to address lower performance in any of their identified areas of weakness in the Behavioral Health domain. MDHHS could then review the program interventions in comparison to the root cases to ensure each ICO is appropriately addressing known barriers.
- MDHHS has expanded its MI Health Link program's quality withhold measures based on low performance and measures that have the greatest potential to impact a large volume of members. MDHHS should continue its efforts to implement quality initiatives that drive performance improvement and improve overall member health outcomes.

Appendix A. External Quality Review Activity Methodologies

Activity Methodologies

Validation of Quality Improvement Projects

Activity Objectives

Validating QIPs is one of the mandatory EQR activities described at 42 CFR §438.330(b)(1). In accordance with 42 CFR §438.330(d), ICOs are required to have a comprehensive QAPI program, which includes QIPs that focus on both clinical and nonclinical areas. Each QIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The EQR technical report must include information on the validation of QIPs required by the State and underway during the preceding 12 months.

The primary objective of QIP validation is to determine the ICO's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the QIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the QIP to ensure that the ICO designs, conducts, and reports the QIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the QIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported QIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the QIP. Once designed, a QIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the ICO improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's QIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities conducted by the ICO during the QIP.

MDHHS requires that each ICO conduct one QIP that is validated by HSAG. For this year's SFY 2020 validation, ICOs submitted Remeasurement 1 data for the state-mandated QIP topic, *Follow-Up After Hospitalization for Mental Illness*. The selected QIP topic utilizes the NCQA HEDIS *Follow-Up After Hospitalization for Mental Illness (FUH)* methodology. The state-mandated QIP topic addresses follow-up visits with a mental health practitioner following a hospitalization for mental illness. The goal of this QIP is to improve the percentage of discharges for which the member received a follow-up visit within 30 days after discharge. This QIP topic has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care.

HSAG conducted validation activities on the QIP Design (Steps I through VI), Implementation (Steps VII and VIII), and Outcomes (Steps IX and X) stages for each ICO. The QIP topic submitted by the ICOs addressed CMS' requirements related to quality outcomes—specifically, timeliness and access to care and services.

Technical Methods of Data Collection and Analysis

Since these QIPs were initiated in SFY 2019, the methodology used to validate QIPs was based on CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-1] Using this protocol, HSAG, in collaboration with MDHHS, developed the QIP Submission Form, which each ICO completed and submitted to HSAG for review and evaluation. The QIP Submission Form standardized the process for submitting information regarding QIPs and ensured all CMS protocol requirements were addressed.

HSAG, with MDHHS' input and approval, developed a QIP Validation Tool to ensure uniform validation of QIPs. Using this tool, HSAG evaluated each of the QIPs according to the CMS protocols. The HSAG QIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in quality improvement processes. The CMS protocols identify 10 steps that should be validated for each QIP. For the SFY 2020 submissions, the ICOs reported Remeasurement 1 data and were validated for Step I through Step IX in the QIP Validation Tool.

The 10 steps included in the QIP Validation Tool are listed below:

Step I. Appropriate Study Topic
Step II. Clearly Defined, Answerable Study Question(s)
Step III. Correctly Identified Study Population
Step IV. Clearly Defined Study Indicator(s)

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Mar 1, 2021.

Step V. Valid Sampling Techniques (if sampling was used)
Step VI. Accurate/Complete Data Collection
Step VII. Sufficient Data Analysis and Interpretation
Step VIII. Appropriate Improvement Strategies
Step IX. Real Improvement Achieved
Step X. Sustained Improvement Achieved

HSAG used the following methodology to evaluate QIPs conducted by the ICOs to determine if a QIP is valid and to rate the percentage of compliance with CMS' protocol for conducting QIPs.

Each required step is evaluated on one or more elements that form a valid QIP. The HSAG QIP review team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the QIP process as "critical elements." For a QIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the QIP of *Not Met*. The ICO is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the QIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG assigns the QIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the QIP's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported QIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported QIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Partially Met*.
- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Not Met*.

The ICOs had the opportunity to receive initial QIP validation scores, request additional technical assistance from HSAG, make any necessary corrections, and resubmit the QIP for final validation. HSAG conducted a final validation for any resubmitted QIPs and documented the findings and recommendations for each QIP. Upon completion of the final validation, HSAG prepared a report of its

findings and recommendations for each ICO. These reports, which complied with 42 CFR §438.364, were provided to MDHHS and the ICOs.

Description of Data Obtained and Related Time Period

For SFY 2020, the ICOs submitted the QIP Remeasurement 1 data (Steps I through VIII) for their QIP topic. The ICOs used the HEDIS measure specifications for the *Follow-Up After Hospitalization for Mental Illness* study indicator. HSAG obtained the data needed to conduct the QIP validation from the ICOs' QIP Summary Forms. These forms provided data and detailed information about each of the QIPs and the activities completed. The ICOs submitted each QIP Summary Form according to the approved timeline. After initial validation, the ICOs received HSAG's feedback and technical assistance, and resubmitted the QIP Summary Forms for final validation. The study indicator measurement period dates for the QIP are listed in Table A-1.

Table A-1—Description of Data Obtained and Measurement Periods

Data Obtained	Period to Which the Data Applied
Baseline	HEDIS Year 2019/Calendar Year 2018
Remeasurement 1	HEDIS Year 2020/Calendar Year 2019
Remeasurement 2	HEDIS Year 2021/Calendar Year 2020

Performance Measures

Performance Measure Validation

Activity Objectives

42 CFR §438.350(a) requires states that contract with ICOs to perform validation of performance measures as one of the mandatory EQR activities. The primary objectives of the PMV activities were to:

- Evaluate the accuracy of the performance measure data reported by the ICO.
- Determine the extent to which the specific performance measures reported by the ICO followed the State and federal specifications and reporting requirements.
- Identify overall strengths and areas for improvement in the PMV.

HSAG validated a set of performance measures that were selected by MDHHS for validation. Table A-2 lists the performance measures calculated by the ICOs for CY 2019 (i.e., January 1, 2019 through December 31, 2019), along with the performance measure number. The performance measures are numbered as they appear in the *Medicare-Medicaid Capitated Financial Alignment Reporting*

Requirements [A-2] and the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements: Michigan-Specific Reporting Requirements*[A-3] technical specification manuals. Since data were not available for one performance measure (i.e., Core Measure 9.3—*Minimizing Institutional Length of Stay*) for CY 2019, HSAG conducted a readiness review of information systems and processes used for data collection and reporting that will be used to calculate future performance measure rates.

Table A-2—Performance Measures for Validation or Readiness Review

Performance Measure	Description
Core Measure 9.1	*Emergency Department (ED) Behavioral Health Services Utilization*
Core Measure 9.3*	*Minimizing Institutional Length of Stay*
MI2.3	*Members With Documented Discussion of Care Goals*
MI3.1	*Number of Critical Incident and Abuse Reports for Members Receiving Long-Term Services and Supports (LTSS)*

*HSAG conducted a readiness review for this measure.

Technical Methods of Data Collection and Analysis

HSAG developed the PMV protocol for ICOs in accordance with the CMS *External Quality Review (EQR) Protocols, October 2019.*[A-4] The CMS Core Reporting Requirements document (issued November 1, 2019, and effective as of January 1, 2020) provides the reporting specifications that ICOs were required to follow.

The CMS PMV Protocol identifies key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of the data:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The ICOs were required to submit a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation.

[A-2] The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements*. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CoreReportingReqsCY2020.pdf. Accessed on: Mar 1, 2021.

[A-3] The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements: Michigan-Specific Reporting Requirements*. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MIReportingRequirements2019.pdf. Accessed on: Mar 1, 2021.

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 1, 2021.

Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

- **Source code (programming language) for performance measures**—ICOs that calculated the performance measures using computer programming language were required to submit source code for each performance measure being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the state-defined performance measure specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). ICOs that did not use computer programming language to calculate the performance measures were required to submit documentation describing the actions taken to calculate each measure.
- **Performance measure reports**—HSAG also reviewed the ICO performance measure reports provided by the ICOs for CY 2019. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The ICOs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each measure for data verification.

Performance Measure Activities

HSAG conducted a three-and-a-half-hour Webex review with each ICO between September 9, 2020, and September 17, 2020. HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The Webex review activities are described in sequential order below.

- **Opening session**—The opening session included introductions of the validation team and key ICO staff members involved in the PMV activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key ICO staff members familiar with the processing, monitoring, and calculation of the performance measures. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.

- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance measures was generated. HSAG performed PSV to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Primary Source Verification (PSV)**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each ICO provided HSAG with measure-level detail files that included the data the ICOs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the ICOs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and Webex review, these data were also reviewed for verification, both live and using screen shots in the ICOs' systems, which provided the ICOs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final measure reporting. Instances could exist in which a sample case is acceptable based on clarification during the Webex and follow-up documentation provided by the ICOs. Using this technique, HSAG assessed the ICOs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the ICOs have system documentation that supports that the measures appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the Webex meeting and reviewed the documentation requirements for any post-Webex activities.

Post-Webex Review Activities

- **Follow-up Documentation—**The ICOs had at least three business days after the Webex review to submit all follow-up items to HSAG. Follow-up documentation submitted by each ICO was reviewed by HSAG. This follow-up review was conducted to confirm information provided during the Webex review by the ICO. In instances when the follow-up documentation did not meet requirements to complete the validation process, additional documentation and questions were requested by HSAG, or an additional Webex review was recommended. In certain instances, ICOs had to provide multiple rounds of follow-up documentation when the prior submission failed to provide HSAG with the necessary information or data.

Final Validation Results

Based on the validation activities described above, HSAG provided each ICO a validation designation for Core Measure 9.1, MI2.3, and MI3.1. The ICO received a validation designation of either *Reportable (R)*, *Do Not Report (DNR)*, *Not Applicable (NA)*, or *Not Reported (NR)* for each performance measure. Table A-3 includes a definition of each validation designation.

Table A-3—Measure-Specific Validation Designations

Validation Designation	Definition
REPORTABLE (R)	Measure data were compliant with State and federal specifications.
DO NOT REPORT (DNR)	Measure data were materially biased and should not be reported.
NOT APPLICABLE (NA)	The ICO was not required to report the measure.
NOT REPORTED (NR)	Measure was not reported because the ICO did not offer the required benefit.

According to the protocol, the validation designation for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of *R*.

Description of Data Obtained and Related Time Period

HSAG validated data submitted for the appropriate quarterly reporting periods. The reporting periods and are specified in Table A-4.

Table A-4—Reporting Periods

Reporting Period
Quarter 1: January 1, 2019–March 31, 2019
Quarter 2: April 1, 2019–June 30, 2019
Quarter 3: July 1, 2019–September 30, 2019
Quarter 4: October 1, 2019–December 31, 2019

Performance Measure Rates

Activity Objectives

HSAG completed a review of each ICO's performance measure data that was audited by an organization licensed to conduct NCQA HEDIS Compliance Audits™,[A-5] for 2019, as provided by MDHHS, for the SFY 2020 EQR.

Technical Methods of Data Collection and Analysis

MDHHS and CMS required each ICO to contract with an organization licensed by NCQA to conduct HEDIS Compliance Audits and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS 2019 performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR.

Description of Data Obtained and Related Time Period

In accordance with the three-way contract between CMS, MDHHS, and each ICO, HEDIS data must be reported consistent with Medicare requirements. The ICOs are required to report a combined set of core measures annually. For this EQR, HSAG reviewed HEDIS 2019 reported data.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the ICOs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D and the QAPI requirements described in 42 CFR §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the seven ICOs with which MDHHS contracts.

The review standards are separated into 11 performance areas. MDHHS elected to review the full set of standards over the previous year's (SFY 2019) review as displayed in Table A-5.

[A-5] HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Table A-5—Compliance Review Standards

MI Health Link Compliance Review
Standard I—Availability of Services
Standard II—Assurance of Adequate Capacity and Services
Standard III—Coordination and Continuity of Care
Standard IV—Coverage and Authorization of Services
Standard V—Provider Selection
Standard VI—Confidentiality
Standard VII—Grievance and Appeal Systems
Standard VIII—Subcontractual Relationships and Delegation
Standard IX—Practice Guidelines
Standard X—Health Information Systems
Standard XI—Quality Assessment and Performance Improvement Program

After the SFY 2019 compliance review, ICOs were required to develop a CAP for each element that did not achieve full compliance. For the SFY 2020 review period, MDHHS requested that HSAG conduct a comprehensive desk review of the ICOs' completed SFY 2019 CAPs. The goal of this CAP activity was to ensure that each ICO achieved full compliance, to the extent possible, with all federal and State requirements reviewed as part of the compliance review activities.

This report presents the combined results of the SFY 2019 compliance review and SFY 2020 CAP review. MDHHS and the individual ICOs use the information and findings from the compliance reviews to:

- Evaluate the quality and timeliness of and access to healthcare services furnished by the ICOs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance reviews of the ICOs, HSAG developed standardized tools for use in the compliance reviews. The content of the tools was based on applicable federal Medicaid managed care regulations and the requirements set forth in the three-way contract agreement among CMS, the State of Michigan, and the ICOs. For SFY 2020, HSAG used the completed SFY 2019 CAP templates that were customized based on each ICO's performance in that review. The customized tools (progress report and CAP review templates) included only those standards for which the ICO had scored less than 100 percent and only those elements for which the ICO had scored *Not Met*. The templates were enhanced to document the ICO's progress on implementing, and HSAG's evaluation of, each plan of action. The review processes and scoring methodology used by HSAG in evaluating the ICOs'

compliance were consistent with the CMS publication, *Protocol 3. Review of Compliance With Medicaid and Chip Managed Care Regulations*: *A Mandatory EQR-Related Activity*, October 2019.[A-6]

For each of the ICOs, HSAG's desk review consisted of the following activities:

- Preparing and forwarding to each ICO a detailed timeline and description of the CAP review process.
- Reviewing each plan of action.
- Providing feedback, as needed, and approval of each plan of action.
- Preparing and forwarding to each ICO the progress report.
- Monitoring the progress of each plan of action through two progress reports submitted by the ICOs.
- Preparing and forwarding to each ICO the CAP review templates.
- Providing technical assistance to the ICOs, as requested, or as deemed required.
- Reviewing supporting documentation submitted by the ICOs for each plan of action.
- Outreaching to ICOs on elements that do not appear to meet requirements and/or require additional clarification from the ICOs after HSAG's desk review of supporting documentation.
- Reviewing additional documentation and/or ICO responses to HSAG's requests for clarification.
- Evaluating the degree to which each plan of action resulted in compliance with federal Medicaid managed care regulations and the associated MDHHS contract requirements.

Reviewers used the CAP review templates to document findings regarding ICO compliance with the standards. Based on the evaluation of findings, reviewers noted compliance with each element. The CAP review templates listed the score for each element evaluated.

HSAG evaluated and scored each element addressed in the CAP review as *Met* or *Not Met*. The overall score for each of the 11 standards was determined by totaling the number of *Met* (1 point) and *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Since only those elements that required a CAP were evaluated during the SFY 2020 CAP review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2019 review remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards. The scoring methodology used for the prior and current years' activities is displayed in Table A-6.[A-7]

[A-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid And Chip Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 1, 2021.

[A-7] Since this year's compliance review activity included a review of elements that received a score of *Not Met* during the previous year's compliance review, all scoring definitions may not apply to the CAP review (for example, case file reviews and systems demonstrations were included in the SFY 2019 reviews, but were not included in the SFY 2020 CAP review).

Table A-6—Scoring Methodology[A-8]

Compliance Score	Point Value	Definition
Met	Value = 1 point	*Met* indicates "full compliance" defined as all of the following: • All documentation and data sources reviewed, including ICO data and documentation, case file review, and systems demonstrations for a regulatory provision or component thereof are present and provide supportive evidence of congruence. • Staff members are able to provide responses to reviewers that are consistent with one another, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Value = 0 points	*Not Met* indicates "noncompliance" defined as one or more of the following: • Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision. • Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and/or do not provide sufficient evidence of congruence with the regulatory provision. Any findings of *Not Met* for these components would result in an overall finding of "noncompliance" for the provision, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The provision is required by federal or State rule, but MDHHS has indicated that the rule is still in the process of being implemented. • The requirement does not apply to the MI Health Link line of business during the review period.

Description of Data Obtained and Related Time Period

To assess the ICO's compliance with federal regulations and contract requirements, HSAG obtained information from a wide range of written documents produced by the ICO, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures

[A-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and Chip Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 1, 2021.

- Management/monitoring reports
- Member and provider materials
- Letter templates
- Narrative and/or data reports across a broad range of performance and content areas

Table A-7 lists the major data sources used by HSAG in determining the ICO's performance in complying with requirements and the time period to which the data applied.

Table A-7—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
SFY 2019 CAP	CAP submissions as of October 8, 2019
SFY 2019 CAP resubmission, if applicable	CAP submissions as of December 10, 2019
Progress Report #1	Status of each plan of action as of February 25, 2020
Progress Report #2	Status of each plan of action as of April 28, 2020
Desk review documentation	Documentation in effect as of July 31, 2020

Network Adequacy Validation

Provider Network Data Structure and Processes

Activity Objectives

HSAG's SFY 2020 NAV activities sought to prepare for the anticipated SFY 2021 NAV activities scheduled to begin with the ICOs' October 1, 2020, network data submissions. To address this goal, HSAG collaborated with MDHHS to conduct two key activities during SFY 2020 to determine how the ICOs currently collect and report data and develop documentation to standardize future data collection and analyses:

1. Develop and administer a questionnaire to collect network data structure information from the ICOs, including information on how each ICO identifies Medicaid and LTSS providers in its data systems.
2. Streamline the existing network process documentation and implement enhanced documentation for the ICOs' October 1, 2020, network adequacy reporting.

Technical Methods of Data Collection and Analysis

HSAG collaborated with MDHHS to develop a 10-element provider data structure questionnaire with the goal of eliciting targeted information regarding each ICO's provider data structure and methods for identifying and classifying providers associated with the state plan services (e.g., eye examinations) and MI Health Link waiver services (e.g., adult day programs). The questionnaire also solicited the ICOs' feedback regarding how they monitor network capacity among contracted providers (e.g., how the ICO tracks the number of individual practitioners associated with a service location for private duty nursing).

HSAG incorporated MDHHS' feedback on the draft questionnaire before distributing a final version for the ICOs' completion.

HSAG asked each ICO to complete one questionnaire, regardless of the number of regions served. Prior to distributing the questionnaire to the ICOs, HSAG hosted a webinar with the ICOs and MDHHS to describe the purpose and content of the questionnaire, as well as the expected timeline for the ICOs' participation. After receiving the completed questionnaires, HSAG reviewed the ICOs' responses and collaborated with the ICOs to resolve questions identified during HSAG's review process.

Following receipt of the ICOs' questionnaire responses, HSAG used findings from its review of the existing MDHHS NAV process documentation to inform the development of a suite of updated NAV process documentation and data request materials. HSAG incorporated MDHHS' feedback on the draft documents before distributing a final version to each ICO in August 2020. Prior to distributing the data request documents to the ICOs, HSAG hosted a webinar with the ICOs and MDHHS to describe the purpose of the NAV, updates to the existing NAV process, and the expected timeline for the ICOs' participation. ICOs were invited to ask clarifying questions regarding the updated NAV data request, and HSAG and MDHHS collaborated to supply responses during August 2020 to ensure the ICOs were allowed adequate time to prepare their October 1, 2020, NAV data submissions containing Medicaid and LTSS provider files and corresponding information on the ICOs' MI Health Link members.

Description of Data Obtained and Related Time Period

Beginning in January 2020, HSAG conducted an extensive review of MDHHS' existing network process documentation and the three-way contract between CMS, MDHHS, and the ICOs selected to deliver services to program members. HSAG also researched NAV best practices from publicly available CMS documentation.

HSAG distributed the MDHHS-approved provider data structure questionnaire to each ICO in May 2020, regarding their current provider network structures. In addition to the qualitative responses for the 10 questionnaire elements, four elements requested that the ICO include supplemental documentation supporting its responses (e.g., data layouts or sample reports).

Secret Shopper Survey

Activity Objectives

The primary purpose of the SFY 2020 secret shopper survey was to collect appointment availability information for routine dental care among new patients enrolled with an ICO under the MI Health Link program. As a secondary survey objective, HSAG evaluated the accuracy of selected provider data elements related to members' access to dental practitioners. Specific survey objectives included the following:

- Determine whether dental service locations accepted ICOs' members and the degree to which this information aligned with the ICOs' provider data.

- Determine whether dental service locations accepted new MI Health Link patients for the requested ICO.
- Determine appointment availability with the sampled dental locations for preventive dental care.

Technical Methods of Data Collection and Analysis

To address the survey objectives, HSAG conducted a secret shopper telephone survey of dental practitioners' offices contracted with ICOs serving Regions 1, 4, 7, and 9. The secret shopper approach allows for objective data collection from healthcare providers while minimizing potential bias introduced by revealing the surveyor's identity. Secret shopper callers inquired about appointment availability for routine dental care for Medicaid managed care members served by at least one of the participating ICOs.

Each ICO submitted dental provider data to HSAG, reflecting dental practitioners[A-9] actively enrolled with the ICO to serve members in the MI Health Link program as of July 15, 2020. Out-of-state dental practitioners located in Indiana, Ohio, or Wisconsin were included in the study with the exception of three providers in Ohio.[A-10] HSAG randomly selected survey cases by ICO from a de-duplicated list of unique provider locations.[A-11]

During the survey, HSAG's callers used an MDHHS-approved script to complete survey calls to all sampled provider locations, recording survey responses in an electronic data collection tool.

Description of Data Obtained and Related Time Period

Survey calls for the MI Health Link dental provider secret shopper survey were originally scheduled to take place beginning in March 2020; however, MDHHS instructed HSAG to postpone the survey due to the COVID-19 public health emergency. MDHHS approved HSAG to begin survey calls on September 9, 2020, after receiving the ICOs' confirmation that routine dental services were available. Calls were completed on October 5, 2020.

[A-9] Following HSAG's review of the ICOs' dental provider data, MDHHS confirmed that the eligible population would include general and pediatric dentists. While MI Health Link members must be 21 years of age or older, MDHHS opted to include pediatric dentists in the eligible population, as these providers may serve a limited number of adults with special healthcare needs. Dental specialists such as denturists, oral surgeons, and periodontists were excluded from the eligible population.

[A-10] Per MDHHS' direction, HSAG excluded three locations in Ohio that were located too far from the Michigan state line to be likely to supply routine dental services to ICO members.

[A-11] HSAG identified unique provider locations within each ICO and region using the telephone number and United States Postal Service (USPS) standardized address. The number of individual providers associated with each unique provider location varied.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS 5.0H Adult Medicaid Health Plan Survey

Activity Objectives

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with healthcare. The surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS surveys are recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey. The method of data collection for the CAHPS survey was a three-wave, mail-only protocol, except for sampled members that completed the survey in Spanish via computer-assisted telephone interviewing (CATI). For the CAHPS 5.0H Adult Medicaid Health Plan Survey, adult members included as eligible for the survey were 21 years of age or older as of December 31, 2019.

The survey questions were categorized into various measures of member experience. These measures included four global ratings, four composite measures, one individual item measure, and three Effectiveness of Care measures. The global ratings reflected patients' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The individual item measure is an individual question that looks at a specific area of care (i.e., *Coordination of Care*). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation in the adult population.

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite and individual item measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite and individual item question response choices were "Never," "Sometimes," "Usually," or "Always." A positive or top-box response was defined as a response of "Always" or "Usually." The percentage of top-box responses is referred to as a top-box score for the measures. For the Effectiveness of Care measures, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

Description of Data Obtained and Related Time Period

The survey was administered to eligible adult members in the MI Health Link ICOs from May to August 2020.

HCBS CAHPS Survey

Activity Objectives

The goal of the HCBS CAHPS Survey is to gather direct feedback from Medicaid members receiving HCBS about their experiences and the quality of the LTSS they receive. The survey provides state Medicaid agencies with standard individual experience metrics for HCBS programs that are applicable to all populations served by these programs, including frail elderly and people with one or more disabilities, such as physical disabilities, cognitive disabilities, intellectual impairments, or disabilities due to mental illness.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the HCBS CAHPS Survey. The method of data collection for the surveys was via CATI. Members could complete the survey over the telephone in either English or Spanish. Prior to survey administration, a pre-notification letter was sent out to members alerting them to expect a telephone call to complete the survey, and assured members that the survey was sponsored by the federal government and endorsed by MDHHS. For the HCBS CAHPS Survey, adult members included as eligible for the survey were 21 years of age or older as of April 30, 2020, and were currently enrolled in the MI Health Link program and had received at least one qualifying personal care service or were currently enrolled in the MI Health Link HCBS waiver.

The survey questions were categorized into various measures of member experience. The survey included 96 core questions that yielded 19 measures. These measures included three global ratings, seven composite measures, three recommendation measures, five unmet need measures, and one physical safety measure. The global ratings reflect overall member experience with the personal assistance and behavioral health staff, homemaker, and case manager. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "*Helpful Case Manager*" or "*Personal Safety and Respect*"). The recommendation measures evaluate whether a member would recommend their personal assistance and behavioral health staff, homemaker, or case manager to family and friends. The unmet need measures assess whether certain needs are not being met due to lack of staff. The physical safety measure evaluates whether any staff hit or hurt the member.

HSAG calculated mean scores for each measure. Mean scores were transformed to a 0 to 100 scale for each measure.

Description of Data Obtained and Related Time Period

The survey was administered to eligible adult members in the MI Health Link ICOs from June to August 2020.