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SFY 2018–2019 External Quality Review Technical Report *for* Medicaid Health Plans

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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' 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 Michigan Medicaid managed care program. The Michigan Medicaid managed care program's managed care entities include 11 Medicaid Health Plans (MHPs) contracted with MDHHS to provide medical services to Medicaid recipients in Michigan. The MHPs include:

- Aetna Better Health of Michigan
- Blue Cross Complete of Michigan
- HAP Empowered
- McLaren Health Plan
- Meridian Health Plan of Michigan
- Molina Healthcare of Michigan
- Priority Health Choice, Inc.
- Total Health Care, Inc.
- Trusted Health Plan
- UnitedHealthcare Community Plan
- Upper Peninsula Health Plan

Scope of External Quality Review (EQR) Activities

To conduct this assessment, HSAG used the results of mandatory external quality review (EQR) activities, as described in 42 CFR §438.358. The purpose of these activities, in general, is to provide valid and reliable data and information about the MHPs' performance. For the state fiscal year (SFY) 2018–2019 assessment, HSAG used findings from the following mandatory EQR activities to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each MHP. More detailed information about each activity is provided in ***Section 4*** of this report.

- **Compliance Monitoring:** MDHHS evaluated the MHPs' compliance with federal Medicaid managed care regulations using a compliance review process. HSAG examined, compiled, and analyzed the results as presented in the MHP compliance review documentation provided by MDHHS.
- **Validation of Performance Measures:** Each MHP underwent a National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] Compliance Audit™[1-2] conducted by an NCQA-licensed audit organization. HSAG performed an independent audit of the audit findings to determine the validity of each performance measure.
- **Validation of Performance Improvement Projects (PIPs):** HSAG reviewed one PIP for each MHP to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the MHPs' performance in providing quality, timely, and accessible healthcare services to Michigan Medicaid members. For each MHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MHP's performance. For a more detailed and comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MHP, please refer to ***Section 5*** of this report.

The overall findings and conclusions for all MHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Michigan Medicaid managed care program specific to the provision of medical services. For a more detailed discussion of the strengths, weaknesses, conclusions, and recommendations for the Michigan Medicaid managed care program, please refer to ***Section 6*** of this report.

Michigan Department of Health and Human Services

Program Strengths

Through completion of this annual comprehensive EQR technical report, HSAG aggregated and analyzed the performance results for the MDHHS managed care program, identifying areas of strength across the program. Through the compliance monitoring review activity, the program demonstrated areas of high performance in managing and adhering to expectations established for the Medicaid program through State and federal requirements. Specifically, the overall statewide average performance score for the six program areas reviewed was 95 percent. Only one standard, Members, scored below 90 percent.

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] HEDIS Compliance Audit™ is a trademark of NCQA.

As demonstrated through the performance measure activities, 28 of the 64 statewide rates with available national benchmarks demonstrated improvement from HEDIS 2018 to HEDIS 2019. Additionally, 14 measure rates from HEDIS 2018 to HEDIS 2019 indicated a statistically significant improvement. Statewide performance that demonstrated a statistically significant increase spanned multiple domains including Child & Adolescent Care, Access to Care, Obesity, and Living With Illness. These marked improvement efforts demonstrated the MHPs were providing more high-quality, accessible, and timely medical services than in the previous year. Multiple domains (Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, Living With Illness, and Utilization) had one or more statewide rates that performed at or above the 75th percentile, indicating members were receiving these recommended services, which can positively impact their overall health and wellbeing.

Further, through their participation in the PIP, the MHPs are focusing their efforts on improving the timeliness of prenatal care and eliminating disparities related to timely receipt of prenatal care. Through implementation of this PIP, the MHPs are implementing initiatives and interventions to support improvement in the health of pregnant women and their infants before, during, and after pregnancy.

Program Opportunities for Improvement

This annual comprehensive assessment also revealed that predominant areas of the program had opportunities for improvement when overall program performance was evaluated through the compliance monitoring review, performance measure validation (PMV), and PIP activities. Children's access to preventive care and services and pregnancy care, specifically prenatal care, are key areas of opportunity for the Michigan Medicaid managed care program.

Access to Care—Children's Preventive Services

Although 28 of the statewide performance measure rates with national benchmarks demonstrated improvement from HEDIS 2018 to HEDIS 2019, more than half of the statewide rates (36 measure rates or 56.3 percent) demonstrated a decline in performance during this time frame. Eleven measure rates in the Child & Adolescent Care domain demonstrated a statistically significant decline. These included *Childhood Immunization Status—Combination 2*, *Combination 3*, *Combination 4*, *Combination 5*, *Combination 6*, *Combination 7*, *Combination 8*, *Combination 9*, *and Combination 10*; *Lead Screening in Children*; and *Adolescent Well-Care Visits*.

Additionally, all four indicator rates within the *Children and Adolescents' Access to Primary Care Practitioners* measure demonstrated a statistically significant decline from the previous year. All indicator rates within the *Childhood Immunization Status* and *Children and Adolescents' Access to Primary Care Practitioners* measures also performed below the national Medicaid 50th percentile. Further, the *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure in the Utilization domain also ranked below the national Medicaid 50th percentile, suggesting some members may be using the emergency department (ED) for care due to challenges accessing a primary care provider (PCP).

In addition to having a sufficient network of providers available to see members in a timely manner, the MHPs must also ensure that members have accurate information available to make educated decisions about their healthcare, including current provider directory data from which to choose available providers. The SFY 2018–2019 compliance monitoring review revealed an opportunity to improve the information available in the MHPs' provider directories. The second lowest scoring program area statewide was the Providers standard, with all 11 MHPs receiving findings related to the MHP Provider Directory Accuracy category due to discrepancies between the information published in the provider directory and the information shared by provider offices through a select number of random calls. These inaccuracies in provider information could lead to potential access issues and dissatisfied members.

Pregnancy Care—Prenatal Services

As demonstrated through the PMV and PIP activities, performance related to prenatal care indicated additional opportunities for improvement. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* HEDIS performance measure experienced a statistically significant decline in performance from the SFY 2017–2018 review period. Additionally, this measure rate was below the national Medicaid 50th percentile. Nine out of 11 MHPs performed below the national Medicaid 50th percentile for the percentage of deliveries that received a timely prenatal care visit, with six MHPs performing below the national Medicaid 25th percentile. Low performance in the Pregnancy Care domain continued even with implementation of the State-mandated PIP, *Addressing Disparities in Timeliness of Prenatal Care*, in SFY 2016–2017. In SFY 2018–2019, eight of 11 MHPs did not meet their goal to reduce disparities and/or improve the timeliness of prenatal care for its pregnant members.

Program Recommendations

To improve statewide performance in the quality and timeliness of, and access to care, HSAG makes the following recommendations to MDHHS in the performance areas of Access to Care—Children's Preventive Services and Pregnancy Care—Prenatal Services. Please refer to ***Section 6*** of this report for more detailed recommendations.

Access to Care—Children's Preventive Services

- Complete and accurate provider directories are necessary for members to have adequate information that facilitates provider selection and access to care in a timely manner. MDHHS could consider expanding its provider data validation activities by conducting a review of each MHP's provider data systems and provider directories, and subsequently updating or developing guidelines regarding the collection and maintenance of provider data.
- To increase the percentage of children receiving regular preventive care from their pediatricians or PCPs, HSAG recommends MDHHS initiate a State-mandated PIP to specifically target this issue.

Pregnancy Care—Prenatal Services

- In alignment with Michigan's vision to have zero preventable maternal and infant deaths and zero health disparities, MDHHS should leverage the 2020–2023 Mother Infant Health & Equity Improvement Plan initiative and develop a Pay for Performance (P4P) Bonus Program that focuses

on the MHPs' expectations for partnering with MDHHS to achieve the goals of the 2020–2023 Mother Infant Health & Equity Improvement Plan.

Aetna Better Health of Michigan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Aetna Better Health of Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Aetna Better Health of Michigan** received a total compliance score of 94 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was below the statewide average.
- **Aetna Better Health of Michigan** scored 100 percent compliance in the Administrative standard, indicating strong performance in this program area.
- **Aetna Better Health of Michigan** scored 88 percent and 89 percent, respectively, in the Members and Management Information Systems (MIS) standards, indicating that additional focus is needed in these program areas.
- **Aetna Better Health of Michigan** was fully compliant with six out of seven evaluated Information Systems (IS) standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Aetna Better Health of Michigan**'s HEDIS performance measure reporting.
- **Aetna Better Health of Michigan** ranked at or above the 75th percentile for 11 out of 63 measure rates (17.5 percent), four of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care, Obesity, and Living With Illness domains.
- **Aetna Better Health of Michigan** had 39 out of 63 measure rates (61.9 percent) fall below the 50th percentile, 28 of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization, where rates in each of these domains fell below the 25th percentile.
- **Aetna Better Health of Michigan** received a *Met* score in 73 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

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 recommends that **Aetna Better Health of Michigan** update its quality improvement (QI) initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **Aetna Better Health of Michigan** should incorporate these improvement efforts in its QI strategy within the Quality Assessment and Performance Improvement Program (QAPIP) to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Aetna Better Health of Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **Aetna Better Health of**

Michigan's internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **Aetna Better Health of Michigan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **Aetna Better Health of Michigan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

Blue Cross Complete of Michigan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Blue Cross Complete of Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Blue Cross Complete of Michigan** received a total compliance score of 98 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was above the statewide average.
- **Blue Cross Complete of Michigan** scored 100 percent compliance in the Administrative, MIS, and Program Integrity standards, indicating strong performance in these program areas. No standards received a compliance score of less than 94 percent.
- **Blue Cross Complete of Michigan** was fully compliant with all evaluated IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Blue Cross Complete of Michigan**'s HEDIS performance measure reporting.
- **Blue Cross Complete of Michigan** ranked at or above the 75th percentile for 15 of the 63 measure rates (23.8 percent), two of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Living With Illness domain.
- **Blue Cross Complete of Michigan** had 33 of 63 measure rates (52.4 percent) fall below the 50th percentile, seven of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care, Pregnancy Care, and Living With Illness, where one or more rates in each of these domains fell below the 25th percentile.
- **Blue Cross Complete of Michigan** received a *Met* score in 90 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.
- **Blue Cross Complete of Michigan** has not yet demonstrated significant improvement in the PIP study indicator results or met the plan-specific goals for both study indicators.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Blue Cross Complete of Michigan** to members, HSAG recommends that **Blue Cross Complete of Michigan** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **Blue Cross Complete of Michigan** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals,

benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Blue Cross Complete of Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **Blue Cross Complete of Michigan**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **Blue Cross Complete of Michigan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **Blue Cross Complete of Michigan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

HAP Empowered

Based on the aggregated results of the SFY 2018–2019 EQR activities, **HAP Empowered** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **HAP Empowered** received a total compliance score of 92 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was below the statewide average.
- **HAP Empowered** scored 100 percent compliance in the Administrative, Members, and MIS standards, indicating strong performance in these program areas.
- **HAP Empowered** scored 87 percent and 88 percent, respectively, in the Providers and Program Integrity standards, indicating that additional focus is needed in these program areas.
- **HAP Empowered** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **HAP Empowered**'s HEDIS performance measure reporting.
- **HAP Empowered** ranked at or above the 75th percentile for 11 of 57 measure rates (19.3 percent), three of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Living With Illness and Utilization domains.
- **HAP Empowered** had 38 out of 57 measure rates (66.7 percent) fall below the 50th percentile, 28 of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, Pregnancy Care, and Living With Illness, where rates in each of these domains fell below the 25th percentile.
- **HAP Empowered** received a *Met* score in 91 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Improving the Timeliness of Prenatal Care for Black Women.*
- **HAP Empowered** has not yet demonstrated significant improvement in the PIP study indicator results or met the plan-specific goals for the study indicator.

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 recommends that **HAP Empowered** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **HAP Empowered** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **HAP Empowered** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **HAP Empowered**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **HAP Empowered** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **HAP Empowered** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

McLaren Health Plan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **McLaren Health Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **McLaren Health Plan** received a total compliance score of 98 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was above the statewide average.
- **McLaren Health Plan** scored 100 percent compliance in the Administrative, Members, Quality, and MIS standards, indicating strong performance in these program areas. No standards received a compliance score of less than 93 percent.
- **McLaren Health Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **McLaren Health Plan**'s HEDIS performance measure reporting.
- **McLaren Health Plan** ranked at or above the 75th percentile for five of the 64 measure rates (7.8 percent), none of which exceeded the 90th percentile.
- **McLaren Health Plan** had 30 out of 64 measure rates (46.9 percent) fall below the 50th percentile, five of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care where several rates in the domain fell below the 25th percentile.
- **McLaren Health Plan** received a *Met* score in 100 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **McLaren Health Plan** to members, HSAG recommends that **McLaren Health Plan**

update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **McLaren Health Plan** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **McLaren Health Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **McLaren Health Plan**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **McLaren Health Plan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **McLaren Health Plan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

Meridian Health Plan of Michigan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Meridian Health Plan of Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Meridian Health Plan of Michigan** received a total compliance score of 97 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was above the statewide average.
- **Meridian Health Plan of Michigan** scored 100 percent compliance in the Administrative, Quality, and MIS standards, indicating strong performance in these program areas. No standards received a compliance score of less than 94 percent.
- **Meridian Health Plan of Michigan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Meridian Health Plan of Michigan**'s HEDIS performance measure reporting.
- **Meridian Health Plan of Michigan** ranked at or above the 75th percentile for 12 of the 64 measure rates (18.8 percent), two of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care and Access to Care domains.
- **Meridian Health Plan of Michigan** had 22 of 64 measure rates (34.4 percent) fall below the 50th percentile, four of which fell below the 25th percentile. Opportunities for improvement include a focus on Living With Illness, where several rates in the domain fell below the 25th percentile.
- **Meridian Health Plan of Michigan** received a *Met* score in 95 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.
- **Meridian Health Plan of Michigan** has not yet demonstrated significant improvement in the PIP study indicator results or met the plan-specific goals for both study indicators.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Meridian Health Plan of Michigan** to members, HSAG recommends that **Meridian Health Plan of Michigan** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **Meridian Health Plan of Michigan** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Meridian Health Plan of Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **Meridian Health Plan of Michigan**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **Meridian Health Plan of Michigan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **Meridian Health Plan of Michigan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

Molina Healthcare of Michigan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Molina Healthcare of Michigan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Molina Healthcare of Michigan** received a total compliance score of 96 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was above the statewide average.
- **Molina Healthcare of Michigan** scored 100 percent compliance in the Administrative, Quality, and Program Integrity standards, indicating strong performance in these program areas.
- **Molina Healthcare of Michigan** scored 81 percent in the Members standard, indicating that additional focus is needed in this program area.
- **Molina Healthcare of Michigan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Molina Healthcare of Michigan**'s HEDIS performance measure reporting.
- **Molina Healthcare of Michigan** ranked at or above the 75th percentile for 12 of the 64 measure rates (18.8 percent), two of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care and Access to Care domains.
- **Molina Healthcare of Michigan** had 20 of 64 measure rates (31.3 percent) fall below the 50th percentile, one of which fell below the 25th percentile. Opportunities for improvement include a focus on the Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization domains.

- **Molina Healthcare of Michigan** received a *Met* score in 86 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.
- **Molina Healthcare of Michigan** has not yet demonstrated significant improvement in the PIP study indicator results or met the plan-specific goals for both study indicators.

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 recommends that **Molina Healthcare of Michigan** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **Molina Healthcare of Michigan** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Molina Healthcare of Michigan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **Molina Healthcare of Michigan**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **Molina Healthcare of Michigan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **Molina Healthcare of Michigan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

Priority Health Choice, Inc.

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Priority Health Choice, Inc.** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Priority Health Choice, Inc.** received a total compliance score of 98 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was above the statewide average. Additionally, **Priority Health Choice, Inc.** and two other MHPs were the second highest performing plans.
- **Priority Health Choice, Inc.** scored 100 percent compliance in the Administrative, Members, Quality, and Program Integrity standards, indicating strong performance in these program areas. No standards received a compliance score of less than 90 percent.
- **Priority Health Choice, Inc.** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Priority Health Choice, Inc.**'s HEDIS performance measure reporting.
- **Priority Health Choice, Inc.** ranked at or above the 75th percentile for 41 of the 63 measure rates (65.1 percent), 16 of which exceeded the 90th percentile. Measure rates that exceeded the 90th

percentile were in the Child & Adolescent Care, Access to Care, Obesity, Living With Illness, and Utilization domains.

- **Priority Health Choice, Inc.** had nine of 63 measure rates (14.3 percent) fall below the 50th percentile, seven of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care, Access to Care, and Living With Illness, where several rates in these domains fell below the 25th percentile.
- **Priority Health Choice, Inc.** received a *Met* score in 81 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Improving the Timeliness of Prenatal Care for African-American Women*.
- **Priority Health Choice, Inc.** has not yet demonstrated significant improvement in the PIP study indicator results or met the plan-specific goals for the study indicator.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Priority Health Choice, Inc.** to members, HSAG recommends that **Priority Health Choice, Inc.** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **Priority Health Choice, Inc.** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Priority Health Choice, Inc.** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **Priority Health Choice, Inc.**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **Priority Health Choice, Inc.** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **Priority Health Choice, Inc.** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

Total Health Care, Inc.

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Total Health Care, Inc.** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Total Health Care, Inc.** received a total compliance score of 99 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was above the statewide average. Additionally, **Total Health Care, Inc.** was the overall highest performing MHP.
- **Total Health Care, Inc.** scored 100 percent compliance in the Administrative, Members, Quality, MIS, and Program Integrity standards, indicating strong performance in these program areas. No standards received a compliance score of less than 97 percent.
- **Total Health Care, Inc.** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Total Health Care, Inc.**'s HEDIS performance measure reporting.
- **Total Health Care, Inc.** ranked at or above the 75th percentile for 14 of the 63 measure rates (22.2 percent), five of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Living With Illness domain.
- **Total Health Care, Inc.** had 37 of 63 measure rates (58.7 percent) fall below the 50th percentile, 18 of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization, where several rates in these domains fell below the 25th percentile.
- **Total Health Care, Inc.** received a *Met* score in 97 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Improving Timeliness of Prenatal Care for Women Ages 23 to 28.*

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Total Health Care, Inc.** to members, HSAG recommends that **Total Health Care, Inc.** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **Total Health Care, Inc.** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Total Health Care, Inc.** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **Total Health Care, Inc.**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **Total Health Care, Inc.** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **Total Health Care, Inc.** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

Trusted Health Plan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Trusted Health Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Trusted Health Plan** received a total compliance score of 81 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was below the statewide average. Additionally, **Trusted Health Plan** was the overall lowest performing MHP.
- **Trusted Health Plan** scored 100 percent compliance in the Administrative standard, indicating strong performance in this program area**.**
- **Trusted Health Plan** scored 77 percent, 13 percent, 87 percent, and 83 percent, respectively, in the Providers, Members, Quality, and MIS standards, indicating that additional focus is needed in these program areas.
- **Trusted Health Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Trusted Health Plan**'s HEDIS performance measure reporting.
- **Trusted Health Plan** ranked at or above the 75th percentile for eight of the 56 measure rates (14.3 percent), five of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Women—Adult Care, Living With Illness, and Utilization domains.
- **Trusted Health Plan** had 42 of 56 measure rates (75.0 percent) fall below the 50th percentile, 36 of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care, Women—Adult Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization, where several rates in these domains fell below the 25th percentile.
- **Trusted Health Plan** received a *Met* score in 86 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Improving the Timeliness of Prenatal Care*.
- **Trusted Health Plan** has not yet demonstrated significant improvement in the PIP study indicator results or met the plan-specific goals for the study indicator.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Trusted Health Plan** to members, HSAG recommends that **Trusted Health Plan** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **Trusted Health Plan** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Trusted Health Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **Trusted Health Plan**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart

D and 42 CFR 438.330 under Subpart E. Further, **Trusted Health Plan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **Trusted Health Plan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

UnitedHealthcare Community Plan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **UnitedHealthcare Community Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **UnitedHealthcare Community Plan** received a total compliance score of 95 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was equal to the statewide average.
- **UnitedHealthcare Community Plan** scored 100 percent compliance in the Quality and Program Integrity standards, indicating strong performance in these program areas.
- **UnitedHealthcare Community Plan** scored 87 percent and 88 percent, respectively, in the Providers and Members standards, indicating that additional focus is needed in these program areas.
- **UnitedHealthcare Community Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **UnitedHealthcare Community Plan**'s HEDIS performance measure reporting.
- **UnitedHealthcare Community Plan** ranked at or above the 75th percentile for 18 of the 64 measure rates (28.1 percent), seven of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Access to Care, Living With Illness, and Utilization domains.
- **UnitedHealthcare Community Plan** had 20 of 64 measure rates (31.3 percent) fall below the 50th percentile, one of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization, where several rates in each domain fell below the 50th percentile.
- **UnitedHealthcare Community Plan** received a *Met* score in 76 percent of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.
- **UnitedHealthcare Community Plan** has not yet demonstrated significant improvement in the PIP study indicator results or met the plan-specific goals for both study indicators.

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **UnitedHealthcare Community Plan** to members, HSAG recommends that **UnitedHealthcare Community Plan** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **UnitedHealthcare Community Plan** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for

sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **UnitedHealthcare Community Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Additionally, **UnitedHealthcare Community Plan**'s internal monitoring and auditing plan should include an annual evaluation of compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. Further, **UnitedHealthcare Community Plan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **UnitedHealthcare Community Plan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

Upper Peninsula Health Plan

Based on the aggregated results of the SFY 2018–2019 EQR activities, **Upper Peninsula Health Plan** demonstrated both strengths and weaknesses. HSAG concludes the following:

- **Upper Peninsula Health Plan** received a total compliance score of 96 percent across all program areas reviewed during the SFY 2018–2019 compliance review, which was slightly above the statewide average.
- **Upper Peninsula Health Plan** scored 100 percent compliance in the Administrative, Members, and Quality standards, indicating strong performance in these program areas.
- **Upper Peninsula Health Plan** scored 89 percent in the MIS standard, indicating that additional focus is needed in this program area.
- **Upper Peninsula Health Plan** was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's certified HEDIS compliance auditor. During review of the IS standards, the auditor identified no issues that impacted **Upper Peninsula Health Plan**'s HEDIS performance measure reporting.
- **Upper Peninsula Health Plan** ranked at or above the 75th percentile for 28 of the 63 measure rates (44.4 percent), 16 of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care, Access to Care, Obesity, Pregnancy Care, Living With Illness, and Utilization domains.
- **Upper Peninsula Health Plan** had 14 of 63 measure rates (22.2 percent) that fell below the 50th percentile, five of which fell below the 25th percentile. Opportunities for improvement include a focus on Child & Adolescent Care, Women—Adult Care, and Access to Care, where rates in these domains fell below the 25th percentile.
- **Upper Peninsula Health Plan** received a *Met* score of 100 of the applicable Design, Implementation, and Outcomes stages reviewed during the SFY 2018–2019 PIP, *Addressing Disparities in Timeliness of Prenatal Care*.

- **Upper Peninsula Health Plan** reported rates for both study indicators that met the goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups.

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 recommends that **Upper Peninsula Health Plan** update its QI initiatives to address the performance measures requiring improvement, listed in ***Section 5***. **Upper Peninsula Health Plan** should incorporate these improvement efforts in its QI strategy within the QAPIP to prioritize areas of low performance. The strategy should include data trends and root cause analyses with actionable and measurable goals, benchmarks, and interventions, addressing development and implementation of mechanisms for sustaining and spreading improvement in health outcomes, member satisfaction, and other focus areas. **Upper Peninsula Health Plan** should also develop comprehensive and effective plans of action to mitigate any deficiencies identified during the SFY 2018–2019 compliance monitoring review. Further, **Upper Peninsula Health Plan** should take proactive steps to ensure a successful PIP, including identifying any barriers to success and subsequently implementing interventions to address those barriers in a timely manner. Finally, **Upper Peninsula Health Plan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 5***.

2. Introduction to the Annual Technical Report

Purpose of Report

States that provide Medicaid services through contracts with MHPs are required to conduct EQR activities of the MHPs and to ensure that the results of those activities are used to perform an external, independent assessment and to produce an annual report. The annual assessment evaluates each MHP's performance related to the quality of, timeliness of, and access to the care and services it provides. To meet the requirement to conduct this annual evaluation and produce this report of results, MDHHS contracted with HSAG as its external quality review organization (EQRO).

Organizational Structure of Report

As mandated by CFR §438.364 and in compliance with the Centers for Medicare & Medicaid Services' (CMS') EQR protocols and the External Quality Review Toolkit for States, this technical report:

- Describes how data from EQR activities conducted in accordance with §438.358 were aggregated and analyzed by HSAG.
- Describes the scope of the EQR activities.
- Assesses each MHP's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the MHPs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the MHPs, including recommendations for each individual MHP and recommendations for MDHHS to target Michigan's Quality Strategy to improve the quality of care provided by the Michigan Medicaid managed care program.
- Contains methodological and comparative information for all MHPs.
- Assesses the degree to which each MHP has addressed the recommendations for QI made by the EQRO during the SFY 2018–2019 EQR.

This report is composed of six sections: Executive Summary, Introduction to the Annual Technical Report, Overview of the Michigan Medicaid Managed Care Program, External Quality Review Activities, Assessment of MHP Performance, and MHP Comparative Information With Recommendations for MDHHS.

Section 1—Executive Summary

The Executive Summary section presents a high-level overview of the EQR activities, conclusions, and recommendations for the MDHHS managed care program and the MHPs.

Section 2—Introduction to the Annual Technical Report

The Introduction section provides information about the purpose, contents, and organization of the annual technical report.

Section 3—Overview of Michigan Medicaid Managed Care Program

The Overview of the Michigan Medicaid Managed Care Program section gives a description of the Michigan Medicaid managed care program, brief descriptions of each of the MHPs that contract with MDHHS to provide services to members, and a brief overview of Michigan's Quality Strategy and goals for the health of Michigan's Medicaid population.

Section 4—External Quality Review Activities

The External Quality Review Activities section presents information about each of the EQR activities conducted, including the activity's objectives, technical methods of data collection and analysis, a description of the data obtained, and the time period under review.

Section 5—Assessment of MHP Performance

The Assessment of MHP Performance section presents the MHP-specific results for each of the EQR activities conducted during the SFY 2018–2019 review period.

Section 6—MHP Comparative Information With Recommendations for MDHHS

The MHP Comparative Information With Recommendations for MDHHS section presents summarized data and comparative information about the MHPs' performance. This section also identifies areas in which MDHHS could leverage or modify Michigan's Quality Strategy to promote improvement based on MHP performance.

3. Overview of Michigan Medicaid Managed Care Program

Managed Care in Michigan and Overview of MHPs

MDHHS oversees the health insurance programs for the State of Michigan. Most individuals in Michigan receiving full Medicaid benefits are enrolled in managed care through the Comprehensive Health Care Program and must choose an MHP that services their county of residence. MHPs are responsible for providing, arranging, and reimbursing most medical services, including acute, primary, and specialty services, and prescription drugs. Coverage for mental health and substance use disorder services, and long-term services and supports for Medicaid members with mental illnesses, substance use disorders, or developmental disabilities is provided through the Managed Specialty Supports and Services program through regional Prepaid Inpatient Health Plans (PIHPs). In 2014, Michigan also implemented a new 1115 demonstration to expand its Medicaid managed care program to include adults with income up to 133 percent of the federal poverty level. This program, called the Healthy Michigan Plan (HMP), provides comprehensive benefits through both the MHPs and PIHPs.

Overview of MHPs

During the SFY 2018–2019 review period, MDHHS contracted with 11 qualified MHPs. These MHPs are responsible for the provision of services to the approximately 1.8 million Michigan Medicaid managed care members. Table 3-1 provides a profile for each MHP.

Table 3-1—MHP Profiles

Medicaid Health Plan	Total Number of Members*	Covered Services	Number of Counties Served*
Aetna Better Health of Michigan	39,790	All MHPs cover medically necessary services such as the following: • Ambulance • Doctor visits • Emergency care • Family planning and pregnancy care • Health checkups • Hearing and speech • Home health and hospice care • Hospital care, including surgery • Immunizations • Laboratory and X-rays • Medical supplies • Prescriptions • Mental health • Physical and occupational therapy • Vision	16
Blue Cross Complete of Michigan	208,104		32
HAP Empowered	4,124		7
McLaren Health Plan	201,994		68
Meridian Health Plan of Michigan	489,516		68
Molina Healthcare of Michigan	332,944		68
Priority Health Choice, Inc.	125,262		20
Total Health Care, Inc.	48,364		3
Trusted Health Plan	8,682		3
UnitedHealthcare Community Plan	249,294		65
Upper Peninsula Health Plan	43,756		15

*Data obtained from the December 2019 Medicaid and Healthy Michigan Plan Health Plan Enrollment Report.

Quality Strategy

To carry out its mission to provide opportunities, services, and programs that promote a healthy, safe, and stable environment for Michigan residents to be self-sufficient, MDHHS has established six strategic priority areas. Table 3-2 outlines the MDHHS strategic priorities.

Table 3-2—MDHHS Strategic Priorities

Priorities	
Children	Ensure that Michigan youth are healthy, protected, and supported on their path to adulthood.
Adults	Safeguard, respect, and encourage the wellbeing of Michigan adults in our communities and our care.
Family Support	Support families and individuals on their road to self-sufficiency through responsive, innovative, and accessible service delivery.
Health Services	Transform the healthcare system and behavioral health coordination to improve outcomes for residents.
Population Health	Promote and protect the health, wellness, and safety of all Michigan residents.
Workforce	Strengthen opportunities, promote diversity, and empower our workforce to contribute to Michigan's economic development.

MDHHS has employed a population health management framework and contracted with high-performing health plans in order to build a Medicaid managed care delivery system that maximizes the health status of members, improves member experience, and lowers cost. Specifically, the Michigan Medicaid managed care program and its MHPs are tasked with improving the health status of members through prevention and chronic care management; improving the quality of and safety of care and services delivered to members, including special populations; improving access to care for all members; reducing disparities and increasing equity in care delivered to members; improving member engagement and satisfaction; and containing costs associated with service delivery. Through evidence- and value-based care delivery models, supported by health information technology/health information exchange (HIT/HIE) and a robust quality strategy with focused initiatives, MDHHS supports MHPs in achieving the goals of the Medicaid program and Michigan's strategic priorities. Examples of MDHHS' quality initiatives include:

- **Performance Monitoring Standards—**To monitor health plan performance in the areas of quality, access, customer service, and reporting, MDHHS has established performance monitoring standards that address MDHHS administrative measures (e.g., Member Complaints, Encounter Data Reporting), HMP-specific measures (e.g., Adults' Generic Drug Utilization, Completion of Annual Health Risk Assessment), HMP-specific dental measures (e.g., Diagnostic Dental Services, Preventive Dental Services), CMS Core Set measures, HEDIS measures including health equity

measures, and managed care quality measures (e.g., Blood Lead Testing, Non-Emergent Medical Transportation Encounter Submissions). For each performance area, MDHHS established specific measures, goals, minimum performance standards, data sources used for monitoring, and monitoring intervals. The established measures and goals align with MDHHS' strategic priorities and reflect State and national issues and focus areas.

- **Population Health Management—**The MHPs provide the spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and wellbeing. Effective utilization of these principles maintains and/or improves the physical and psychosocial wellbeing of Medicaid members through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. Population health management also includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on social determinants of health, creating health equity, and supporting efforts to build more resilient communities. MDHHS determined that housing stability was a prevalent issue associated with high ED utilizers. Homelessness was also the focus of engagement efforts between MDHHS and the National Governor's Association to determine the relationship between housing stability and healthcare costs. With the goal to improve the health of the Michigan Medicaid population and to address social determinants of health, MDHHS launched a pilot project to focus on the integration between healthcare, housing, and Medicaid. As part of this project, in SFY 2019, each MHP was required to conduct a baseline analysis activity to develop an in-depth understanding of its population that included a review of literature, data collection, gathering of member input, and analysis. Population health management interventions were subsequently developed to target findings from the analysis. In SFY 2020, on six-month intervals, the MHPs will report the results of the interventions and ongoing assessments to MDHHS.
- **Low Birth Weight Project—**In 2017, low birth weight (LBW) was identified as a target outcome associated with the 2018 P4P initiative for the MHPs. The LBW P4P initiative supports and aligns with the Medicaid Health Equity Project, initiated to promote health equity and monitor racial and ethnic disparities within the Michigan managed care population. In fiscal year (FY) 2018, the project goal was to involve the MHPs, existing home visiting programs, and community health worker programs to design and implement an initiative to improve infant health outcomes by addressing health disparities and health inequities with a particular focus on reducing the *Live Births Weighing Less Than 2,500 Grams (LBW-CH)* measure. Project activities included identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health and incorporating parties who focus on maternity care to identify and implement models of choice through collaborative processes. Through its research, the MHPs will develop interventions that focus on preconception, timeliness of prenatal care, and postpartum care. As part of this project, each MHP conducts a baseline analysis activity to develop an in-depth understanding of LBW that includes a review of literature, data collection, and analysis. LBW interventions are then developed to target findings from the analysis. At six and 12-month intervals, the MHPs report the results of the interventions and ongoing assessments to MDHHS. This project is scheduled to continue through SFY 2020.
- **ED Utilization FY 2018–FY 2020 Focus Bonus—**ED utilization provides a snapshot about quality and access issues faced by Michigan Medicaid members and their surrounding community. MDHHS' FY 2016 and FY 2017 ED utilization reduction efforts were designed for MHPs to create

a process to develop an in-depth understanding of ED utilization relative to each MHP's population, and to develop and implement interventions addressing complex issues that impact member utilization. MDHHS is continuing its efforts to address the needs of high ED utilizers in Michigan. For the next three FYs, the ED Utilization Focus Bonus will concentrate on one of three topics designed to lower inappropriate ED utilization in the Michigan Medicaid managed care population. These topics include integration with behavioral health, substance use disorder treatment, and/or dental services. Each MHP will develop initiatives to improve the effectiveness and performance of ED utilization that focus on reducing or eliminating visits associated with behavioral health, substance use disorder treatment, or dental problems and include an emphasis on the clinical and nonclinical aspects of a member's social system.

- **Cost-Sharing and Value-Based Services—**MHPs are responsible for creating and/or maintaining systems and processes to appropriately implement cost-sharing requirements and to ensure the provision of value-based services for its HMP population. The MHPs are incentivized by MDHHS for continuing to develop and maintain processes related to the collection of cost-sharing, incentives, and value-based services. As part of P4P, MHPs are reviewed on their performance related to HMP measures, tracking and confirmation that incentives are applied as required, implementing wellness programs, and assisting HMP members to meet work requirements.
- **Integration of Behavioral Health and Physical Health Services—**To ensure collaboration and integration among the MHPs and PIHPs, MDHHS developed joint expectations for both entities. These expectations include implementing joint care management processes and working collaboratively to meet set standards for follow-up after hospitalization for mental illness within 30 days of discharge. These efforts are designed to improve Medicaid member's health status, improve the member's experience of care, and reduce unnecessary costs.
- **Alternative Payment Model—**Consistent with MDHHS' initiatives to move provider reimbursement from fee-for-service to value-based payment models, the MHPs will use value-based payment models to reward providers for outcomes, including the quality of services provided, promoting the provision of appropriate services, and reducing the total cost of services provided to Medicaid members. With the ultimate goal of improving quality and outcomes while better managing costs, each MHP submitted an implementation plan to MDHHS describing its planned efforts for increasing the use of alternative payment models through SFY 2020. Additionally, each MHP submitted cost and quality data related to their alternative payment models. For SFY 2019, MDHHS will review each MHP's progress toward increasing use of alternative payment models, improving quality, and reducing costs. MDHHS has added a Care Management and Care Coordination measure and benchmark for SFY 2020.

MDHHS and the MHPs also participate in regularly scheduled meetings to collaboratively discuss and address issues dealing with the Medicaid population. Topics of discussion may include but are not limited to the MHP contract, Medicaid policy and procedure, and performance and monitoring (e.g., HEDIS, Consumer Assessment of Healthcare Providers and Systems [CAHPS®],[3-1] PIPs, etc.).

[3-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Compliance Monitoring

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 MHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement (QAPI) requirements described in 42 CFR §438.330. To meet this requirement, MDHHS performed annual compliance reviews of its 11 contracted MHPs.

The objectives of conducting compliance reviews are to ensure performance and adherence to contractual provisions as well as compliance with federal Medicaid managed care regulations. The reviews also aid in identifying areas of noncompliance and assist MHPs in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection and Analysis

MDHHS is responsible for conducting compliance activities that assess MHPs' conformity with State requirements and federal Medicaid managed care regulations. To meet this requirement, MDHHS identifies the requirements necessary for review during the SFY and divides the requirements into a 12-month compliance monitoring schedule. Annually, the MHPs are provided with a *Compliance Review Timeline* outlining the areas of focus for each month's review and the documents required to be submitted to MDHHS to demonstrate compliance.

This technical report presents the results of the compliance reviews performed during the SFY 2018–2019 contract year. MDHHS conducted a compliance review of six standards as listed below:

- Administrative
- Members
- MIS
- Program Integrity
- Providers
- Quality

MDHHS reviewers used the compliance review tool for each MHP to document its findings and to identify, when applicable, specific action(s) required of the MHP to address any areas of noncompliance with contractual requirements.

For each criterion reviewed, MDHHS assigned one of the following scores:

- *Pass*—The MHP demonstrated full compliance with the requirement(s).
- *Incomplete*—The MHP demonstrated partial compliance with the requirement(s).
- *Fail*—The MHP failed to demonstrate compliance with the requirement(s).

For certain elements within the compliance review tool, MDHHS documented *NCQA: DEEMABLE*, indicating the NCQA-accredited MHP is not required to submit documentation to demonstrate compliance.

From the *FY 2019 Compliance Review Summary* reports provided by MDHHS for each MHP, HSAG calculated a total compliance score for each standard, reflecting the degree of compliance with contractual requirements related to that area, and an overall score for each MHP across all six standards. The total compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points) or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

HSAG drew conclusions and made overall assessments about the quality and timeliness of, and access to care provided by the MHPs using MDHHS-documented findings on the compliance review tools from each standard evaluated during the compliance review.

Description of Data Obtained and Related Time Period

To assess the MHPs' compliance with federal and State requirements, MDHHS obtained information from a wide range of written documents produced by the MHPs, including but not limited to the following:

- Policies and procedures
- Accreditation certificates or letters, organizational charts, governing board member appointment documentation, and board meeting minutes
- Operational plans, health plan profiles, and management and financial reports
- Consolidated Annual Report, including financial information and member and provider incentives
- Provider contracts, network access plan, network access and provider availability documentation, and provider appeal logs
- Subcontract/delegation agreements and monitoring documentation
- Clinical practice guidelines and supporting documentation
- Member material timeliness documentation, including identification (ID) card mailings and new member packets

- Copies of member materials, including new member packets, member handbooks, member newsletters, and provider directories
- Maximum Allowable Cost (MAC) pricing reconsiderations process
- Grievance, appeal, and prior-authorization reports and notice templates
- Quality Improvement Programs (QIPs) and Utilization Management (UM) Programs, QI workplans and worksheets, utilization reports, QI effectiveness reports, and committee meeting minutes
- Enrollment and disenrollment procedures
- PIPs
- Compliance plan and employee training documentation
- Program integrity forms and reports

MDHHS also reviews each MHP's website to determine compliance in several program areas such as the provider appeal process, provider directory components, member material reading level, and website content.

Validation of Performance Measures

Activity Objectives

In accordance with 42 CFR §438.330(c), states must require that Managed Care Organizations (MCOs), PIHPs, Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Management (PCCM) entities submit performance measurement data as part of their QAPIPs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(2). For the MCO, PIHP, PAHP, and PCCM entity, the EQR technical report must include information regarding the validation of performance measures (as required by the State) and/or performance measures calculated by the State during the preceding 12 months.

The primary objectives of the PMV process are to:

- Evaluate the accuracy of the performance measure data collected by the MHP.
- Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess each MHP's support system available to report accurate HEDIS measures.

Technical Methods of Data Collection and Analysis

MDHHS required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit conducted by an NCQA-licensed audit organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's 2019 Volume 5, *HEDIS Compliance Audit: Standards, Policies and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the health plans' processes consistent with CMS' publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-1] To complete the validation of performance measure process according to the CMS protocol, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

Each NCQA HEDIS Compliance Audit was conducted by a certified HEDIS compliance auditor and included the following activities:

Pre-Review Activities: Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix V of the CMS protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. HSAG conducted a thorough review of the Roadmap and supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

On-Site Review Activities: The on-site reviews, which typically lasted one to two days, included:

- An evaluation of system compliance, focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.
- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with MHP staff members involved with any aspect of performance measure reporting.
- A closing conference at which the auditor summarized preliminary findings and recommendations.

Post-On-Site Review Activities: For each performance measure calculated and reported by the MHPs, the auditor aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The auditor assigned each measure one of

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: 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-2.pdf. Accessed on: Feb 25, 2020.

seven audit findings: (1) *Reportable* (a reportable rate was submitted for the measure), (2) *Small Denominator* (the MHP followed the specifications, but the denominator was too small [e.g., <30] to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), (4) *Not Reportable* (the MHP chose not to report the measure), (5) *Not Required* (the MHP was not required to report the measure), (6) *Biased Rate* (the calculated rate was materially biased), or (7) *Un-Audited* (the MHP chose to report a measure that is not required to be audited).

HSAG performed a comprehensive review and analysis of the MHPs' Interactive Data Submission System (IDSS) results, data submission tools, and MHP-specific NCQA HEDIS Compliance Audit reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- An NCQA-licensed audit organization completed the audit.
- An NCQA-certified HEDIS compliance auditor led the audit.
- The audit scope included all MDHHS-selected HEDIS measures.
- The audit scope focused on the Medicaid product line.
- Data were submitted via an auditor-locked NCQA IDSS.
- A final audit opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

Description of Data Obtained and Related Time Period

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table 4-1 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table 4-1—Description of Data Sources

Data Obtained	Measurement Period
NCQA HEDIS Compliance Audit reports were obtained for each MHP, which included a description of the audit process, the results of the IS findings, and the final audit designations for each performance measure.	Calendar Year (CY) 2018 (HEDIS 2019)
Performance measure reports, submitted by the MHPs using NCQA's IDSS, were analyzed and subsequently validated by HSAG.	CY 2018 (HEDIS 2019)
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2017 (HEDIS 2018)

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a QAPIP, which includes PIPs that focus on both clinical and nonclinical areas. Each PIP 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 PIPs required by the State and underway during the preceding 12 months.

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

1. HSAG evaluates the technical structure of the PIP to ensure that the MHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP 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 PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP'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 MHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP 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 QI strategies and activities conducted by the MHP during the PIP.

MDHHS requires that each MHP conduct one PIP subject to validation by HSAG. For this year's SFY 2018–2019 validation, MHPs submitted Remeasurement 1 data for the State-mandated PIP topic, *Addressing Disparities in Timeliness of Prenatal Care*. The selected PIP topic is based on the HEDIS *Prenatal and Postpartum Care* measure; however, each MHP was required to use historical data to

identify disparities within its population related to timeliness of prenatal care. Disparities could be one or more of the following:

- Race/Ethnicity/Language
- Enrollee Age
- Geographic Region

This topic has the potential to improve the health of pregnant members through increasing early initiation of prenatal care. Women who do not receive adequate or timely prenatal care are at an increased risk of complications and poor birth outcomes. The selected study topic addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The methodology used to validate PIPs was based on the 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.[4-2] Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Submission Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured all CMS PIP protocol requirements were addressed.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify 10 steps that should be validated for each PIP. For the SFY 2018–2019 submissions, the MHPs reported Remeasurement 1 data and were validated for Step I through Step IX in the PIP Validation Tool.

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

Step I.	Review the Selected Study Topic
Step II.	Review the Study Question(s)
Step III.	Review the Identified Study Population
Step IV.	Review the Selected Study Indicator(s)
Step V.	Review Sampling Methods (if sampling was used)
Step VI.	Review the Data Collection Procedures

[4-2] 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/medicaid-managed-care/externalquality-review/index.html. Accessed on: Feb 25, 2020.

Step VII.	Review Data Analysis and Interpretation of Study Results
Step VIII.	Assess the Improvement Strategies
Step IX.	Assess for Real Improvement
Step X.	Assess for Sustained Improvement

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP 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 PIP process as critical elements. For a PIP 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 of *Not Met* for the PIP. The MHP 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 PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG assigns the PIP 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 PIP's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP 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 PIP 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 MHPs had an opportunity to resubmit a revised PIP Submission Form and provide additional information or documentation in response to HSAG's initial validation scores of *Partially Met* or *Not Met*, regardless of whether the evaluation element was critical or noncritical. HSAG offered technical assistance to any MHP that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP. Six of the eleven MHPs requested and received technical assistance from HSAG.

HSAG conducted a final validation for any resubmitted PIPs and documented the findings and recommendations for each PIP. Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MHP. These reports, which complied with 42 CFR §438.364, were provided to MDHHS and the MHPs.

Description of Data Obtained and Related Time Period

For SFY 2018–2019, the MHPs submitted Remeasurement 1 data. The study indicator measurement period dates are listed below.

Table 4-2—Description of Data Obtained and Measurement Periods

Data Obtained	Period to Which the Data Applied
Baseline	November 6, 2016–November 5, 2017
Remeasurement 1	November 6, 2017–November 5, 2018
Remeasurement 2	November 6, 2018–November 5, 2019

5. Assessment of MHP Performance

Methodology

HSAG used findings across mandatory EQR activities conducted during the previous 12 months to evaluate the performance of Medicaid MHPs on providing quality, timely, and accessible healthcare services to Michigan Medicaid managed care members.

To identify strengths and weaknesses and draw conclusions for each MHP, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the Michigan Medicaid managed care program. The composite findings for each MHP were analyzed and aggregated to identify overarching conclusions and focus areas for the MHP in alignment with the priorities of MDHHS.

Aetna Better Health of Michigan (AET)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **Aetna Better Health of Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Aetna Better Health of Michigan**.

EQR Activity Results

Compliance Monitoring

Aetna Better Health of Michigan was evaluated in six program areas referred to as "standards." Table 5-1 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-1 also presents **Aetna Better Health of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-1—Compliance Review Results for AET

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	AET	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	13	1	1	15	90%	91%
3	Members	6	2	0	8	88%	87%

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	AET	Statewide
4	Quality	14	1	0	15	97%	98%
5	MIS	7	2	0	9	89%	95%
6	Program Integrity	27	1	0	28	98%	97%
Overall		**72**	**7**	**1**	**80**	**94%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Aetna Better Health of Michigan demonstrated compliance for 72 of 80 elements, with an overall compliance score of 94 percent, which was below the statewide average of 95 percent. **Aetna Better Health of Michigan** demonstrated strong performance, scoring above 90 percent in four standards, with one standard (Administrative) achieving full compliance. The program areas of strength include the Administrative, Providers, Quality, and Program Integrity standards.

Opportunities for improvement were identified in five of the six standards, which are briefly described below:

- *MHP Provider Directory Accuracy* (February)—"Accepting new (Medicaid) MA (patients) pts" fell below the 75 percent threshold.
- *Benefits Monitoring Program* (February)—Policy scope did not indicate that, prior to implementing new remedies and sanctions, the MHP must obtain written approval from MDHHS.
- *Program Integrity Forms* (February)—Errors and/or discrepancies were noted on the Audits form.
- *Pharmacy/MCO Common Formulary* (April)—Non-compliant National Council for Prescription Drug Programs (NCPDP) rejections.
- *CSHCS Collaboration* (May)—Provision related to collaboration with the local health departments to coordinate care for Children's Special Health Care Services (CSHCS) members was not present in policy.
- *PMR Review* (May)—Lack of clarity regarding the garnishment process.
- *Audited Financial Statement* (June)—Provision that Certificate of Coverage is available on the MHP's website, and policy on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) member and provider incentives not initially submitted.
- *MHP Provider Directory Accuracy* (August)—"Accepting new MA pts" and "Phone # and address listed online correct" fell below the 75 percent requirement. These findings indicated the provider directory had discrepant data.

MDHHS required **Aetna Better Health of Michigan** to develop and implement a corrective action plan (CAP) for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Aetna Better Health of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **Aetna Better Health of Michigan** was fully compliant with six of the seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

Aetna Better Health of Michigan was not fully compliant with the remaining standard:

- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

Aetna Better Health of Michigan erroneously excluded Medicare-Medicaid members and only included Medicaid-only members in the data used to support measure reporting. As a result of this issue, the auditor determined that the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90)* measure calculated using the hybrid methodology was biased (i.e., the rate that **Aetna Better Health of Michigan** calculated using the hybrid method was biased by more than the allowable greater than or less than 5 percentage points). However, the auditor determined that a rate calculated using administrative data only was reportable; therefore, this measure was reported administratively. Following the auditor's review of the finalized rates, no rates were determined to be materially biased.

Table 5-2 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-1] for **Aetna Better Health of Michigan**.

[5-1] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-2—HEDIS 2019 Performance Measure Results for AET

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	63.02%	★
Combination 3	58.64%	★
Combination 4	58.39%	★
Combination 5	46.47%	★
Combination 6	29.68%	★
Combination 7	46.47%	★
Combination 8	29.68%	★
Combination 9	23.84%	★
Combination 10	23.84%	★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	46.96%	★
Lead Screening in Children		
Lead Screening in Children	76.40%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.31%	★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	47.93%	★★
Immunizations for Adolescents		
Combination 1	88.56%	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	92.71%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	71.78%	★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	25.11%	★
Continuation and Maintenance Phase	44.74%	★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	54.55%	★★

Measure	HEDIS 2019	2019 Performance Level
Cervical Cancer Screening		
Cervical Cancer Screening	60.51%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	67.86%	★★★★
Ages 21 to 24 Years	69.88%	★★★★
Total	68.65%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	92.33%	★
Ages 25 Months to 6 Years	80.15%	★
Ages 7 to 11 Years	83.20%	★
Ages 12 to 19 Years	83.04%	★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	69.67%	★
Ages 45 to 64 Years	83.50%	★★
Ages 65+ Years	89.86%	★★★
Total	77.52%	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	35.66%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	87.23%	★★★★
Counseling for Nutrition—Total	81.65%	★★★★
Counseling for Physical Activity—Total	78.72%	★★★★★
Adult BMI Assessment		
Adult BMI Assessment	94.34%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	74.45%	★
Postpartum Care	51.34%	★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	84.43%	★

Measure	HEDIS 2019	2019 Performance Level
*HbA1c Poor Control (>9.0%)**	38.93%	★★
HbA1c Control (<8.0%)	52.31%	★★★
Eye Exam (Retinal) Performed	54.50%	★★
Medical Attention for Nephropathy	90.75%	★★★
Blood Pressure Control (<140/90 mm Hg)	22.06%	★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	52.77%	★
Medication Compliance 75%—Total	31.14%	★★
Asthma Medication Ratio		
Total	52.42%	★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	60.83%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	85.14%	★★★★★
Discussing Cessation Medications	63.71%	★★★★★
Discussing Cessation Strategies	56.10%	★★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	53.29%	★★★
Effective Continuation Phase Treatment	35.48%	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.64%	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	67.48%	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	60.61%	★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	83.46%	★

Measure	HEDIS 2019	2019 Performance Level
Diuretics	83.88%	★
Total	83.65%	★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	25.44%	NC
Total—Black or African American	63.29%	NC
Total—American-Indian and Alaska Native	0.20%	NC
Total—Asian	0.69%	NC
Total—Native Hawaiian and Other Pacific Islander	0.05%	NC
Total—Some Other Race	0.00%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	4.19%	NC
Total—Declined	6.13%	NC
Total—Hispanic or Latino	3.05%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	0.00%	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	0.00%	NC
Language Preferred for Written Materials—Non-English	0.00%	NC
Language Preferred for Written Materials—Unknown	100.00%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	99.06%	NC
Other Language Needs—Non-English	0.67%	NC
Other Language Needs—Unknown	0.28%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	80.69	★
Outpatient Visits—Total	388.39	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	10.02	NC

Measure	HEDIS 2019	2019 Performance Level
Total Inpatient—Average Length of Stay—Total	4.89	NC
Maternity—Discharges per 1,000 Member Months—Total	2.19	NC
Maternity—Average Length of Stay—Total	2.66	NC
Surgery—Discharges per 1,000 Member Months—Total	2.52	NC
Surgery—Average Length of Stay—Total	7.48	NC
Medicine—Discharges per 1,000 Member Months—Total	5.93	NC
Medicine—Average Length of Stay—Total	4.38	NC
Use of Opioids From Multiple Providers*[*,2]		
Multiple Prescribers	15.90%	NC
Multiple Pharmacies	12.05%	NC
Multiple Prescribers and Multiple Pharmacies	4.34%	NC
Use of Opioids at High Dosage*[*,2]		
Use of Opioids at High Dosage	2.80%	NC
Risk of Continued Opioid Use[*,4]		
At Least 15 Days Covered—Total	23.40%	NC
At Least 31 Days Covered—Total	9.32%	NC
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	12.76%	★★★
Index Total Stays—Observed Readmissions—45–54 Years	13.93%	★★★
Index Total Stays—Observed Readmissions—55–64 Years	13.62%	★★★
Index Total Stays—Observed Readmissions—Total	13.40%	★★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-2 shows **Aetna Better Health of Michigan** ranked at or above the 75th percentile for 11 out of 63 measure rates (17.5 percent), four of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care, Obesity, and Living With Illness domains.

Conversely, 39 out of 63 measure rates (61.9 percent) fell below the 50th percentile, 28 of which fell below the 25th percentile. Opportunities for improvement for **Aetna Better Health of Michigan** include a focus on Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization, where rates in each of these domains fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **Aetna Better Health of Michigan** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **Aetna Better Health of Michigan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its African-American and White populations. The goal of **Aetna Better Health of Michigan**'s PIP is to improve the timeliness of prenatal care for the African-American population and eliminate the identified disparity without a decline in performance for the White population.

Table 5-3 outlines the study indicators for the PIP.

Table 5-3—Study Indicators for AET

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible African-American women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible White women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-4 displays the validation results for **Aetna Better Health of Michigan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-4 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-4—PIP Validation Results for AET

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (10/10)**	**0% (0/10)**	**0% (0/10)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	50% (3/6)	50% (3/6)	0% (0/6)
Implementation Total			**56% (5/9)**	**44% (4/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met**			**73% (16/22)**		

*Percentage totals may not equal 100 due to rounding.

Overall, 73 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP. The MHP has opportunities for improvement related to documentation and addressing HSAG's validation feedback in the Implementation and Outcomes stages.

For the first remeasurement period, **Aetna Better Health of Michigan** reported that 41.2 percent of eligible African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 52.7 percent of eligible White women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The Remeasurement 1 goal was set at 54 percent for Study Indicator 1 and 55 percent for Study Indicator 2. The reported rates for both study indicators did not meet the goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups' rates.

Strengths, Weaknesses, and Overall Conclusions

Aetna Better Health of Michigan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Aetna Better Health of Michigan** received a total compliance score of 94 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **Aetna Better Health of Michigan** scored 90 percent or above in the Administrative, Providers, Quality, and Program Integrity standards, indicating generally strong performance in these program areas, but did not perform as well in the Members and MIS standards, as demonstrated by moderate performance scores (88 percent and 89 percent, respectively), reflecting that additional focus is needed in these areas. While 11 of the 63 HEDIS measure rates ranked at or above the 75th percentile, 39 measure rates fell below the 50th percentile, indicating opportunities for improvement for **Aetna Better Health of Michigan** primarily in the Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization domains.

Aetna Better Health of Michigan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-5—Quality, Timeliness, and Access Performance Impact for AET

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 97 percent in the Quality standard, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 98 percent in the Program Integrity standard, indicating that the MHP maintained sufficient administrative resources, staffing, training, policies and procedures, and monitoring and auditing practices to support its compliance program.

Performance Area*	Overall Performance Impact
	• Strength: All three *Chlamydia Screening in Women* indicator rates were at or above the 75th percentile, indicating women were being screened for this sexually transmitted disease. • Strength: All four rates under the Obesity domain were at or above the 75th percentile, including one rate (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*) meeting or exceeding the 90th percentile, indicating children's, adolescents', and adults' BMIs were assessed by a PCP or obstetrician/gynecologist (OB/GYN) during a medical appointment, and physicians could identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: The three *Medical Assistance With Smoking and Tobacco Use Cessation* indicator rates were at or above the 75th percentile, with two rates (*Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*) meeting or exceeding the 90th percentile, indicating a likelihood that healthcare providers were supporting tobacco users and their efforts to quit smoking, which can lead to improvement in members' overall health. • Strength: The MHP designed a scientifically sound PIP, *Addressing Disparities in Timeliness of Prenatal Care*, supported by using key research principals, meeting 100 percent of the requirements in the Design stage. • Weakness: Both *Follow-Up Care for Children Prescribed ADHD Medication* indicator rates fell below the 25th percentile, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a pediatrician. • Weakness: Four *Comprehensive Diabetes Care* indicator rates fell below the 50th percentile, with two rates falling below the 25th percentile, indicating opportunities to improve proper diabetes management, which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: Both *Medication Management for People With Asthma* indicator rates and the *Asthma Medication Ratio* measure rate fell below the 50th percentile, with two of these three rates falling below the 25th percentile, indicating opportunities for better medication management for members with asthma. • Weakness: The *Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rates fell below the 50th percentile, indicating members diagnosed with schizophrenia were not always screened for diabetes and these members with diabetes did not receive a low-density lipoprotein cholesterol (LDL-C) and hemoglobin A1c (HbA1c) test during the year. • Weakness: All three *Annual Monitoring for Patients on Persistent Medications* indicator rates fell below the 25th percentile, indicating members may be at risk for adverse drug events.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: The *Immunizations for Adolescents—Combination 1* measure rate met or exceeded the 90th percentile, indicating that adolescent members received appropriate and timely immunizations, which is important for decreasing future health conditions for these members. • Weakness: All nine *Childhood Immunization Status* indicator rates fell below the 25th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The *Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, and *Adolescent Well-Care Visits* measure rates all fell below the 50th percentile, indicating child and adolescent members were not seeing their PCPs as often as suggested to ensure timely assessment of their health and development. • Weakness: The two *Prenatal and Postpartum Care* indicator rates fell below the 25th percentile, indicating pregnant women were not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy. • Weakness: 17 percent of the MHP's PIP Implementation and Outcomes stages' evaluation elements received a score of *Not Met*, indicating the MHP has opportunities to improve its PIP and its efforts to address disparities in timeliness of prenatal care services.
Access	• Weakness: All four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 25th percentile, indicating child and adolescent members 12 months to 19 years of age were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: Three of the four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates fell below the 50th percentile, with one measure rate falling under the 25th percentile, indicating many members 20 years and older were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 25th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-6, Table 5-7, and Table 5-8 present the recommendations made by HSAG to **Aetna Better Health of Michigan** during the SFY 2017–2018 EQR, **Aetna Better Health of Michigan**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **Aetna Better Health of Michigan** addressed those recommendations.

Table 5-6—Compliance Monitoring Recommendations—AET

HSAG's Recommendations
Aetna Better Health of Michigan should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Providers • Members • Program Integrity **Aetna Better Health of Michigan** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Summary of AET's Response
Providers: When issues were identified with provider directory accuracy, **Aetna Better Health of Michigan**'s Provider Experience team outreached to providers to understand and remediate accuracy issues. CAPs were developed and submitted to MDHHS for the February 2018 and August 2018 issues and outlined the following: **Aetna Better Health of Michigan** identified some standing protocols and interventions from the 2018 Compliance Review findings that continued in 2019 to ensure all gaps identified are remediated which included: • **Aetna Better Health of Michigan** required all providers with 100 or more assigned members to update their provider roster monthly. • Providers with members from one to 99 members are required to submit rosters on a quarterly basis. Providers are instructed to immediately inform their provider representative or contact the provider call center to update demographic changes. • During field visits, provider relations representatives verify with the office staff that they are accepting new members and confirm if there are any changes. All non-compliant providers are referred to network contracting as the provider is in breach of contract. • Beginning quarter four (Q4) 2019, quarterly newsletters include articles that emphasize the need to keep the plan updated on any changes to provider demographics and whether they are accepting new plan members. • All Joint Operating Committee (JOC) meetings with provider groups include the provider data integrity and provider roster/directory as a standing agenda item. JOC schedules for select providers take place as monthly/quarterly meetings as applicable.

Summary of AET's Response
Other interventions: • **Aetna Better Health of Michigan** issued a Provider Bulletin during Q4 2019 to remind providers to proactively advise when they are closing panels; and to remind on contract requirements for notification. • Provider Relations reached out to all providers surveyed to determine if these providers moved to another service location without notifying the health plan as well as for all other corrective actions relative the entire survey pool. • Provider Relations staff continue to work directly with these providers on required record updates. • The staff have been reminded during team meetings the significance of roster/record maintenance for all providers assigned to them. • Provider education was ongoing throughout 2019 and continues into 2020. Education includes webinars and on-site visits for new and existing providers. • Plan-initiated secret shopping contacts to provider offices to confirm availability and acceptance of new patients. • Special emphasis has been placed on full roster maintenance and clean-up projects to improve the overall accuracy and timeliness of data supplied by contracted providers. Emphasis is on PCP and high-volume specialists. • **Aetna Better Health of Michigan** created a provider data department with its primary function to maintain provider data integrity. **Members:** **Aetna Better Health of Michigan** inadvertently omitted submitting evidence that ID cards are mailed first class. **Aetna Better Health of Michigan** submitted a CAP to MDHHS on June 7, 2018, with a copy of policy A-MIMP 4600.83 Print and Mailing that stipulated ID cards must be mailed first class. The April 2019 Compliance Review submission included information verifying ID cards were mailed first class. **Program Integrity:** • **Aetna Better Health of Michigan** submitted corrections as required for each report in SFY 2018. • A Senior Special Investigator Unit (SIU) Investigator was hired in March 2018, creating a singular point of contact for the reporting process. • MDHHS implemented a pre-submission process for the Quarterly Program Integrity reports in May 2019. The preliminary submission allowed MHPs to submit the report for review on the 1st of the month. If any deficiencies were identified, MHPs were provided an opportunity to make corrections for the final submission on the 15th of the month. **Aetna Better Health of Michigan** utilized the pre-submission process for the May and August 2019 submissions.
HSAG's Assessment of the Degree to Which AET Addressed the Recommendations
Based on **Aetna Better Health of Michigan**'s response and the SFY 2018–2019 compliance review findings, **Aetna Better Health of Michigan** addressed the prior year's recommendations; however, **Aetna Better Health of Michigan** continues to have opportunities for improvement related to the provider directory and program integrity forms. **Aetna Better Health of Michigan** received deficient findings for *MHP Provider Directory Accuracy* in February and August 2019 and *Program Integrity Forms* in February 2019.

Table 5-7—Performance Measures Recommendations—AET

HSAG's Recommendations
HSAG recommended that **Aetna Better Health of Michigan** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Child & Adolescent Care** • *Childhood Immunization Status—Combination 2* • *Childhood Immunization Status—Combination 3* • *Childhood Immunization Status—Combination 4* • *Childhood Immunization Status—Combination 5* • *Childhood Immunization Status—Combination 6* • *Childhood Immunization Status—Combination 7* • *Childhood Immunization Status—Combination 8* • *Childhood Immunization Status—Combination 9* • *Childhood Immunization Status—Combination 10* • *Well-Child Visits in the First 15 Months of Life—Six or More Visits* • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* • *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* **Access to Care** • *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* • *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* • *Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years* • *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years* • *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years* • *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years* • *Adults' Access to Preventive/Ambulatory Health Services—Total* **Pregnancy Care** • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* • *Prenatal and Postpartum Care—Postpartum Care* **Living With Illness** • *Comprehensive Diabetes Care—HbA1c Testing* • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* • *Antidepressant Medication Management—Effective Acute Phase Treatment*

HSAG's Recommendations
• *Diabetes Monitoring for People With Diabetes and Schizophrenia* • *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* **Utilization** • *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* HSAG recommended that **Aetna Better Health of Michigan** include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Aetna Better Health of Michigan** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **Aetna Better Health of Michigan** should have included the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement
Summary of AET's Response
Child & Adolescent Care—Childhood Immunization Status Improvement Efforts: • Created new member educational materials that addressed the fears and myths currently associated with vaccinating children (included MDHHS website links for more information on this topic). • Initiated a member email campaign with a vaccination schedule and information on the importance of vaccinating children. • Initiated a member mail campaign with a vaccination schedule and information on the importance of vaccinating children. • Initiated live member phone calls to members from birth to age two, encouraging them to stay on schedule for, and to go get their next series of shots. • Offered a $25 gift card for members completing *Combination 3* by age two. • Offered a provider incentive of $25 per completion of each series.

Summary of AET's Response

Child & Adolescent Care—Well-Child Visits in the First 15 Months of Life Improvement Efforts:

- Live calls starting at birth encouraging members to take their infants in for well visits.
- $25 member gift card incentive for the completion of visits one–three, and another $25 gift card offered for visits four–six.
- Provider incentive of additional $25 per service up to visit five with a bonus of $125 at service six.
- Member emails and text messages.

Child & Adolescent Care—Follow Up Care for Children Prescribed ADHD Medication Improvement Efforts:

- Live calls to the member to determine if the PCP is aware of the medication, and if they have seen the PCP since first being prescribed.
- Complete an Occupational Role Questionnaire/Health Risk Questionnaire (ORQ/HRQ) and assess for unmet needs.

Access to Care—Children and Adolescents' Access to Primary Care Providers Improvement Efforts:

- Live calls to members non-compliant for the measure with the offer of assistance with scheduling the appointment and arranging transportation.
- $25 gift card member incentive.
- Provider incentive of $50.
- Clinic Days with an offer of on-the-spot gift card incentives.
- Various mail, Interactive Voice Response (IVR), and email campaigns.

Access to Care—Adults' Access to Preventive/Ambulatory Health Services Improvement Efforts:

- Live calls to members non-compliant for the measure with the offer of assistance with scheduling the appointment and arranging transportation.
- $25 gift card member incentive.
- Clinic Days with an offer of on-the-spot gift card incentives.
- Various mail, IVR, and email campaigns.

Pregnancy Care—Prenatal and Postpartum Care—Timeliness of Prenatal Care Improvement Efforts:

- Live calls to members identified as pregnant through claims and authorization data, offering assistance with scheduling appointments and arranging transportation.
- Free diaper incentive ($50 value) for 1st prenatal visit in 1st trimester, then another incentive for visits two–six.
- Provider incentive of $100.

Summary of AET's Response
Pregnancy Care—Prenatal and Postpartum Care—Postpartum Care Improvement Efforts: • Live calls to members identified as having a live birth through claims and authorization data, offering assistance with scheduling appointments and arranging transportation. • Free diaper incentive ($50 value) for a postpartum visit within 21-56 days of delivery. • Provider incentive of $100. **Living With Illness—Comprehensive Diabetes Care—HbA1c Testing Improvement Efforts:** • Live member calls to members offering assistance in scheduling appointments and arranging transportation. • $25 gift card member incentive. • $25 provider incentive. **Living With Illness—Comprehensive Diabetes Care—Blood Pressure Control Improvement Efforts:** • Live calls from the clinical team educating members on blood pressure control activities, and encouraging regular visits with PCPs. **Living With Illness—Antidepressant Medication Management Improvement Efforts:** • **Aetna Better Health of Michigan** is presently tracking and trending this measure. **Living With Illness—Diabetes Monitoring for People with Diabetes and Schizophrenia and Adherence to Antipsychotic Medications for Individuals With Schizophrenia Improvement Efforts:** • There is joint collaboration between the clinical team and the behavioral health vendors to share disease management and behavioral health management information, perform outreach, and to ensure the PCP is aware of both. **Utilization—Ambulatory Care-ED Visits Improvement Efforts:** • Implemented case management ED Redirect program that includes mailings and calls when certain non-emergent diagnosis codes come in on claims or through admissions, discharges, and transfers (ADT) feed. • Member educational mailers on when it is appropriate to use the Urgent Care versus the Emergency Room.
HSAG's Assessment of the Degree to Which AET Addressed the Recommendations
Based on the results of the SFY 2018–2019 validation, *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years* and *Total* indicator rates improved to perform at or above the 25th percentile, but below the 50th percentile, and the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* indicator rates improved to perform at or above the 50th percentile. However, the remaining performance measure rates with an applicable benchmark remained below the 25th percentile, indicating while **Aetna Better Health of Michigan** implemented initiatives to improve performance, it still has opportunities to continue performance improvement efforts.

Table 5-8—PIP Recommendations—AET

HSAG's Recommendations
Aetna Better Health of Michigan should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **Aetna Better Health of Michigan** should have ensured the following: • Addressed all validation feedback documented in *Points of Clarification*, *Partially Met*, and *Not Met* validation scores and make necessary corrections prior to the next annual submission. • Developed and implemented innovative, non-passive interventions targeted to the two subgroups for the PIP. • Reevaluated whether it should use mailers as an intervention for an improvement project. • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical. • Sought technical assistance throughout the PIP process to address any questions or concerns.
Summary of AET's Response
Aetna Better Health of Michigan welcomes all feedback from HSAG as the PIP is developed and after the first submission. In 2018, all of the recommendations from HSAG were not addressed in the final Timeliness of Prenatal Care submission. However, all of the recommendations were addressed in the 2019 submission as noted below: • Addressed all validation feedback documented in *Points of Clarification*, *Partially Met*, and *Not Met* validation scores and make necessary corrections prior to the next annual submission. – **Completed in the 2019 submission.** • Developed and implemented innovative, non-passive interventions targeted to the two subgroups for the PIP. – **Non-passive interventions were added to the 2019 submission. Among them are the Aetna Better Health of Michigan outreach contact, community health worker, case manager and Maternal Infant Health Program (MIHP) processes.** • Reevaluated whether it should use mailers as an intervention for an improvement project. – **Mailers are one part of a catalog of interventions which included member contact and incentive, provider contact and incentive as well as health plan system improvements.**

Summary of AET's Response
• Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. – **The methodology was completed accurately in the 2019 submission.** • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. – **A causal/barrier analysis, using fishbone diagram, was included in the 2019 submission**. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. – **Documented using the fishbone diagram in 2019.** • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. – **The initiatives are member interactive and Aetna Better Health of Michigan has the ability to measure the frequency and volume of activity. Making it a one-to-one correlation impacting the study indicator outcome is more difficult as there are a number of initiatives that are affecting the outcome.** • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators, and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical. – **Each of the interventions is measurable and will be reported in 2020.** • Seek technical assistance throughout the PIP process to address any questions or concerns. – **Aetna Better Health of Michigan will seek technical assistance when necessary.**
HSAG's Assessment of the Degree to Which AET Addressed the Recommendations
For the SFY 2017–2018 validation, **Aetna Better Health of Michigan** had opportunities for improvement in Steps IV and VI in the Design stage and Steps VII and VIII in the Implementation stage. HSAG recommended **Aetna Better Health of Michigan** completely define the study indicator denominators, develop and provide a copy of the data collection tool that will be used to collect the study indicator data, estimate the percentage of administrative data completeness, provide a clear and complete narrative summary of the baseline rate for each study indicator, identify any factors that may threaten the validity of the data reported, provide a copy of the QI tools utilized to conduct a causal/barrier analysis, develop active and innovative interventions to address the associated barriers, and implement a process for evaluating the performance of each intervention and its impact to the study indicators. In SFY 2018–2019 validation, **Aetna Better Health of Michigan** addressed all recommendations within the Design stage; however, within the Implementation stage, **Aetna Better Health of Michigan** received similar recommendations for the development of improvement strategies and intervention evaluation methods, indicating the MHP partially addressed the prior year's recommendations.

Recommendations for Program Improvement

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 recommends that **Aetna Better Health of Michigan** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **Aetna Better Health of Michigan** incorporate new improvement efforts as necessary for the following performance measures ranking below the 25th percentile.

Child & Adolescent Care

- *Childhood Immunization Status—Combination 2*, *3*, *4*, *5*, *6*, *7*, *8*, *9*, and *10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Appropriate Testing for Children With Pharyngitis*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Living With Illness

- *Comprehensive Diabetes Care—HbA1c Testing* and *Blood Pressure Control (<140/90 mm Hg)*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Asthma Medication Ratio—Total*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics*, and *Total*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total*

To meet the above recommendation, **Aetna Better Health of Michigan** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Aetna Better Health of Michigan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Aetna Better Health of Michigan** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Aetna Better Health of Michigan** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Members
- Quality
- MIS
- Program Integrity

Aetna Better Health of Michigan was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends 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 recommends 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. Additionally, HSAG recommends **Aetna Better Health of Michigan**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **Aetna Better Health of Michigan** should immediately implement internal corrective action.

Aetna Better Health of Michigan should also take proactive steps to ensure a successful PIP. **Aetna Better Health of Michigan** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments* in the *2018–2019 PIP Validation Report Addressing Disparities in Timeliness of Prenatal Care for Aetna Better Health of Michigan* and make the following necessary corrections prior to the next annual submission:

- Report the type of statistical test conducted and the significance of the results.
- Calculate and report the probability value (*p*-value) between the study indicators, as the focus is on reducing the existing disparity.
- Identify any factors that threaten the year-to-year comparability of the data reported.
- Clearly align the interventions to the associated barrier.
- Develop a methodology to evaluate the effectiveness of each individual intervention and provide the evaluation results/data. Decisions to continue, revise, or discontinue an intervention must be data-driven.
- The PIP has not yet demonstrated significant improvement in the study indicator results; the MHP should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.

Finally, as applicable, **Aetna Better Health of Michigan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

Blue Cross Complete of Michigan (BCC)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **Blue Cross Complete of Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Blue Cross Complete of Michigan**.

EQR Activity Results

Compliance Monitoring

Blue Cross Complete of Michigan was evaluated in six program areas referred to as "standards." Table 5-9 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-9 also presents **Blue Cross Complete of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-9—Compliance Review Results for BCC

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	BCC	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	14	1	0	15	97%	91%
3	Members	7	1	0	8	94%	87%
4	Quality	14	1	0	15	97%	98%
5	MIS	9	0	0	9	100%	95%
6	Program Integrity	28	0	0	28	100%	97%
Overall		**77**	**3**	**0**	**80**	**98%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Blue Cross Complete of Michigan demonstrated compliance for 77 of 80 elements, with an overall compliance score of 98 percent, which was above the statewide average of 95 percent. **Blue Cross Complete of Michigan** demonstrated strong performance, scoring above 90 percent in all six standards, with three standards achieving full compliance (Administrative, MIS, and Program Integrity). The program areas of strength include the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in three of the six standards, which are briefly described below:

- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.
- *Member Grievance and Appeal Resolution* (May)—The requirement that individuals who make decisions on grievances and appeals will not be involved in the previous level of decision making was not included in the member letter template.
- *QIP Evaluation and Work Plan*; *UM Program and Effectiveness* (June)—Previous year's UM effectiveness review and evaluation was not initially submitted.

MDHHS required **Blue Cross Complete of Michigan** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Blue Cross Complete of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **Blue Cross Complete of Michigan** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **Blue Cross Complete of Michigan** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-10 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-2] for **Blue Cross Complete of Michigan**.

[5-2] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-10—HEDIS 2019 Performance Measure Results for BCC

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	70.32%	★★
Combination 3	66.67%	★★
Combination 4	66.18%	★★
Combination 5	53.04%	★
Combination 6	36.01%	★★
Combination 7	52.80%	★
Combination 8	36.01%	★★
Combination 9	30.17%	★★
Combination 10	30.17%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	67.15%	★★★
Lead Screening in Children		
Lead Screening in Children	76.16%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.56%	★★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	58.39%	★★★
Immunizations for Adolescents		
Combination 1	82.24%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	91.71%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	81.05%	★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	44.44%	★★
Continuation and Maintenance Phase	55.26%	★★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	58.63%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	69.10%	★★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	65.45%	★★★★
Ages 21 to 24 Years	69.62%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Total	67.58%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	94.54%	★★
Ages 25 Months to 6 Years	86.68%	★★
Ages 7 to 11 Years	88.66%	★★
Ages 12 to 19 Years	87.41%	★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	75.71%	★★
Ages 45 to 64 Years	83.78%	★★
Ages 65+ Years	84.21%	★★
Total	78.84%	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	33.16%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	86.62%	★★★★
Counseling for Nutrition—Total	78.35%	★★★★
Counseling for Physical Activity—Total	76.16%	★★★★
Adult BMI Assessment		
Adult BMI Assessment	91.97%	★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	75.91%	★
Postpartum Care	60.58%	★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	85.16%	★★
*HbA1c Poor Control (>9.0%)**	44.77%	★★
HbA1c Control (<8.0%)	43.80%	★
Eye Exam (Retinal) Performed	57.42%	★★
Medical Attention for Nephropathy	90.02%	★★
Blood Pressure Control (<140/90 mm Hg)	52.80%	★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	73.93%	★★★★★
Medication Compliance 75%—Total	53.29%	★★★★★

Measure	HEDIS 2019	2019 Performance Level
Asthma Medication Ratio		
Total	64.02%	★★★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	52.55%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	82.89%	★★★★
Discussing Cessation Medications	60.35%	★★★★
Discussing Cessation Strategies	51.54%	★★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	55.52%	★★★
Effective Continuation Phase Treatment	39.14%	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.23%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	60.80%	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.33%	★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	86.77%	★★
Diuretics	86.00%	★
Total	86.44%	★★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	45.97%	NC
Total—Black or African American	35.95%	NC
Total—American-Indian and Alaska Native	0.67%	NC
Total—Asian	1.64%	NC
Total—Native Hawaiian and Other Pacific Islander	2.85%	NC
Total—Some Other Race	0.00%	NC
Total—Two or More Races	0.03%	NC
Total—Unknown	12.88%	NC
Total—Declined	0.00%	NC

Measure	HEDIS 2019	2019 Performance Level
Total—Hispanic or Latino	3.16%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	98.40%	NC
Spoken Language Preferred for Health Care—Non-English	1.59%	NC
Spoken Language Preferred for Health Care—Unknown	0.01%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	98.39%	NC
Language Preferred for Written Materials—Non-English	1.60%	NC
Language Preferred for Written Materials—Unknown	0.01%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	98.78%	NC
Other Language Needs—Non-English	1.20%	NC
Other Language Needs—Unknown	0.01%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	62.97	★★
Outpatient Visits—Total	388.15	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	7.24	NC
Total Inpatient—Average Length of Stay—Total	4.00	NC
Maternity—Discharges per 1,000 Member Months—Total	2.68	NC
Maternity—Average Length of Stay—Total	2.63	NC
Surgery—Discharges per 1,000 Member Months—Total	1.52	NC
Surgery—Average Length of Stay—Total	5.94	NC
Medicine—Discharges per 1,000 Member Months—Total	3.66	NC
Medicine—Average Length of Stay—Total	3.96	NC
***Use of Opioids From Multiple Providers**[*,2]		
Multiple Prescribers	18.34%	NC
Multiple Pharmacies	8.45%	NC
Multiple Prescribers and Multiple Pharmacies	4.08%	NC
***Use of Opioids at High Dosage**[*,2]		
Use of Opioids at High Dosage	2.01%	NC
***Risk of Continued Opioid Use**[*,4]		
At Least 15 Days Covered—Total	16.69%	NC
At Least 31 Days Covered—Total	7.21%	NC

Measure	HEDIS 2019	2019 Performance Level
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	13.37%	★★★
Index Total Stays—Observed Readmissions—45–54 Years	12.83%	★★★★
Index Total Stays—Observed Readmissions—55–64 Years	14.67%	★★★
Index Total Stays—Observed Readmissions—Total	13.63%	★★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-10 shows **Blue Cross Complete of Michigan** ranked at or above the 75th percentile for 15 of the 63 measure rates (23.8 percent), two of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Living With Illness domain. Conversely, 33 of 63 measure rates (52.4 percent) fell below the 50th percentile, seven of which fell below the 25th percentile. Opportunities for improvement for **Blue Cross Complete of Michigan** include a focus on Child & Adolescent Care, Pregnancy Care, and Living With Illness, where several rates in each of these domains fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **Blue Cross Complete of Michigan** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **Blue Cross Complete of Michigan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its African-American and Caucasian women residing in Wayne County. The goal of **Blue Cross Complete of Michigan**'s PIP is to improve the timeliness of prenatal care for the African-American population in Wayne County and eliminate the identified disparity without a decline in performance for Caucasian women.

Table 5-11 outlines the study indicators for the PIP.

Table 5-11—Study Indicators for BCC

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible African-American women residing in Wayne County who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible Caucasian women residing in Wayne County who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-12 displays the validation results for **Blue Cross Complete of Michigan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-12 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-12—PIP Validation Results for BCC

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	33% (1/3)	33% (1/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total*			**33% (1/3)**	**33% (1/3)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**90% (19/21)**		

* Percentage totals may not equal 100 due to rounding.

Overall, 90 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP.

For the first remeasurement period, **Blue Cross Complete of Michigan** reported that 59.5 percent of eligible African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 71.4 percent of eligible White women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The Remeasurement 1 goal was set at 63 percent for Study Indicator 1 and 65.8 percent for Study Indicator 2. The reported rates for both study indicators did not meet the goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

Blue Cross Complete of Michigan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Blue Cross Complete of Michigan** received a total compliance score of 98 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **Blue Cross Complete of Michigan** scored 94 percent or above in the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards, indicating generally strong performance in these program areas. While 15 of the 63 (23.8 percent) HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 33 measure rates (52.4 percent) fell below the 50th percentile, indicating opportunities for improvement for **Blue Cross Complete of Michigan** primarily in the Child & Adolescent Care, Access to Care, Pregnancy Care, and Living With Illness domains.

Blue Cross Complete of Michigan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-13—Quality, Timeliness, and Access Performance Impact for BCC

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 97 percent in the Quality standard, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 100 percent in the MIS standard, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The MHP received a performance score of 100 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider. • Strength: All three *Chlamydia Screening in Women* indicator rates ranked at or above the 75th percentile, indicating women are being screened for this sexually transmitted disease. • Strength: All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicator rates ranked at or above the 75th percentile, indicating children's and adolescents' BMIs were assessed by a PCP or OB/GYN during a medical appointment, and physicians could identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: The two *Medication Management for People With Asthma* indicator rates exceeded the 90th percentile, indicating adult and child members diagnosed with persistent asthma were dispensed appropriate asthma controller medications and remained on the medications for the majority of their treatment period. • Strength: The three *Medical Assistance With Smoking and Tobacco Use Cessation* indicator rates ranked at or above the 75th percentile, indicating many adults who are tobacco smokers or users received cessation advice and discussed cessation medications to help quit tobacco and improve overall health. • Strength: The MHP designed a scientifically sound PIP, *Addressing Disparities in Timeliness of Prenatal Care*, supported by using key research principals, and also performed well with data analysis and improvement strategies, meeting 100 percent of the requirements in the Design and Implementation stages. • Weakness: All six *Comprehensive Diabetes Care* indicator rates fell below the 50th percentile, with two of the rates (*HbA1c Control [<8.0%]* and *Blood Pressure Control [<140/90 mm Hg]*) falling below the 25th percentile, indicating opportunities

Performance Area*	Overall Performance Impact
	to improve proper diabetes management, which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: The *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure rate fell below the 25th percentile, indicating members diagnosed with schizophrenia and diabetes did not always receive an LDL-C and HbA1c test during the year and, therefore, may have an increased risk for declining health. • Weakness: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure rate fell below the 50th percentile, indicating members may be at risk for relapse or even hospitalization due to medication nonadherence. • Weakness: All three *Annual Monitoring for Patients on Persistent Medications* indicator rates fell below the 50th percentile, with one indicator rate (*Diuretics*) falling below the 25th percentile, indicating members may be at risk for adverse drug events.
Timeliness	• Strength: The MHP received a performance score of 94 percent in the Members standard, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Weakness: All nine *Childhood Immunization Status* indicator rates fell below the 50th percentile, with two rates (*Combination 5* and *7*) falling below the 25th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: Both *Prenatal and Postpartum Care* indicator rates fell below the 50th percentile, with the *Timeliness of Prenatal Care* indicator rate falling below the 25th percentile, indicating pregnant women were not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy. • Weakness: 67 percent of the MHP's PIP Outcomes stage evaluation elements received a score of *Partially Met* or *Not Met*, indicating the MHP did not meet the goal of removing the existing disparity and has opportunities to improve its PIP and its efforts to address disparities in timeliness of prenatal care services.
Access	• Weakness: Both *Follow-Up Care for Children Prescribed ADHD Medication* indicator rates fell below the 50th percentile, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a practitioner. • Weakness: All four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 50th percentile, indicating children and adolescents were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: All four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates fell below the 50th percentile, indicating many members 20 years and older were not accessing ambulatory or preventive care services from their physicians.

Performance Area*	Overall Performance Impact
	• Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 50th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-14, Table 5-15, and Table 5-16 present the recommendations made by HSAG to **Blue Cross Complete of Michigan** during the SFY 2017–2018 EQR, **Blue Cross Complete of Michigan**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **Blue Cross Complete of Michigan** addressed those recommendations.

Table 5-14—Compliance Monitoring Recommendations—BCC

HSAG's Recommendations
Blue Cross Complete of Michigan should have developed meaningful plans of action to bring into compliance the following deficient program area: • Providers **Blue Cross Complete of Michigan** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies

Summary of BCC's Response

Blue Cross Complete of Michigan submitted detailed CAPs to MDHHS to document steps taken to address deficiencies related to provider directory information accuracy in the annual compliance review process. MDHHS reviewed and accepted the action plans provided by **Blue Cross Complete of Michigan**. **Blue Cross Complete of Michigan** continues to work on improving the accuracy of provider directory information.

Detailed narrative of deficiency

As part of the annual compliance review process, MDHHS conducted secret shopper calls to a sample of PCPs identified as open to new patients on the online provider directory on **Blue Cross Complete of Michigan**'s website. These calls were made four times per year to validate the accuracy of PCP open access status reported in the provider directory on **Blue Cross Complete of Michigan**'s website. The secret shopper calls made during the months of February and August were evaluated and plans receiving below the 75 percent accuracy standard set by MDHHS received an *Incomplete* score for this criterion and were required to submit a CAP to MDHHS. **Blue Cross Complete of Michigan** did not meet the standard for the reviews conducted in February and August for both FY 2017 and FY 2018.

Detailed corrective action steps to resolve each deficiency

- **Blue Cross Complete of Michigan** conducted a review of provider records with inaccurate open access information identified during the secret shopper calls. A common issue identified was lack of provider notification to **Blue Cross Complete of Michigan** of the change in provider information.
- **Blue Cross Complete of Michigan**'s Provider Network Management educated provider offices of the contractual requirement to report provider practice changes to **Blue Cross Complete of Michigan** and worked to update provider records in our system accordingly.
- Education was performed telephonically, through in-person visits to the provider office and included in provider newsletter communications more broadly.
- Provider Network Management team conducts a provider directory accuracy collection process on a quarterly basis surveying all hospitals, behavioral health, obstetrics and gynecology, and PCPs at least annually. Provider Directory forms are pre-populated using the same data source used for the online provider directory. Forms are sent to provider offices by mail for validation of provider directory information and requesting any updates be returned to the plan for processing.
- **Blue Cross Complete of Michigan** implemented a prioritization of change requests including updates to the provider open to new patient information.
- **Blue Cross Complete of Michigan** included provider directory accuracy as a standing agenda item on practitioner and office manager meetings.
- Provider Network Management staff conducted secret shopper calls on a sample of PCPs and specialists. Results of the reviews were shared with providers and re-education was performed as needed with provider office staff.
- **Blue Cross Complete of Michigan** compliance staff conducted quarterly secret shopper calls for PCPs sharing results with the Provider Network Management team for appropriate follow up.
- **Blue Cross Complete of Michigan** conducted time study for provider data management processing resulting in additional full-time equivalent (FTE) positions being added to the department.

Summary of BCC's Response
Any resources required to resolve the deficiency Resources required to resolve the deficiency included existing provider network management staff and the addition of new FTEs to manage provider information change requests received from the provider network. Also require cooperation of the office staff in the provider network office. **Due dates for completing corrective action plan** • **Blue Cross Complete of Michigan** targeted to have provided education completed for providers identified as out of compliance as a result of the MDHHS secret shopper calls by October 26, 2018. • Any necessary updates of provider information in **Blue Cross Complete of Michigan**'s system were to be processed by November 9, 2018. • Ongoing communication continued in provider newsletters, provider meetings, office manager meetings, and on-site visits. • Provider directory validation process continued on a quarterly basis to ensure all hospitals, behavioral health, OB/GYN, and PCP providers were reviewed annually. • Prioritization of panel updates related to open or closed to new members continue be processed on a bi-weekly basis. • **Blue Cross Complete of Michigan** Compliance and Provider Network Account executives continued to conduct secret shopper calls for a sample of provider offices. This process is ongoing. • Additional staffing resources were completed in April 2018. **Any required deliverables to show that a deficiency has been resolved** MDHHS continues to monitor plan performance related to the accuracy of the plan provider directory. During secret shopper calls performed in August 2019 for the FY 2019 compliance review, the accuracy rating was above the 75 percent threshold resulting in a passing score. **Any dependencies to resolve deficiencies** Potential dependencies impacting deficiencies include maintenance of staff levels to ensure timely oversight, education and processing of provider information changes requests occur. Staff turnovers at provider network offices and proper education of provider staff to report changes to **Blue Cross Complete of Michigan** timely may also be a dependency.
HSAG's Assessment of the Degree to Which BCC Addressed the Recommendations
Based on **Blue Cross Complete of Michigan**'s response and the SFY 2018–2019 compliance review findings, **Blue Cross Complete of Michigan** addressed the prior year's recommendations; however, **Blue Cross Complete of Michigan** continues to have opportunities for improvement related to the provider directory. **Blue Cross Complete of Michigan** MHP received a deficient finding for *MHP Provider Directory Accuracy* in February.

Table 5-15—Performance Measures Recommendations—BCC

HSAG's Recommendations
HSAG recommended that **Blue Cross Complete of Michigan** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Access to Care** • *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* **Pregnancy Care** • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* **Living With Illness** • *Controlling High Blood Pressure* • *Diabetes Monitoring for People With Diabetes and Schizophrenia* HSAG further recommended that **Blue Cross Complete of Michigan** include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Blue Cross Complete of Michigan** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **Blue Cross Complete of Michigan** should have included the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement
Summary of BCC's Response
Blue Cross Complete of Michigan strives to meet the Quality Compass benchmark of the 75th percentile for all HEDIS measures and maintained a comprehensive Gaps in Care Dashboard that was monitored on a monthly basis. **Blue Cross Complete of Michigan** developed improvement strategies that target both members and provider performance. The Corporate HEDIS team regularly produced in-depth analyses of priority HEDIS measures and identified opportunities and strategies for improvement. The **Blue Cross Complete of Michigan** Medical Director, Provider Network Management team, and the Quality Director made in-person visits to high-volume Provider Groups who were performing below expectations for HEDIS measures.

Summary of BCC's Response
In an effort to improve the performance of the below HEDIS measures, **Blue Cross Complete of Michigan** implemented the following strategies. ***Child Access to Care—Ages 25 months to 6 years*** • Gaps in Care report monitoring to identify members that have not completed visits in the required HEDIS time frame. • Telephonic outreach to the measure's targeted population. • Door-to-door outreach to those members **Blue Cross Complete of Michigan** has been unable to reach telephonically. • Provider incentive—Providers were offered an incentive if the member closes the gap in care within the required HEDIS time frame. • Gaps in care reminder for members utilizing the **Blue Cross Complete of Michigan** mobile app. ***Timeliness of Prenatal Care*** • Hosted member baby showers to educate and assist members in scheduling prenatal care. • Diaper program—Members were offered a pack of diapers if they close the gap in care within the required HEDIS time frame. • Bright Start—Maternity member outreach program conducted by Case Management. • Bright Start referred the case to the Community Outreach team if unable to reach the member and the Community Health Navigator (CHN) attempted to reach the member by completing a door-to-door visit. • Member Education—Member newsletter articles highlighting the importance of prenatal care. • Partnering with contracted MIHP Providers to encourage and educate the members about the importance of prenatal visits. • Member Incentive—$50 gift card if the member closes the gap in care within the required HEDIS time frame. • Implemented Keys to your Care (KTYC) texting program. KTYC is an opt-in member texting program that educates women about having a healthy pregnancy and reminds members about the importance of prenatal care. • Monthly Interdepartmental Maternity Workgroup focusing on improving maternity HEDIS measures. • Developed and mailed a Women's Health Guide that included content about the importance of prenatal care. • Made several enhancements to the **Blue Cross Complete of Michigan** Early Identification report to allow earlier outreach to pregnant members and encourage early and regular prenatal care. • Targeted high-volume OB/GYN offices to participate in the Maternity Health Risk Assessment (HRA) process for early identification of pregnant members. ***Controlling High Blood Pressure*** • Implemented blood pressure cuff benefit for members with uncontrolled hypertension. • Member newsletter articles about the importance of controlling hypertension.

Summary of BCC's Response
Diabetes Monitoring for People With Diabetes and Schizophrenia • **Blue Cross Complete of Michigan** held bi-annual Healthcare Integration Advisory Council (HIAC) meetings, which hosted our behavioral health partners and discussed performance of behavioral health HEDIS measures. • Attended monthly meetings with the PIHPs across all of our regions to confidentially identify shared members and to develop a shared care plan. • Community Care Management Team (CCMT) consisting of a nurse, social worker, and CHN made in-home visits to members identified with complex health needs. • Published a provider newsletter article about the importance of diabetes monitoring for people with schizophrenia. • Published a member newsletter article about the importance of diabetes monitoring for people with schizophrenia. • Hired Behavioral Health Care Managers to assist with outreach to members with behavioral health diagnoses.
HSAG's Assessment of the Degree to Which BCC Addressed the Recommendations
HSAG recommended that **Blue Cross Complete of Michigan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. While the *Controlling High Blood Pressure* rate could not be compared to percentiles in HEDIS 2019, only the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* measure rate improved to rank above the 25th percentile, indicating **Blue Cross Complete of Michigan** still has opportunities to continue performance improvement efforts even with current interventions in place.

Table 5-16—PIP Recommendations—BCC

HSAG's Recommendations
Blue Cross Complete of Michigan should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **Blue Cross Complete of Michigan** should have ensured the following: • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Summary of BCC's Response
Blue Cross Complete of Michigan followed the approved PIP methodology and has taken all proactive steps to ensure a successful PIP. **Blue Cross Complete of Michigan** completed a causal/barrier analysis to identify barriers to desired outcomes and implemented interventions to address those barriers. The Technical Assistance (TA) calls with HSAG have been helpful and **Blue Cross Complete of Michigan** has made every effort to implement the suggestions offered by HSAG. **Blue Cross Complete of Michigan** regularly monitors our improvement strategies that impact study indicator outcomes and work to refine strategies on an ongoing basis.
HSAG's Assessment of the Degree to Which BCC Addressed the Recommendations
For the SFY 2017–2018 validation, **Blue Cross Complete of Michigan** designed a PIP that was appropriate for measuring and monitoring PIP outcomes, and reported accurate baseline measurement results and improvement strategies; therefore, HSAG had no required follow-up recommendations. HSAG did provide the following recommendations for **Blue Cross Complete of Michigan**'s consideration as it progressed to Remeasurement 1: complete an annual causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner, as interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate; implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes; and implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators. In the SFY 2018–2019 validation, **Blue Cross Complete of Michigan** addressed all recommendations for consideration within the PIP submission.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Blue Cross Complete of Michigan** to members, HSAG recommends that **Blue Cross Complete of Michigan** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **Blue Cross Complete of Michigan** incorporate new improvement efforts as necessary for the following performance measures ranking below the 25th percentile.

Child & Adolescent Care

- *Childhood Immunization Status—Combination 5* and *7*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Living With Illness

- *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*

To meet the above recommendation, **Blue Cross Complete of Michigan** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Blue Cross Complete of Michigan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Blue Cross Complete of Michigan** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Blue Cross Complete of Michigan** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Members
- Quality

Blue Cross Complete of Michigan was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends that **Blue Cross Complete 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 recommends that **Blue Cross Complete of Michigan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. Additionally, HSAG recommends **Blue Cross Complete of Michigan**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **Blue Cross Complete of Michigan** should immediately implement internal corrective action.

Blue Cross Complete of Michigan should also take proactive steps to ensure a successful PIP. **Blue Cross Complete of Michigan** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments* in the *2018–2019 PIP Validation Report Addressing Disparities in Timeliness of Prenatal Care for Blue Cross Complete of Michigan* and make the following necessary corrections prior to the next annual submission:

- The PIP has not yet demonstrated significant improvement in the study indicator results nor met the plan-specific goals for both study indicators. **Blue Cross Complete of Michigan** should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.

Finally, as applicable, **Blue Cross Complete of Michigan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

HAP Empowered (HAP)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **HAP Empowered**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **HAP Empowered**.

EQR Activity Results

Compliance Monitoring

HAP Empowered was evaluated in six program areas referred to as "standards." Table 5-17 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-17 also presents **HAP Empowered**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-17—Compliance Review Results for HAP

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	HAP	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	12	2	1	15	87%	91%
3	Members	8	0	0	8	100%	87%
4	Quality	13	2	0	15	93%	98%
5	MIS	9	0	0	9	100%	95%
6	Program Integrity	23	3	2	28	88%	97%
Overall		**70**	**7**	**3**	**80**	**92%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

HAP Empowered demonstrated compliance for 70 of 80 elements, with an overall compliance score of 92 percent, which was below the statewide average of 95 percent. **HAP Empowered** demonstrated strong performance, scoring at or above 90 percent in four standards, with three standards (Administrative, Members, MIS) achieving full compliance. The program areas of strength include the Administrative, Members, Quality, and MIS standards.

Opportunities for improvement were identified in three of the six standards, which are briefly described below:

- *Program Integrity Forms* (November)—Errors and/or discrepancies were noted on the Audits, Provider Disenrollments, and Overpayments forms.
- *Community Health Worker (CHW) Policy and Procedure* (January)—Policy did not demonstrate a CHW to member ratio of at least one full-time CHW per 15,000 members.
- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.
- *Program Integrity Forms* (February)—Errors and/or discrepancies were noted on the Data Mining form.
- *Program Integrity Forms* (May)—Errors and/or discrepancies were noted on the Provider Disenrollments form.
- *QIP Evaluation and Work Plan; UM Program and Effectiveness* (June)—Outdated Annual Quality Program Worksheet was initially submitted.
- *MHP Provider Directory Accuracy* (August)—"Accepting new MA pts" fell below the 75 percent threshold.
- *Maternal Infant Health Program (MIHP)* (August)—Locations and agendas for MIHP scheduled meetings were not initially submitted.

MDHHS required **HAP Empowered** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

HAP Empowered was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **HAP Empowered** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **HAP Empowered** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-18 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-3] for **HAP Empowered**.

Table 5-18—HEDIS 2019 Performance Measure Results for HAP

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	55.32%	★
Combination 3	55.32%	★
Combination 4	53.19%	★
Combination 5	38.30%	★
Combination 6	27.66%	★
Combination 7	38.30%	★
Combination 8	27.66%	★
Combination 9	17.02%	★
Combination 10	17.02%	★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	NA	NC
Lead Screening in Children		
Lead Screening in Children	63.83%	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	48.59%	★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	34.33%	★
Immunizations for Adolescents		
Combination 1	NA	NC
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	83.87%	★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NA	NC
Continuation and Maintenance Phase	NA	NC
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	57.25%	★★

[5-3] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS 2019	2019 Performance Level
Cervical Cancer Screening		
Cervical Cancer Screening	56.34%	★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	NA	NC
Ages 21 to 24 Years	45.95%	★
Total	39.34%	★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	89.74%	★
Ages 25 Months to 6 Years	59.34%	★
Ages 7 to 11 Years	68.18%	★
Ages 12 to 19 Years	72.64%	★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	71.98%	★★
Ages 45 to 64 Years	88.33%	★★★
Ages 65+ Years	88.19%	★★★
Total	83.99%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	41.38%	★★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	86.98%	★★★★
Counseling for Nutrition—Total	63.31%	★★
Counseling for Physical Activity—Total	62.13%	★★
Adult BMI Assessment		
Adult BMI Assessment	82.99%	★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	60.61%	★
Postpartum Care	59.09%	★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	83.70%	★
*HbA1c Poor Control (>9.0%)**	40.15%	★★
HbA1c Control (<8.0%)	49.88%	★★
Eye Exam (Retinal) Performed	58.88%	★★★
Medical Attention for Nephropathy	93.67%	★★★★★

Measure	HEDIS 2019	2019 Performance Level
Blood Pressure Control (<140/90 mm Hg)	59.12%	★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	70.37%	★★★★
Medication Compliance 75%—Total	50.00%	★★★★
Asthma Medication Ratio		
Total	37.68%	★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	51.82%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	83.23%	★★★★
Discussing Cessation Medications	65.69%	★★★★★
Discussing Cessation Strategies	54.22%	★★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	53.49%	★★★
Effective Continuation Phase Treatment	41.09%	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	68.80%	★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	61.54%	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	69.31%	★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	82.12%	★
Diuretics	82.29%	★
Total	82.19%	★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	56.78%	NC
Total—Black or African American	23.97%	NC
Total—American-Indian and Alaska Native	0.00%	NC
Total—Asian	0.02%	NC
Total—Native Hawaiian and Other Pacific Islander	0.02%	NC

Measure	HEDIS 2019	2019 Performance Level
Total—Some Other Race	3.38%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	15.83%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	3.38%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	97.26%	NC
Spoken Language Preferred for Health Care—Non-English	0.18%	NC
Spoken Language Preferred for Health Care—Unknown	2.55%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	97.26%	NC
Language Preferred for Written Materials—Non-English	0.18%	NC
Language Preferred for Written Materials—Unknown	2.55%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	97.26%	NC
Other Language Needs—Non-English	0.18%	NC
Other Language Needs—Unknown	2.55%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	66.17	★★
Outpatient Visits—Total	524.20	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	12.01	NC
Total Inpatient—Average Length of Stay—Total	5.15	NC
Maternity—Discharges per 1,000 Member Months—Total	1.35	NC
Maternity—Average Length of Stay—Total	2.54	NC
Surgery—Discharges per 1,000 Member Months—Total	3.18	NC
Surgery—Average Length of Stay—Total	7.45	NC
Medicine—Discharges per 1,000 Member Months—Total	8.02	NC
Medicine—Average Length of Stay—Total	4.51	NC
Use of Opioids From Multiple Providers[*,2]		
Multiple Prescribers	15.29%	NC
Multiple Pharmacies	3.51%	NC
Multiple Prescribers and Multiple Pharmacies	2.18%	NC
Use of Opioids at High Dosage[*,2]		
Use of Opioids at High Dosage	0.00%	NC

Measure	HEDIS 2019	2019 Performance Level
Risk of Continued Opioid Use*[4]		
At Least 15 Days Covered—Total	28.28%	NC
At Least 31 Days Covered—Total	11.52%	NC
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	13.89%	★★★
Index Total Stays—Observed Readmissions—45–54 Years	0.00%	★★★★★
Index Total Stays—Observed Readmissions—55–64 Years	15.38%	★★★
Index Total Stays—Observed Readmissions—Total	12.86%	★★★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-18 shows that, due to small membership, seven of 64 measure rates (10.9 percent) for **HAP Empowered** received an *NA* (Small Denominator) audit designation (i.e., denominators were too small to report a valid rate). Eleven of 57 measure rates (19.3 percent) ranked at or above the 75th percentile, three of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Living With Illness and Utilization domains. Conversely, 38 of 57 measure rates (66.7 percent) fell below the 50th percentile, 28 of which fell below the 25th percentile. Opportunities for improvement for **HAP Empowered** include a focus on Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, Pregnancy Care, and Living With Illness, where rates in each of these domains fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **HAP Empowered** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **HAP Empowered** analyzed historical data to identify potential disparity within its population related to timeliness of prenatal care. However, due to **HAP Empowered**'s small population, no disparity was identified. **HAP Empowered** determined through data analysis that its focus and goal for the PIP needed to be improving the timeliness of prenatal care for its Black population. MDHHS approved the topic selection.

Table 5-19 outlines the study indicator for the PIP.

Table 5-19—Study Indicator for HAP

PIP Topic	Study Indicator
Improving the Timeliness of Prenatal Care for Black Women	The percentage of eligible Black women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-20 displays the validation results for **HAP Empowered**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-20 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-20—PIP Validation Results for HAP

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (10/10)**	**0% (0/10)**	**0% (0/10)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**91% (20/22)**		

Overall, 91 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP.

For the first remeasurement period, **HAP Empowered** reported that 48 percent of eligible Black women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The goal for the PIP was set at 83.6 percent.

Strengths, Weaknesses, and Overall Conclusions

HAP Empowered demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **HAP Empowered** received a total compliance score of 92 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **HAP Empowered** scored 90 percent or above in the Administrative, Members, Quality, and MIS standards, indicating generally strong performance in these program areas, but did not perform as well in the Providers and Program Integrity standards, as demonstrated by moderate performance scores (87 percent and 88 percent, respectively), reflecting that additional focus is needed in these areas. While 11 of the 57 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 38 measure rates fell below the 50th percentile, indicating opportunities for improvement for **HAP Empowered** primarily in the Child and Adolescent Care domain.

HAP Empowered's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-21—Quality, Timeliness, and Access Performance Impact for HAP

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 93 percent in the Quality standard, indicating that the MHP had most components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 100 percent in the MIS standard, indicating that overall the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate ranked at or above the 75th percentile, indicating many adults diagnosed with acute bronchitis were not dispensed an antibiotic which helps avoid harmful side effects and possible resistance to antibiotics. • Strength: One of the six *Comprehensive Diabetes Care* indicator rates (*Medical Attention for Nephropathy*) exceeded the 90th percentile, indicating many adults received medical attention for nephropathy which is essential to reduce risks for complications. • Strength: Both *Medication Management for People With Asthma* indicator rates ranked at or above the 75th percentile, indicating adult and child members diagnosed with persistent asthma were dispensed appropriate asthma controller medications and remained on the medications for the majority of their treatment period. • Strength: All three *Medical Assistance With Smoking and Tobacco Use Cessation* indicator rates ranked at or above the 75th percentile, with one indicator rate (*Discussing Cessation Medications*) exceeding the 90th percentile, indicating many adults who are tobacco smokers or users received cessation advice and discussed cessation medications and strategies to help quit tobacco and improve overall health. • Strength: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure rate ranked at or above the 75th percentile, indicating many adults with schizophrenia were dispensed and remained on an antipsychotic for most of their treatment period, which reduces the risk of relapse and complications. • Strength: The *Plan All-Cause Readmissions* measure had two indicator rates that ranked at or above the 75th percentile, suggesting members were receiving adequate coordination of care after being discharged from an inpatient hospital stay. • Strength: The MHP designed a scientifically sound PIP, *Improving the Timeliness of Prenatal Care for Black Women*, supported by using key research principles, and performed well with data analysis and improvement strategies, meeting 100 percent of the requirements in the Design and Implementation stages. • Weakness: The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and the *Adolescent Well-Care Visits* measure rates fell below the 25th percentile,

Performance Area*	Overall Performance Impact
	indicating children between the ages of 3 and 6 and adolescents were not seeing their PCPs as often as suggested to ensure timely assessment of their health and development. • Weakness: The *Appropriate Treatment for Children With Upper Respiratory Infection* measure fell below the 25th percentile, indicating many children diagnosed with an upper respiratory infection were prescribed an antibiotic inappropriately, which can lead to antibiotic-resistant bacteria. • Weakness: The *Cervical Cancer Screening* and *Breast Cancer Screening* measures fell below the 50th percentile, indicating many women were not screened for these types of cancer, which are highly treatable if detected early. • Weakness: Both reportable *Chlamydia Screening in Women* indicator rates fell below the 25th percentile, indicating women between the ages of 21 to 24 years were not being screened for this sexually transmitted disease. • Weakness: Two of the three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicator rates fell below the 50th percentile, indicating many children did not receive counseling for nutrition or physical activity from their PCP or OB/GYN, which can help lower the risk of becoming obese and developing related diseases. • Weakness: Four of the six *Comprehensive Diabetes Care* indicator rates fell below the 50th percentile, including one indicator rate (*HbA1c Testing*) falling below the 25th percentile, demonstrating opportunities to improve proper diabetes management which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: Although the MHP demonstrated strength in its members being dispensed and remaining on asthma controller medications through treatment, the *Asthma Medication Ratio—Total* measure rate fell below the 25th percentile, indicating an opportunity to improve the ratio of controller medications to total asthma medications and reducing the prevalence of asthma attacks. • Weakness: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure rates fell below the 25th percentile, indicating members diagnosed with schizophrenia or bipolar disorder were not always screened for diabetes and members with diabetes and schizophrenia did not receive an LDL-C and HbA1c test during the year. • Weakness: All three *Annual Monitoring for Patients on Persistent Medications* indicator rates fell below the 25th percentile, indicating many adults may be at risk for adverse drug events.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: The MHP received a performance score of 100 percent in the Members standard, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: 100 percent of the MHP's PIP Design and Implementation stages evaluation elements received a score of *Met*, indicating the MHP is on track to effectively address timeliness of prenatal care services. • Weakness: All nine *Childhood Immunization Status* indicator rates fell below the 25th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The *Lead Screening in Children* measure rate fell below the 50th percentile, indicating that children were not always receiving capillary or venous lead blood tests in a timely manner to detect and treat potential lead exposure. • Weakness: Both *Prenatal and Postpartum Care* indicator rates fell below the 25th percentile, indicating pregnant women were not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy. • Weakness: The MHP did not demonstrate statistically significant improvement over the baseline for the PIP study indicator for the Remeasurement 1 measurement period, meeting 33 percent of the evaluation elements. The study indicator demonstrated a nonstatistical decrease over the baseline.
Access	• Weakness: Although the MHP received a moderate performance score of 87 percent in the Providers standard, deficiencies related to provider directory information indicate members may experience challenges locating and accessing providers to obtain treatment. • Weakness: All four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 25th percentile, indicating children and adolescents of all ages were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: One of the four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates fell below the 50th percentile, indicating many adults between the ages of 20 and 44 years were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 50th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-22, Table 5-23, and Table 5-24 present the recommendations made by HSAG to **HAP Empowered** during the SFY 2017–2018 EQR, **HAP Empowered**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **HAP Empowered** addressed those recommendations.

Table 5-22—Compliance Monitoring Recommendations—HAP

HSAG's Recommendations
HAP Empowered should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Administrative • Providers • Quality • MIS • Program Integrity **HAP Empowered** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Summary of HAP's Response
Administrative: **HAP Empowered**'s deficiency was related to securing a plan member on the Governing Body. **HAP Empowered** continuously reviewed recruiting and member engagement practices specific to the Governing Body to meet the one-third member requirement on the Governing Board. Below are continuous efforts to solicit, recruit, and secure a plan member: 1. Announcement published in **HAP Empowered**'s newsletter. 2. Communication through Care Coordinators with respective members. 3. Leveraging **HAP Empowered**'s Executive Community Liaison as a channel of outreach to members. Additional interventions included leveraging current Medicare-Medicaid plan (MMP) members to provide insight into **HAP Empowered**'s operations and other relationships with contracted vendors servicing enrollees.

Summary of HAP's Response
HAP Empowered will continue to market the Governing Body to members to increase and sustain participation as required. **Providers:** **HAP Empowered** encountered deficiencies with the accuracy of "acceptance of new members" in the provider directory. **HAP Empowered** implemented a CAP to address issues with accuracy of "acceptance of new members" shown in the provider directory. The CAP included an increase in the amount of PCP outreach by the Provider Data Quality team to verify "acceptance of new members" to ensure online directory information was accurate and current. Additionally, **HAP Empowered** will randomly select 20 PCPs monthly from the online provider directory showing "new member acceptance" status as part of monitoring the accuracy of information displayed in online directory. All PCPs identified with inaccurate information by the Provider Data Quality team will be updated immediately with accurate information and correction of "acceptance of new member" status accordingly. Additional intervention included a standing bi-weekly meeting with Compliance to review potential issues or barriers that may impede the success of effectively meeting the Compliance Review requirements for the accuracy of provider directory. The monitoring and review of the provider directory was ongoing as the criticality of directory information accuracy is heavily relied upon by members seeking to find providers in their immediate area of residence or community. **Quality:** **HAP Empowered** had a couple of deficiencies related to improving access to dental care and information on prior authorization decisions related to CSHCS outlined within the Quality Program content. To ensure contents of the Quality Program met the Compliance Review and contractual requirements, Compliance reviews the requirements with the respective business owners of the program document and sends out notification two weeks in advance of submission due date. Additional intervention included both internal quality checks (QCs) by business owners and high-level QCs by the Compliance submitter against previous and new requirements for the Quality Program to ensure accurate and complete content. The requirements review and QCs were ongoing based on newly released Compliance Review requirements for the Quality Program document content and other Quality-related submissions. **MIS:** **HAP Empowered**'s deficiency for MIS was related to the HIT/HIE not being submitted as required.

Summary of HAP's Response
HAP Empowered implemented a notification alert that is sent by Compliance at least two weeks in advance of submission due date to business owner or stakeholder reminding of submission. This notification also includes the requirement for submission to ensure accurate and complete information is submitted as required. Additional intervention included reviewing newly released Compliance Review Timeline with all identified business owners or stakeholders to ensure agreed accountability and responsibility to submit assigned deliverables in a timely manner as required for monthly review. The actions and intervention were ongoing for all applicable elements related to MIS submissions. **Program Integrity:** **HAP Empowered** had consistent deficiencies with errors and/or discrepancies in all measurements within the quarterly Program Integrity submissions. **HAP Empowered** implemented additional steps in the QC process to potentially identify to mitigate and reduce errors and/or discrepancies within the Tips & Grievances, Data Mining/Algorithm, Audit Form, Disenrollment and Overpayments Collected form sections of Program Integrity reporting. The additional steps in the QC process included the following: 1. Compliance reviewed the various issues identified with submission with respective business owners (Investigations, Claims, Pharmacy and Credentialing) and suggested additional QC on specific data submission. 2. Business owners now conduct an internal QC prior to submission to Compliance to identify potential errors in submission to correct. When data submission is provided by a third-party vendor, the expected requirement is for a data QC to be conducted prior to providing data to **HAP Empowered**. This becomes part of the internal QC process as well. 3. Compliance conducts a second high-level QC for errors specific to cell formatting, date ranges, missing data, etc. 4. In addition to step 3, another compliance staff member will conduct a high-level QC prior to the Program Integrity Report being submitted to MDHHS. The above QC steps were ongoing and conducted prior to each Program Integrity submission to identify and eliminate errors previously identified as part of Compliance Reviews. Additional intervention by Compliance was to send out a reminder two weeks prior to submission due date to respective business owners with extract of requirements from the Compliance Review Timeline highlighted to review along with submission. Finally, errors not identified in the various internal QC steps are reviewed in detailed with business owners when implementing a CAP for MDHHS approval to improve process.
HSAG's Assessment of the Degree to Which HAP Addressed the Recommendations
Based on **HAP Empowered**'s response and the SFY 2018–2019 compliance review findings, **HAP Empowered** addressed the prior year's recommendations; however, **HAP Empowered** continues to have opportunities for improvement related to the provider directory and program integrity forms. **HAP Empowered** received deficient findings for *MHP Provider Directory Accuracy* in February 2019 and *Program Integrity Forms* in November and February 2019.

Table 5-23—Performance Measures Recommendations—HAP

HSAG's Recommendations
HSAG recommended that **HAP Empowered** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Child & Adolescent Care** • *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* • *Adolescent Well-Care Visits* • *Appropriate Treatment for Children With Upper Respiratory Infection* **Women—Adult Care** • *Chlamydia Screening in Women—Ages 21 to 24 Years* **Access to Care** • *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years* • *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years* **Pregnancy Care** • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* **Living With Illness** • *Asthma Medication Ratio—Total* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* • *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* HSAG further recommended that **HAP Empowered** include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **HAP Empowered** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **HAP Empowered** should have included the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement

Summary of HAP's Response
HAP Empowered implemented a Medicaid Performance Measures Workgroup focused on improving the auto assignment and performance measures. Areas of focus include: Access to Care, Child and Adult, Women's Care, Living With Illness, Prevention and Screening HEDIS measures and CAHPS overall measures. The workgroup meets monthly and reviews current HEDIS performance, discusses barriers, and develops interventions to improve performance. A Medicaid dashboard has also been developed which tracks measure performance compared to benchmarks. This is refreshed monthly and reviewed during workgroup meetings. **HAP Empowered** will also be including the recommendations above for the QAPIP in the 2020 QM program, 2019 evaluation and 2020 workplan documents. Additional initiatives and projects in development or underway include the following: • **Telephonic Outreach:** Outbound calls placed for Child & Adolescent Care, Women—Adult Care, Access to Care measures, and Pregnancy Care. • **Mom and Baby Program:** $15 incentive rewarded to members for each prenatal care appointment made (maximum of three). $30 incentives rewarded to members for postpartum care. • **HAP Empowered Your Health Reward Program**: Incentive program rewarding members for having annual appointments and health screenings. $30 incentives awarded for Well-Child Visits, Adolescent Well-Care Visits, and Women—Adult Care Services (Chlamydia Screening). • **P4P Provider Incentive**: Provider incentive to assist with gap closure for health services (Child and Adolescent Care, Women—Adult Care, Access to Care, and Pregnancy Care). • **HAP Empowered Portal**: Member and provider portal implemented to introduce gaps of care information and education for Child & Adolescent Care, Chlamydia Screening, Access to Care, and Prenatal Care measures. • **Customer Service Tool**: A communication dashboard to assist with gap closure. The customer service tool is used to alert members to have screenings including Child & Adolescent Care, Women—Adult Care, Access to Care, and Pregnancy Care. • **Medicaid Dashboard**: Developed a tracking dashboard to assess rates, progress to national percentiles, and gap closure volumes.
HSAG's Assessment of the Degree to Which HAP Addressed the Recommendations
HSAG recommended that **HAP Empowered** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. Based on the results of the SFY 2018–2019 validation, the *Adults Access to Preventive/Ambulatory Services—Ages 20 to 44 Years* indicator rate improved to rank above the 50th percentile; however, the remaining performance measure rates with an appropriate comparison remained below the 25th percentile, indicating that, while **HAP Empowered** implemented initiatives, it still has opportunities to continue performance improvement efforts.

Table 5-24—PIP Recommendations—HAP

HSAG's Recommendations
HAP Empowered should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **HAP Empowered** should have ensured the following: • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Summary of HAP's Response
HAP Empowered analyzes HEDIS results to measure the effectiveness of interventions and to identify additional opportunities for improvement. The data used to support the PIP comes from the HEDIS software that includes claims and encounter data. Statistical significance is calculated using the Fisher's test: Two-tailed *p*-value. Performance rates are compared to established benchmarks and assesses the effectiveness of interventions on an ongoing basis. **HAP Empowered** reviews and evaluates rates in comparison to the State goals and NCQA benchmarks. For Remeasurement period 1, **HAP Empowered** continued working with a prenatal care workgroup 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 prenatal care. 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. Sessions were also held to brainstorm and prioritize barriers. Barriers were prioritized into three main focus areas. The workgroup completed the following activities throughout 2018 and early 2019: • 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 • Revise or discontinue interventions when necessary The quality team continued use of a fishbone diagram to identify barriers to Black/African-American women obtaining prenatal care during prenatal care 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 three focus areas where the team strategized to identify

Summary of HAP's Response
interventions that would have the most impact. The data used to identify barriers were the HEDIS 2019 data stratified by race. **HAP Empowered** also held a focus group with members in April 2019. The intent of the focus group was to identify the challenges, barriers, implicit bias, resource utilization and the doctor-patient relationship of women who recently had a live birth or were currently pregnant. The findings will help to revise interventions and identify opportunities for improvement. Related to evaluation of interventions, HAP Empowered evaluated each intervention by reviewing HEDIS results and comparing baseline to remeasurement periods. All interventions were tracked to determine if the intervention had an impact on the rate. A tracking log was maintained of the interventions to compare rates each year. The Excel tracking logs are imported into an Access database and used for outreach effectiveness reporting for all the interventions. The reports determine whether the outreach had an impact on members receiving prenatal care. **HAP Empowered** will continue in its data mining and analysis to compare changes in percentages stratified by race as the study indicator. **HAP Empowered** will continue to follow the approved PIP methodology to calculate and report data accurately as the PIP progresses to Remeasurement period 2.
HSAG's Assessment of the Degree to Which HAP Addressed the Recommendations
For the SFY 2017–2018 validation, **HAP Empowered** designed a PIP that was appropriate for measuring and monitoring PIP outcomes, and reported accurate baseline measurement results and improvement strategies; therefore, HSAG had no required follow-up recommendations. HSAG did provide the following recommendations for **HAP Empowered**'s consideration as it progressed to Remeasurement 1: complete an annual causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner, as interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate; implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes; and implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators. In the SFY 2018–2019 validation, **HAP Empowered** addressed all recommendations for consideration within the PIP submission.

Recommendations for Program Improvement

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 recommends that **HAP Empowered** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **HAP Empowered** incorporate new improvement efforts as necessary for the following performance measures ranking below the 25th percentile.

Child & Adolescent Care

- *Childhood Immunization Status—Combination 2, 3, 4, 5, 6, 7, 8, 9,* and *10*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

Women—Adult Care

- *Chlamydia Screening in Women—Ages 21 to 24 Years* and *Total*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*

Obesity

- *Adult BMI Assessment*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Living With Illness

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Asthma Medication Ratio—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics*, and *Total*

To meet the above recommendation, **HAP Empowered** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **HAP Empowered** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **HAP Empowered** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement

- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **HAP Empowered** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Quality
- Program Integrity

HAP Empowered was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends 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 recommends 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. Additionally, HSAG recommends **HAP Empowered**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **HAP Empowered** should immediately implement internal corrective action.

HAP Empowered should also take proactive steps to ensure a successful PIP. **HAP Empowered** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments* in the *2018–2019 PIP Validation Report Improving the Timeliness of Prenatal Care for Black Women for HAP Empowered* and make the following necessary corrections prior to the next annual submission:

- The PIP has not yet demonstrated significant improvement in the study indicator results nor met the plan-specific goals for both study indicators. The MHP should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.

Finally, as applicable, **HAP Empowered** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

McLaren Health Plan (MCL)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **McLaren Health Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **McLaren Health Plan**.

EQR Activity Results

Compliance Monitoring

McLaren Health Plan was evaluated in six program areas referred to as "standards." Table 5-25 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-25 also presents **McLaren Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-25—Compliance Review Results for MCL

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	MCL	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	13	2	0	15	93%	91%
3	Members	8	0	0	8	100%	87%
4	Quality	15	0	0	15	100%	98%
5	MIS	9	0	0	9	100%	95%
6	Program Integrity	27	1	0	28	98%	97%
Overall		**77**	**3**	**0**	**80**	**98%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

McLaren Health Plan demonstrated compliance for 77 of 80 elements, with an overall compliance score of 98 percent, which was above the statewide average of 95 percent. **McLaren Health Plan** demonstrated strong performance, scoring at or above 90 percent in all six standards, with four standards achieving full compliance (Administrative, Members, Quality, and MIS). The program areas of strength include the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in two of the six standards, which are briefly described below:

- *Program Integrity Forms* (November)—Errors and/or discrepancies were noted on the Provider Disenrollments form.
- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.
- *MAC Pricing* (March)—MAC Pricing policy did not identify three national drug codes.

MDHHS required **McLaren Health Plan** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

McLaren Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **McLaren Health Plan** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **McLaren Health Plan** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-26 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-4] for **McLaren Health Plan**.

[5-4] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-26—HEDIS 2019 Performance Measure Results for MCL

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	70.56%	★★
Combination 3	63.99%	★
Combination 4	62.77%	★
Combination 5	53.77%	★
Combination 6	33.09%	★★
Combination 7	52.80%	★
Combination 8	32.85%	★★
Combination 9	27.98%	★
Combination 10	27.74%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	70.56%	★★★
Lead Screening in Children		
Lead Screening in Children	82.73%	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.56%	★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	49.88%	★★
Immunizations for Adolescents		
Combination 1	83.45%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	89.96%	★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	86.51%	★★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	50.35%	★★★
Continuation and Maintenance Phase	61.34%	★★★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	61.99%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	65.21%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	54.65%	★★★
Ages 21 to 24 Years	65.24%	★★★

Measure	HEDIS 2019	2019 Performance Level
Total	59.23%	★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	94.66%	★★
Ages 25 Months to 6 Years	86.68%	★★
Ages 7 to 11 Years	90.20%	★★
Ages 12 to 19 Years	88.90%	★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	77.87%	★★
Ages 45 to 64 Years	86.81%	★★★
Ages 65+ Years	83.33%	★★
Total	81.45%	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	34.26%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	79.32%	★★★
Counseling for Nutrition—Total	66.67%	★★
Counseling for Physical Activity—Total	63.26%	★★
Adult BMI Assessment		
Adult BMI Assessment	94.40%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	83.70%	★★★
Postpartum Care	67.64%	★★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	87.83%	★★★
*HbA1c Poor Control (>9.0%)**	42.58%	★★
HbA1c Control (<8.0%)	47.69%	★★
Eye Exam (Retinal) Performed	58.64%	★★★
Medical Attention for Nephropathy	90.75%	★★★
Blood Pressure Control (<140/90 mm Hg)	67.15%	★★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	65.36%	★★★
Medication Compliance 75%—Total	41.75%	★★★

Measure	HEDIS 2019	2019 Performance Level
Asthma Medication Ratio		
Total	66.58%	★★★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	67.40%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	79.45%	★★★
Discussing Cessation Medications	58.23%	★★★★
Discussing Cessation Strategies	45.20%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	56.77%	★★★
Effective Continuation Phase Treatment	40.88%	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.10%	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	73.23%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	82.22%	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	66.40%	★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	86.05%	★★
Diuretics	86.29%	★★
Total	86.15%	★★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	64.93%	NC
Total—Black or African American	19.55%	NC
Total—American-Indian and Alaska Native	0.51%	NC
Total—Asian	0.63%	NC
Total—Native Hawaiian and Other Pacific Islander	0.07%	NC
Total—Some Other Race	5.59%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	8.72%	NC
Total—Declined	0.00%	NC

Measure	HEDIS 2019	2019 Performance Level
Total—Hispanic or Latino	5.59%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	76.22%	NC
Spoken Language Preferred for Health Care—Non-English	0.60%	NC
Spoken Language Preferred for Health Care—Unknown	23.18%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	0.00%	NC
Language Preferred for Written Materials—Non-English	0.00%	NC
Language Preferred for Written Materials—Unknown	100.00%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	65.51	★★
Outpatient Visits—Total	577.22	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	7.80	NC
Total Inpatient—Average Length of Stay—Total	3.38	NC
Maternity—Discharges per 1,000 Member Months—Total	2.57	NC
Maternity—Average Length of Stay—Total	2.01	NC
Surgery—Discharges per 1,000 Member Months—Total	1.99	NC
Surgery—Average Length of Stay—Total	5.15	NC
Medicine—Discharges per 1,000 Member Months—Total	3.91	NC
Medicine—Average Length of Stay—Total	3.14	NC
***Use of Opioids From Multiple Providers**[*,2]		
Multiple Prescribers	21.41%	NC
Multiple Pharmacies	7.02%	NC
Multiple Prescribers and Multiple Pharmacies	3.76%	NC
***Use of Opioids at High Dosage**[*,2]		
Use of Opioids at High Dosage	1.80%	NC
***Risk of Continued Opioid Use**[*,4]		
At Least 15 Days Covered—Total	13.49%	NC
At Least 31 Days Covered—Total	5.97%	NC

Measure	HEDIS 2019	2019 Performance Level
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	16.67%	★★
Index Total Stays—Observed Readmissions—45–54 Years	15.82%	★★★
Index Total Stays—Observed Readmissions—55–64 Years	14.87%	★★★
Index Total Stays—Observed Readmissions—Total	15.91%	★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-26 shows **McLaren Health Plan** ranked at or above the 75th percentile for five of the 64 measure rates (7.8 percent), none of which exceeded the 90th percentile. Conversely, 30 out of 64 measure rates (46.9 percent) fell below the 50th percentile, five of which fell below the 25th percentile. Opportunities for improvement for **McLaren Health Plan** include a focus on Child & Adolescent Care, where several rates in the domain fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **McLaren Health Plan** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **McLaren Health Plan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its members residing in rural areas (Regions 6 and 7). The goal of the PIP is to improve the timeliness of prenatal care for women residing in Region 7 and eliminate the identified disparity without a decline in performance for women residing in Region 6.

Table 5-27 outlines the study indicators for the PIP.

Table 5-27—Study Indicators for MCL

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible pregnant women residing in Region 7 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible pregnant women residing in Region 6 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-28 displays the validation results for **McLaren Health Plan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-28 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-28—PIP Validation Results for MCL

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (10/10)**	**0% (0/10)**	**0% (0/10)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	100% (3/3)	0% (0/3)	0% (0/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (22/22)**		

Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP.

For the first remeasurement period, **McLaren Health Plan** reported that 85.5 percent of eligible women residing in Region 7 received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 74.2 percent of eligible women residing in Region 6 received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The reported rates for both study indicators met the goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

McLaren Health Plan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **McLaren Health Plan** received a total compliance score of 98 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **McLaren Health Plan** scored 90 percent or above in the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards, indicating generally strong performance in all reviewed program areas. While five of the 64 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 30 measure rates fell below the 50th percentile, indicating opportunities for improvement for **McLaren Health Plan** primarily in the Child & Adolescent Care, Access to Care, Obesity, Living With Illness, and Utilization domains.

McLaren Health Plan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-29—Quality, Timeliness, and Access Performance Impact for MCL

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 100 percent in the Quality standard, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 100 percent in the MIS standard, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The MHP received a performance score of 98 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider.

Performance Area*	Overall Performance Impact
	• Strength: The *Appropriate Testing for Children With Pharyngitis* measure rate ranked at or above the 75th percentile, indicating many children diagnosed with pharyngitis received appropriate testing and treatment. • Strength: The *Adult BMI Assessment* measure rate ranked at or above the 75th percentile, indicating that adult members were receiving BMI assessments during visits with their primary care practitioners. • Strength: One of the three *Medical Assistance With Smoking and Tobacco Use Cessation* indicator rates ranked at or above the 75th percentile, indicating many adults who are tobacco smokers or users discussed cessation medications with their primary care practitioner to help quit tobacco and improve overall health. • Strength: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure rate ranked at or above the 75th percentile, indicating many adults with schizophrenia were dispensed and remained on an antipsychotic for most of their treatment period, which reduces the risk of relapse and complications. • Strength: The MHP designed a scientifically sound PIP, *Addressing Disparities in Timeliness of Prenatal Care*, supported by using key research principles, and performed well with data analysis and improvement strategies, meeting 100 percent of the requirements in the Design and Implementation stages. • Weakness: The *Appropriate Treatment for Children with Upper Respiratory Infection* measure rate fell below the 50th percentile, indicating many children diagnosed with an upper respiratory infection were prescribed an antibiotic inappropriately, which can lead to antibiotic-resistant bacteria. • Weakness: The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and the *Adolescent Well-Care Visits* measure rates fell below the 50th percentile, indicating many children and adolescents were not seeing their PCPs or OB/GYNs as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Weakness: Two of the three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicator rates fell below the 50th percentile, indicating opportunities for PCPs and OB/GYNs to provide counseling on nutrition and physical activity to children and adolescents for maintaining a healthy weight and lifestyle. • Weakness: Two of the six *Comprehensive Diabetes Care* indicator rates fell below the 50th percentile, indicating opportunities to improve proper diabetes management, which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate fell below the 50th percentile, indicating members diagnosed with schizophrenia were not always screened for diabetes during the year. • Weakness: All three *Annual Monitoring for Patients on Persistent Medications* indicator rates fell below the 50th percentile, indicating many members may be at risk of adverse drug events.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: The MHP received a performance score of 100 percent in the Members standard, indicating that members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: The *Lead Screening in Children* measure rate ranked at or above the 75th percentile, indicating children were appropriately tested for lead poisoning by 2 years of age. • Strength: The MHP demonstrated statistically significant improvement over the baseline for PIP Study Indicator 1 for the Remeasurement 1 measurement period, meeting the goal of removing the regional disparity related to the timeliness of prenatal care. • Weakness: All nine *Childhood Immunization Status* indicator rates fell below the 50th percentile, including five indicator rates that fell below the 25th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening diseases.
Access	• Weakness: All four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 50th percentile, indicating children were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: Three of the four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates fell below the 50th percentile, indicating many adults between the ages of 20 and 44 years and adults 65 years and older were not accessing ambulatory or preventive care services from their physicians. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 50th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-30, Table 5-31, and Table 5-32 present the recommendations made by HSAG to **McLaren Health Plan** during the SFY 2017–2018 EQR, **McLaren Health Plan**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **McLaren Health Plan** addressed those recommendations.

Table 5-30—Compliance Monitoring Recommendations—MCL

HSAG's Recommendations
McLaren Health Plan should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Administration • Providers • Program Integrity **McLaren Health Plan** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Summary of MCL's Response
McLaren Health Plan did not provide a response as to how the MHP addressed the recommendations made in the prior year's technical report; however, MDHHS required a CAP for deficient elements.
HSAG's Assessment of the Degree to Which MCL Addressed the Recommendations
Based on the SFY 2018–2019 compliance review findings, **McLaren Health Plan** addressed the prior year's recommendations; however, **McLaren Health Plan** continues to have opportunities for improvement related to the provider directory and program integrity forms. **McLaren Health Plan** received deficient findings for *MHP Provider Directory Accuracy* in February 2019 and *Program Integrity Forms* in November 2019.

Table 5-31—Performance Measures Recommendations—MCL

HSAG's Recommendations
HSAG recommended that **McLaren Health Plan** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Child & Adolescent Care** • *Appropriate Treatment for Children With Upper Respiratory Infection* **Access to Care** • *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years* **Living With Illness** • *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* **Utilization** • *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* HSAG further recommended that **McLaren Health Plan** include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **McLaren Health Plan** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **McLaren Health Plan** should have included the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement

Summary of MCL's Response

McLaren Health Plan submitted the following action plans to MDHHS in July 2019.

Child Access to Care 12–24 Months

Action Plan:

- Distributing gaps in care reports monthly
- Newsletter articles on the importance of accessing primary care services
- Continue to offer outreach services to provider offices where **McLaren Health Plan** staff will assist in scheduling patients for well visits
- Developed Quality Quick Tips monthly education to providers
- HEDIS manuals distributed
- Utilize population health software to determine gaps and high and low utilizing providers to be used as an educational tool
- Increased coordination with MIHP and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- Access to care days developed and implemented

Results: Performance measure rate increased to 94.66 percent in 2018, which was still below the 75th percentile, but a 2 percent increase from the previous year's rate.

Child Access to Care 25 Months–6 Years

Action Plan:

- Distributing gaps in care reports monthly
- Newsletter articles on the importance of accessing primary care services
- Continue to offer outreach services to provider offices where **McLaren Health Plan** staff will assist in scheduling patients for well visits
- Developed Quality Quick Tips monthly education to providers
- HEDIS manuals distributed
- Utilize population health software to determine gaps and high and low utilizing providers to be used as an educational tool
- Increased coordination with MIHP and WIC
- Access to care days developed and implemented

Results: Performance measure rate increased to 86.68 percent in 2018, which was still below the 75th percentile, but a 3 percent increase from the previous year's rate.

Adolescent Well Visit

Action Plan:

- Distributing gaps in care reports monthly via the Michigan Health Information Network (MiHIN) and **McLaren Health Plan**'s provider portal
- Gaps in care reporting via provider offices and physician hospital organizations
- Newsletter articles on the importance of well visits

Summary of MCL's Response

- Continue to offer outreach services to provider offices where **McLaren Health Plan** staff will assist in scheduling patients for well visits
- HEDIS manuals distributed to all PCPs with tips on when and how to bill for well visits
- Development of monthly Quality Quick Tips PCP fax on specific topics such as adolescent well visits
- Increase coordination with CHWs and health departments

Results: Performance measure rate increased by 5 percent to 50 percent, which did not meet the 75th percentile but was a statistically significant increase. As a significant increase occurred in 2018, **McLaren Health Plan** will continue all interventions and monitor throughout 2019.

Annual Monitoring—ACE/ARBS

Action Plan:

- Distributing gaps in care reports monthly
- Changed pharmacy benefit manager (PBM) effective January 1, 2019
- Developed Quality Quick Tips monthly education to providers
- HEDIS manuals distributed
- Utilize population health software to determine gaps and high and low utilizing providers to be used as an educational tool

Results: Performance measure rate remained stable at 86.05 percent in 2018, which was still below the 75th percentile.

Annual Monitoring—ED visits rate

Action Plan:

- **McLaren Health Plan** increased its outreach to members utilizing the ED in 2018 through work with Community Health Innovation Regions for members identified with inappropriate or preventable ED services, as well as members utilizing the ED for oral health care
- Increased collaborative efforts with CHW outreach
- In 2019, **McLaren Health Plan** developed a comprehensive ED program and hired a dedicated outreach staff person to monitor ED utilization and includes stratification of number of visits and intensity of outreach efforts

Results: The 2018 ED visits per member months decreased significantly to 65.51 percent.

HMP—Preventive Dental Care

Action Plan:

- Provider and member newsletter articles on the importance of dental care
- Additional PCP faxes regarding education to providers on importance of encouraging a dental home
- Collaboration with dental managed care organization on member education for members that have not received dental or medical care in the past 12 months
- HMP member focus study to assist in determining barriers to receiving ambulatory dental services
- Continued coordination with CHWs to locate and assist in accessing dental care
- Continued coordination with Federally Qualified Health Centers (FQHCs) that house dental services

Summary of MCL's Response
Results: Preventive dental services rate per April 2019 performance measure review (PMR) (October 1, 2017–September 30, 2018) was 20.75 percent. The rate decreased from April 2018 and was at the 50th percentile. **Outreach and Engagement to Facilitate Entry to Primary Care** **Action Plan:** • Member education of HRAs and PCP visit requirements through phone calls, website, portal, and newsletters • Provider education of HRA and PCP visit requirements through PCP Connection faxes, website, portal, and provider newsletters • Welcome/HRA calls for all newly enrolled members within 30 days of enrollment • Assistance offered to members in setting up a PCP visit (three-way calls to office) • Three Touch approach—Initial call; follow up call for members not reached in the initial call; sorry we missed you postcard • Member education on the transportation benefit • Monthly Gaps in Care reports to Providers for any HMP member who has not completed his or her HRA • Fax follow up to assigned PCP and claim review after multiple failed contact attempts **Results:** Based on MDHHS performance monitoring reports, **McLaren Health Plan**'s outreach and engagement rate decreased by 1.92 percent to 46.70 percent. **McLaren Health Plan** will continue and increase interventions throughout 2019. **Appropriate Treatment for Children with Upper Respiratory Infection (URI)** **Action Plan:** • Provider and member newsletter articles on the importance of appropriate use of antibiotics • Additional PCP faxes regarding education to providers on importance of appropriate treatment of respiratory diagnoses • Development of Quality Quick Tips PCP faxes on measures like URI • Continued distribution of HEDIS manual • Continued targeted education to those providers not prescribing antibiotics appropriately per HEDIS guidelines **Results:** Performance measure rate increased by 4 percent to 89.96 percent, which did not meet the 75th percentile but was a significant increase to nearly the 50th percentile. **McLaren Health Plan** will continue all interventions and monitor throughout 2019. **WCC—Nutritional Counseling Rate** **Action Plan:** • Provider newsletter articles on the importance of discussion or guidance regarding nutrition • Additional PCP faxes regarding education to providers on importance of reviewing BMI and nutritional behaviors • Development of Quality Quick Tips PCP faxes • Continued provider incentive

Summary of MCL's Response
• Continued education to PCPs regarding the ability to submit supplemental data throughout the year showing nutritional counseling • Monthly gaps in care reporting **Results:** Performance measure rate increased by 3 percent to 66.67 percent, which did not meet the 75th percentile but was a significant increase. **McLaren Health Plan** will continue all interventions and monitor throughout 2019. **WCC—Physical Activity Counseling** **Action Plan:** • Provider newsletter articles on the importance of discussion or guidance regarding physical activity • Additional PCP faxes regarding education to providers on importance of reviewing BMI and physical activity behaviors • Development of Quality Quick Tips PCP faxes on measures • Continued provider incentive • Continued education to PCPs regarding the ability to submit supplemental data throughout the year showing nutritional counseling • Monthly gaps in care reporting **Results:** Performance measure rate increased by 7 percent to 63.26 percent, which did not meet the 75th percentile but was a significant increase. **McLaren Health Plan** will continue all interventions and monitor throughout 2019.
HSAG's Assessment of the Degree to Which MCL Addressed the Recommendations
HSAG recommended that **McLaren Health Plan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. Based on the results of the SFY 2018–2019 validation, all five measure rates that fell below the 25th percentile in SFY 2017–2018 improved to rank at or above the 25th percentile but below the 50th percentile in SFY 2018–2019, indicating **McLaren Health Plan** fully addressed the prior recommendations.

Table 5-32—PIP Recommendations—MCL

HSAG's Recommendations
McLaren Health Plan should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **McLaren Health Plan** should have ensured the following: • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Summary of MCL's Response
While **McLaren Health Plan** provided the PIP Summary Form completed during the PIP validation activity, it did not provide a summary of how it addressed the prior year's technical report recommendations.
HSAG's Assessment of the Degree to Which MCL Addressed the Recommendations
For the SFY 2017–2018 validation, **McLaren Health Plan** designed a PIP that was appropriate for measuring and monitoring PIP outcomes, and reported accurate baseline measurement results and improvement strategies; therefore, HSAG had no required follow-up recommendations. HSAG did provide the following recommendations for **McLaren Health Plan**'s consideration as it progressed to Remeasurement 1: complete an annual causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner, as interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate; implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes; and implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators. In the SFY 2018–2019 validation, **McLaren Health Plan** addressed all recommendations for consideration within the PIP submission.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **McLaren Health Plan** to members, HSAG recommends that **McLaren Health Plan** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **McLaren Health Plan** incorporate new improvement efforts as necessary for the following performance measure ranking below the 25th percentile.

Child & Adolescent Care

- *Childhood Immunization Status—Combination 3, 4, 5, 7,* and *9*

To meet the above recommendation, **McLaren Health Plan** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **McLaren Health Plan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented above, **McLaren Health Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **McLaren Health Plan** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Program Integrity

McLaren Health Plan was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends that **McLaren 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 recommends that **McLaren Health Plan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. Additionally, HSAG recommends **McLaren Health Plan**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **McLaren Health Plan** should immediately implement internal corrective action.

McLaren Health Plan should also take proactive steps to ensure a successful PIP. **McLaren Health Plan** should address all feedback in the *2018–2019 PIP Validation Report Addressing Disparities in Timeliness of Prenatal Care for McLaren Health Plan* and consider the following recommendations in the next annual submission:

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Continue to evaluate the effectiveness of each individual intervention and report the findings of the evaluation analysis in the next annual submission.

Finally, as applicable, **McLaren Health Plan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

Meridian Health Plan of Michigan (MER)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **Meridian Health Plan of Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Meridian Health Plan of Michigan**.

EQR Activity Results

Compliance Monitoring

Meridian Health Plan of Michigan was evaluated in six program areas referred to as "standards." Table 5-33 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-33 also presents **Meridian Health Plan of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-33—Compliance Review Results for MER

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	MER	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	14	1	0	15	97%	91%
3	Members	7	1	0	8	94%	87%
4	Quality	15	0	0	15	100%	98%
5	MIS	9	0	0	9	100%	95%
6	Program Integrity	25	3	0	28	95%	97%
Overall		**75**	**5**	**0**	**80**	**97%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Meridian Health Plan of Michigan demonstrated compliance for 75 of 80 elements, with an overall compliance score of 97 percent, which was above the statewide average of 95 percent. **Meridian Health Plan of Michigan** demonstrated strong performance, scoring above 90 percent in all six standards, with three standards (Administrative, Quality, and MIS) achieving full compliance. The program areas of strength include the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in three of the six standards, which are briefly described below:

- *Program Integrity Forms* (November)—Errors and/or discrepancies were noted on the Tips and Grievances, Data Mining, and Audits forms.
- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.
- *Benefits Monitoring Program* (February)—Policy did not indicate that prior to implementing new remedies and sanctions, the MHP must obtain written approval from MDHHS.

MDHHS required **Meridian Health Plan of Michigan** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Meridian Health Plan of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **Meridian Health Plan of Michigan** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **Meridian Health Plan of Michigan** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-34 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-5] for **Meridian Health Plan of Michigan**.

[5-5] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-34—HEDIS 2019 Performance Measure Results for MER

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	72.02%	★★
Combination 3	67.40%	★★
Combination 4	66.91%	★★
Combination 5	56.93%	★★
Combination 6	40.39%	★★★
Combination 7	56.45%	★★
Combination 8	40.39%	★★★
Combination 9	34.79%	★★
Combination 10	34.79%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	76.40%	★★★★★
Lead Screening in Children		
Lead Screening in Children	78.42%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.32%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	60.34%	★★★
Immunizations for Adolescents		
Combination 1	86.37%	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	88.76%	★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	81.77%	★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	44.78%	★★
Continuation and Maintenance Phase	56.86%	★★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	64.00%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	64.59%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	63.13%	★★★★
Ages 21 to 24 Years	69.90%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Total	66.33%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	96.49%	★★★
Ages 25 Months to 6 Years	89.92%	★★★
Ages 7 to 11 Years	91.91%	★★★
Ages 12 to 19 Years	91.43%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	80.18%	★★★
Ages 45 to 64 Years	88.46%	★★★
Ages 65+ Years	96.22%	★★★★★
Total	83.40%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	34.93%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	83.70%	★★★★
Counseling for Nutrition—Total	72.99%	★★★
Counseling for Physical Activity—Total	69.59%	★★★
Adult BMI Assessment		
Adult BMI Assessment	94.16%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	79.81%	★★
Postpartum Care	69.59%	★★★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	88.08%	★★★
*HbA1c Poor Control (>9.0%)**	40.88%	★★
HbA1c Control (<8.0%)	49.15%	★★
Eye Exam (Retinal) Performed	67.61%	★★★★
Medical Attention for Nephropathy	91.24%	★★★
Blood Pressure Control (<140/90 mm Hg)	69.59%	★★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	64.59%	★★★
Medication Compliance 75%—Total	39.39%	★★★

Measure	HEDIS 2019	2019 Performance Level
Asthma Medication Ratio		
Total	62.95%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure[2]	59.37%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	80.83%	★★★
Discussing Cessation Medications	56.05%	★★★
Discussing Cessation Strategies	47.62%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	53.57%	★★★
Effective Continuation Phase Treatment	37.03%	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.06%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	71.46%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	72.06%	★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	69.06%	★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	84.95%	★
Diuretics	85.23%	★
Total	85.06%	★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	54.61%	NC
Total—Black or African American	18.96%	NC
Total—American-Indian and Alaska Native	0.37%	NC
Total—Asian	0.66%	NC
Total—Native Hawaiian and Other Pacific Islander	0.05%	NC
Total—Some Other Race	0.19%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	5.12%	NC
Total—Declined	20.05%	NC

Measure	HEDIS 2019	2019 Performance Level
Total—Hispanic or Latino	5.10%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	98.62%	NC
Spoken Language Preferred for Health Care—Non-English	1.38%	NC
Spoken Language Preferred for Health Care—Unknown	0.00%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	98.62%	NC
Language Preferred for Written Materials—Non-English	1.38%	NC
Language Preferred for Written Materials—Unknown	0.00%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	98.62%	NC
Other Language Needs—Non-English	1.38%	NC
Other Language Needs—Unknown	0.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	68.41	★★
Outpatient Visits—Total	396.93	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	7.59	NC
Total Inpatient—Average Length of Stay—Total	3.98	NC
Maternity—Discharges per 1,000 Member Months—Total	2.99	NC
Maternity—Average Length of Stay—Total	2.54	NC
Surgery—Discharges per 1,000 Member Months—Total	1.76	NC
Surgery—Average Length of Stay—Total	6.45	NC
Medicine—Discharges per 1,000 Member Months—Total	3.69	NC
Medicine—Average Length of Stay—Total	3.64	NC
Use of Opioids From Multiple Providers[*,2]		
Multiple Prescribers	18.12%	NC
Multiple Pharmacies	5.64%	NC
Multiple Prescribers and Multiple Pharmacies	3.10%	NC
Use of Opioids at High Dosage[*,2]		
Use of Opioids at High Dosage	2.28%	NC
Risk of Continued Opioid Use[*,4]		
At Least 15 Days Covered—Total	15.52%	NC
At Least 31 Days Covered—Total	6.76%	NC

Measure	HEDIS 2019	2019 Performance Level
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	15.79%	★★
Index Total Stays—Observed Readmissions—45–54 Years	16.57%	★★
Index Total Stays—Observed Readmissions—55–64 Years	15.89%	★★
Index Total Stays—Observed Readmissions—Total	16.05%	★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-34 shows **Meridian Health Plan of Michigan** ranked at or above the 75th percentile for 12 of the 64 measure rates (18.8 percent), two of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care and Access to Care domains. Conversely, 22 of 64 measure rates (34.4 percent) fell below the 50th percentile, four of which fell below the 25th percentile. Opportunities for improvement for **Meridian Health Plan of Michigan** include a focus on Living With Illness, where several rates in the domain fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **Meridian Health Plan of Michigan** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **Meridian Health Plan of Michigan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its women members residing in rural areas (Regions 3 and 5). The goal of the PIP is to improve the timeliness of prenatal care for women residing in Region 3 and eliminate the identified disparity without a decline in performance for the women residing in Region 5.

Table 5-35 outlines the study indicators for the PIP.

Table 5-35—Study Indicators for MER

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible pregnant women residing in Region 3 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

PIP Topic	Study Indicators
	2. The percentage of eligible pregnant women residing in Region 5 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-36 displays the validation results for **Meridian Health Plan of Michigan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-36 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-36—PIP Validation Results for MER

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% (10/10)**	**0% (0/10)**	**0% (0/10)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Outcomes	IX.	Real Improvement Achieved	67% (2/3)	0% (0/3)	33% (1/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**67% (2/3)**	**0% (0/3)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**95% (21/22)**		

Overall, 95 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP.

For the remeasurement period, **Meridian Health Plan of Michigan** reported that 70.5 percent of eligible women residing in Region 3 received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 77.1 percent of eligible women residing in Region 5 received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The reported rates for both study indictors demonstrated a decline over the baseline measurement period; however, the MHP met the goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

Meridian Health Plan of Michigan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Meridian Health Plan of Michigan** received a total compliance score of 97 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **Meridian Health Plan of Michigan** scored 94 percent or above for all standards, indicating generally strong performance in all program areas reviewed. While 12 of the 64 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 22 measure rates fell below the 50th percentile, indicating opportunities for improvement for **Meridian Health Plan of Michigan** primarily in the Child & Adolescent Care, Pregnancy Care, Living With Illness, and Utilization domains.

Meridian Health Plan of Michigan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-37—Quality, Timeliness, and Access Performance Impact for MER

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 100 percent in the Quality standard, indicating that the MHP had most components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 100 percent in the MIS standard, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The MHP received a performance score of 95 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider. • Strength: The *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure rate exceeded the 90th percentile, indicating many children and adolescents were seeing their PCPs as often as suggested to ensure assessment of their physical, emotional, and social development. • Strength: All three *Chlamydia Screening in Women* indicator rates ranked at or above the 75th percentile, indicating many women ages 16 to 24 were screened for this sexually transmitted disease which can lead to serious and irreversible complications if left untreated. • Strength: The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* indicator rate and the *Adult BMI Assessment* measure rate ranked at or above the 75th percentile, indicating many child, adolescent, and adult BMIs were assessed by a PCP or OB/GYN to monitor weight problems and identify those who are at risk for obesity. • Strength: One of the six *Comprehensive Diabetes Care* indicator rates ranked at or above the 75th percentile, indicating many members received a retinal eye exam which is essential for proper diabetes management and to reduce risks for complications. • Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate ranked at or above the 75th percentile, indicating members diagnosed with schizophrenia were appropriately screened for diabetes during the year. • Strength: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure rate ranked at or above the 75th percentile, indicating many members were dispensed an antipsychotic medication and remained on the medication

Performance Area*	Overall Performance Impact
	for most of their treatment period, which reduces the risk of relapse and hospitalization. • Strength: The MHP designed a scientifically sound PIP, *Addressing Disparities in Timeliness of Prenatal Care*, supported by using key research principles, and performed well with data analysis and improvement strategies, meeting 100 percent of the requirements in the Design and Implementation stages. • Weakness: The *Appropriate Treatment for Children With Upper Respiratory Infection* measure rate fell below the 50th percentile, indicating many children diagnosed with an upper respiratory infection were prescribed an antibiotic inappropriately, which can lead to antibiotic-resistant bacteria. • Weakness: Two of the six *Comprehensive Diabetes Care* indicator rates fell below the 50th percentile, indicating opportunities to improve proper diabetes management, which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: The *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure rate fell below the 25th percentile, indicating adult members diagnosed with schizophrenia and cardiovascular disease did not receive an LDL-C test and, therefore, did not receive appropriate screening and monitoring to detect any decline in health. • Weakness: All three *Annual Monitoring for Patients on Persistent Medications* indicator rates fell below the 25th percentile, indicating many members may be at risk of adverse drug events.
Timeliness	• Strength: The MHP received a performance score of 94 percent in the Members standard, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: The *Immunizations for Adolescents—Combination 1* indicator rate ranked at or above the 75th percentile, indicating that members 13 years of age were receiving vaccines in a timely manner to protect them from serious and potentially life-threatening diseases. • Strength: The *Prenatal and Postpartum Care—Postpartum Care* indicator rate ranked at or above the 75th percentile, indicating that women received appropriate postpartum care visits in a timely manner. • Weakness: Seven of the nine *Childhood Immunization Status* indicator rates fell below the 50th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening diseases. • Weakness: The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator rate fell below the 50th percentile, indicating that women were not receiving timely prenatal visits with their physician. • Weakness: The MHP met 67 percent of the PIP evaluation elements. While the MHP met the goal of removing the regional disparity related to timeliness of prenatal care, the plan also demonstrated a non-statistically significant decrease in performance across both study indicators.

Performance Area*	Overall Performance Impact
Access	• Strength: One of the four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates exceeded the 90th percentile, indicating many adults 65 years of age and older were accessing ambulatory or preventive care services from their physicians. • Weakness: Both *Follow-Up Care for Children Prescribed ADHD Medication* indicator rates fell below the 50th percentile, indicating opportunities to improve medication management to control symptoms of hyperactivity, impulsiveness, and inability to sustain concentration. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 50th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-38, Table 5-39, and Table 5-40 present the recommendations made by HSAG to **Meridian Health Plan of Michigan** during the SFY 2017–2018 EQR, **Meridian Health Plan of Michigan**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **Meridian Health Plan of Michigan** addressed those recommendations.

Table 5-38—Compliance Monitoring Recommendations—MER

HSAG's Recommendations
Meridian Health Plan of Michigan should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Providers • MIS • Program Integrity **Meridian Health Plan of Michigan** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies

Summary of MER's Response
• The recommendations provided were general and summarized general QI concepts. These concepts are already implemented by the QI team.   – It is helpful to see a checklist of questions/activities for how to look at the data from multiple viewpoints. This is something we plan to add to our work plans and annual evaluations to be more robust. • The strengths and weaknesses section of the report lists out poor performing HEDIS measures but could also be summarized more clearly in a table since actions are listed. There is value to strengths and weaknesses pointing and correlations between operational areas and outcomes impacts (e.g., success of MIHP partnerships). This would be beneficial if this type of information was increased. The report is not generated and provided to plans until after the activities should be in place (e.g., report received in March 2019 for 2017 activities and Meridian began taking action in 2018 based on 2017 data and so on).
HSAG's Assessment of the Degree to Which MER Addressed the Recommendations
Based on **Meridian Health Plan of Michigan**'s response and the SFY 2018–2019 compliance review findings, **Meridian Health Plan of Michigan** addressed the prior year's recommendations; however, **Meridian Health Plan of Michigan** continues to have opportunities for improvement related to the provider directory and program integrity forms. **Meridian Health Plan of Michigan** received deficient findings for *MHP Provider Directory Accuracy* in February 2019 and *Program Integrity Forms* in November 2019.

Table 5-39—Performance Measures Recommendations—MER

HSAG's Recommendations
HSAG recommended that **Meridian Health Plan of Michigan** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Child & Adolescent Care** • *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* **Living With Illness** • *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* **Utilization** • *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* HSAG further recommended that **Meridian Health Plan of Michigan** include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses?

HSAG's Recommendations
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Meridian Health Plan of Michigan** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **Meridian Health Plan of Michigan** should have included the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement
Summary of MER's Response
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase • HEDIS 2018 Rate; Initiation – 40.71 percent and Continuation and Maintenance – 47.91 percent • HEDIS 2019 Rate; Initiation – 44.78 percent and Continuation and Maintenance – 56.86 percent • Identified Barriers and Opportunities – Implement interventions that will improve medication management to control symptoms of hyperactivity, impulsiveness, and inability to sustain concentration. – Plan member focused interventions: telephonic outreach and educational infographic detailing ways to improve symptoms associated with ADHD. • Noted Disparities – African-American population approximately 14 percent below current overall rate and 17 percent below Caucasian rate (Initiation) – African-American population approximately 11 percent below current overall rate and 13 percent below Caucasian rate (Continuation); Regions 7 and 9 are 5 to 10 percent above average • Current Activities – Provider education on measure – Electronic medical record (EMR) access to review medical records • Proposed – Utilization of attestation form to ease provider reporting **Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Diuretics** Not applicable. This measure was retired. **Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total** This was measured through the implementation of two State PIPs aimed at lowering ED Utilization

Summary of MER's Response
• ED PIP aimed at decreasing high utilizers and decreasing the disparity between Caucasians and African Americans – Baseline: 3.56 percent of target Caucasian population were high utilizers; 6.41 percent of target African-American population were high utilizers – 18 months of intervention: reduced to 1.55 percent of target Caucasian population classified as high utilizers and 3.53 percent of target African-American population classified as high utilizers • ED PIP aimed at reducing utilization for dental reasons (in progress) – Baseline: 103.79/1,000 claims for dental reason in target population – Six months of intervention: 91.10/1,000 claims for dental reason in target population • Identified Barriers and Opportunities – African-American population was utilizing the ED more than Caucasian counterpart; decrease ED utilization overall while decreasing the variance in the population – Lack of knowledge of benefits; lack of preventive services; opportunity to increase education and connect members to dental homes • Noted Disparities – Disparity between racial groups classified as high utilizer – Ages 20–44 more likely to utilize ED for dental reasons • Current Activities – Outreach to members utilizing ED – Connecting members with dental home and education on importance of preventive care – Connecting with community partners – Utilization of member incentives
HSAG's Assessment of the Degree to Which MER Addressed the Recommendations
HSAG recommended that **Meridian Health Plan of Michigan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. Based on the results of the SFY 2018–2019 validation, the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* and *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* indicator rates improved to rank at or above the 25th percentile but below the 50th percentile; however, the rates for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* indicators remained below the 25th percentile, indicating **Meridian Health Plan of Michigan** has opportunities to continue performance improvement efforts in these performance areas. Additionally, although **Meridian Health Plan of Michigan** indicated that the *Annual Monitoring for Patients on Persistent Medications* measure was *Not Applicable* since the measure was retired, this measure did not retire until HEDIS 2020; therefore, **Meridian Health Plan of Michigan** should have proceeded with implementing a plan for improved performance.

Table 5-40—PIP Recommendations—MER

HSAG's Recommendations
Meridian Health Plan of Michigan should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **Meridian Health Plan of Michigan** should have ensured the following: • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Summary of MER's Response
Meridian Health Plan of Michigan currently includes improvements for HEDIS rates in internal tracking and the annual evaluation documents. **Meridian Health Plan of Michigan** also develops QI activities for low performing measures. **Meridian Health Plan of Michigan** will ensure measures recommended in the EQR are included in these documents. These items will also be included in our work plan documents. In 2019, **Meridian Health Plan of Michigan** implemented HEDIS measure owners that meet bi-weekly to discuss changes, trends, and interventions. Measure owners also report on the progress toward set goals.
HSAG's Assessment of the Degree to Which MER Addressed the Recommendations
For the SFY 2017–2018 validation, **Meridian Health Plan of Michigan** designed a PIP that was appropriate for measuring and monitoring PIP outcomes, and reported accurate baseline measurement results and improvement strategies; therefore, HSAG had no required follow-up recommendations. HSAG did provide the following recommendations for **Meridian Health Plan of Michigan**'s consideration as it progressed to Remeasurement 1: complete an annual causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner, as interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate; implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes; and implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators. In the SFY 2018–2019 validation, **Meridian Health Plan of Michigan** addressed all recommendations for consideration within the PIP submission.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Meridian Health Plan of Michigan** to members, HSAG recommends that **Meridian Health Plan of Michigan** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **Meridian Health Plan of Michigan** incorporate new improvement efforts as necessary for the following performance measures ranking below the 25th percentile.

Living With Illness

- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics*, and *Total*

Meridian Health Plan of Michigan should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Meridian Health Plan of Michigan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Meridian Health Plan of Michigan** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Meridian Health Plan of Michigan** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Members
- Program Integrity

Meridian Health Plan of Michigan was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends that **Meridian Health Plan 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 recommends that **Meridian Health Plan of Michigan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. Additionally, HSAG recommends **Meridian Health Plan of Michigan**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **Meridian Health Plan of Michigan** should immediately implement internal corrective action.

Meridian Health Plan of Michigan should also take proactive steps to ensure a successful PIP. **Meridian Health Plan of Michigan** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments* in the *2018–2019 PIP Validation Report Addressing Disparities in Timeliness of Prenatal Care for Meridian Health Plan of Michigan* and make the following necessary corrections prior to the next annual submission:

- The PIP has not yet demonstrated significant improvement in the study indicator results for both study indicators. The MHP should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.

Finally, as applicable, **Meridian Health Plan of Michigan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

Molina Healthcare of Michigan (MOL)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **Molina Healthcare of Michigan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Molina Healthcare of Michigan**.

EQR Activity Results

Compliance Monitoring

Molina Healthcare of Michigan was evaluated in six program areas referred to as "standards." Table 5-41 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-41 also presents **Molina Healthcare of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-41—Compliance Review Results for MOL

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	MOL	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	13	1	1	15	90%	91%
3	Members	5	3	0	8	81%	87%
4	Quality	15	0	0	15	100%	98%
5	MIS	8	1	0	9	94%	95%
6	Program Integrity	28	0	0	28	100%	97%
Overall		**74**	**5**	**1**	**80**	**96%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Molina Healthcare of Michigan demonstrated compliance for 74 of 80 elements, with an overall compliance score of 96 percent, which was above the statewide average of 95 percent. **Molina Healthcare of Michigan** demonstrated strong performance, scoring at or above 90 percent in five standards, with three standards (Administrative, Quality, and Program Integrity) achieving full compliance. The program areas of strength include the Administrative, Providers, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in three of the six standards, which are briefly described below:

- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.
- *Member Material* (April)—*ID Card and Member Handbook Mailed within 10 days*—New member packets were not sent within the 10-day timeline.
- *Member Handbook Requirements* (April)—In the reporting year, there were four instances in which the member handbook was not mailed timely.
- *Pharmacy/MCO Common Formulary* (April)—Non-compliant NCPDP rejections.
- *Written Member Appeal Decisions Rendered* (May)—Not all expedited appeals were resolved within the 72-hour time frame.
- *MHP Provider Directory Accuracy* (August)—"Accepting new MA pts" and "Was the phone # and address listed online correct?" fell below the 75 percent threshold.

MDHHS required **Molina Healthcare of Michigan** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Molina Healthcare of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **Molina Healthcare of Michigan** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **Molina Healthcare of Michigan** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-42 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-6] for **Molina Healthcare of Michigan**.

Table 5-42—HEDIS 2019 Performance Measure Results for MOL

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	75.91%	★★★
Combination 3	71.29%	★★★
Combination 4	70.32%	★★★
Combination 5	61.80%	★★★
Combination 6	38.93%	★★
Combination 7	61.07%	★★★
Combination 8	38.93%	★★
Combination 9	33.82%	★★
Combination 10	33.82%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	68.37%	★★★
Lead Screening in Children		
Lead Screening in Children	78.83%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.16%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	52.55%	★★
Immunizations for Adolescents		
Combination 1	88.56%	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	89.95%	★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	76.39%	★★

[5-6] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS 2019	2019 Performance Level
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	54.32%	★★★★
Continuation and Maintenance Phase	68.20%	★★★★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	59.49%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	67.40%	★★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	66.65%	★★★★
Ages 21 to 24 Years	70.08%	★★★★
Total	68.09%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	95.44%	★★
Ages 25 Months to 6 Years	87.60%	★★★
Ages 7 to 11 Years	90.88%	★★★
Ages 12 to 19 Years	90.40%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	78.52%	★★★
Ages 45 to 64 Years	87.40%	★★★
Ages 65+ Years	94.07%	★★★★★
Total	82.47%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	34.92%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	81.27%	★★★
Counseling for Nutrition—Total	75.18%	★★★
Counseling for Physical Activity—Total	72.02%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Adult BMI Assessment		
Adult BMI Assessment	93.19%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	71.05%	★
Postpartum Care	67.64%	★★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	87.10%	★★
*HbA1c Poor Control (>9.0%)**	41.36%	★★
HbA1c Control (<8.0%)	49.15%	★★
Eye Exam (Retinal) Performed	59.37%	★★★
Medical Attention for Nephropathy	90.02%	★★
Blood Pressure Control (<140/90 mm Hg)	61.56%	★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	58.19%	★★
Medication Compliance 75%—Total	34.84%	★★
Asthma Medication Ratio		
Total	60.16%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	54.01%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	80.00%	★★★
Discussing Cessation Medications	56.54%	★★★
Discussing Cessation Strategies	45.59%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	57.07%	★★★
Effective Continuation Phase Treatment	40.40%	★★★

Measure	HEDIS 2019	2019 Performance Level
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.98%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	71.26%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	76.74%	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.60%	★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	88.22%	★★★
Diuretics	88.21%	★★
Total	88.21%	★★★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	45.40%	NC
Total—Black or African American	34.44%	NC
Total—American-Indian and Alaska Native	0.26%	NC
Total—Asian	0.30%	NC
Total—Native Hawaiian and Other Pacific Islander	0.00%	NC
Total—Some Other Race	0.00%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	19.60%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	6.76%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	98.64%	NC
Spoken Language Preferred for Health Care—Non-English	1.32%	NC
Spoken Language Preferred for Health Care—Unknown	0.04%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC

Measure	HEDIS 2019	2019 Performance Level
Language Preferred for Written Materials—English	98.64%	NC
Language Preferred for Written Materials—Non-English	1.32%	NC
Language Preferred for Written Materials—Unknown	0.04%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	98.64%	NC
Other Language Needs—Non-English	1.32%	NC
Other Language Needs—Unknown	0.04%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	68.48	★★
Outpatient Visits—Total	418.38	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	7.34	NC
Total Inpatient—Average Length of Stay—Total	4.57	NC
Maternity—Discharges per 1,000 Member Months—Total	2.62	NC
Maternity—Average Length of Stay—Total	2.78	NC
Surgery—Discharges per 1,000 Member Months—Total	1.72	NC
Surgery—Average Length of Stay—Total	7.41	NC
Medicine—Discharges per 1,000 Member Months—Total	3.73	NC
Medicine—Average Length of Stay—Total	4.16	NC
***Use of Opioids From Multiple Providers**,*[2]		
Multiple Prescribers	18.63%	NC
Multiple Pharmacies	5.64%	NC
Multiple Prescribers and Multiple Pharmacies	3.37%	NC
***Use of Opioids at High Dosage**,*[2]		
Use of Opioids at High Dosage	1.57%	NC
***Risk of Continued Opioid Use**,*[4]		
At Least 15 Days Covered—Total	19.29%	NC
At Least 31 Days Covered—Total	7.93%	NC

Measure	HEDIS 2019	2019 Performance Level
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	12.72%	★★★★
Index Total Stays—Observed Readmissions—45–54 Years	14.88%	★★★
Index Total Stays—Observed Readmissions—55–64 Years	13.19%	★★★
Index Total Stays—Observed Readmissions—Total	13.51%	★★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-42 shows **Molina Healthcare of Michigan** ranked at or above the 75th percentile for 12 of the 64 measure rates (18.8 percent), two of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care and Access to Care domains. Conversely, 20 of 64 measure rates (31.3 percent) fell below the 50th percentile, one of which fell below the 25th percentile. Opportunities for improvement for **Molina Healthcare of Michigan** include a focus on the Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization domains.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **Molina Healthcare of Michigan** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **Molina Healthcare of Michigan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its African-American and Caucasian populations. The goal of the PIP is to improve the timeliness of prenatal care for the African-American population and eliminate the identified disparity without a decline in performance for the Caucasian population.

Table 5-43 outlines the study indicators for the PIP.

Table 5-43—Study Indicators for MOL

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible African-American women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible Caucasian women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-44 displays the validation results for **Molina Healthcare of Michigan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-44 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-44—PIP Validation Results for MOL

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	83% (5/6)	17% (1/6)	0% (0/6)
Implementation Total			**89% (8/9)**	**11% (1/9)**	**0% (0/9)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**86% (18/21)**		

Overall, 86 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP. The MHP has opportunities for improvement related to documentation and addressing HSAG's validation feedback in the Implementation and Outcomes stages.

For the first remeasurement period, **Molina Healthcare of Michigan** reported that 61.8 percent of eligible African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 70.3 percent of eligible Caucasian women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The Remeasurement 1 goal for both study indicators was set at 87.1 percent. The reported rates for both study indicators did not meet the goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

Molina Healthcare of Michigan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Molina Healthcare of Michigan** received a total compliance score of 96 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **Molina Healthcare of Michigan** scored 90 percent or above in the Administrative, Providers, Quality, MIS, and Program Integrity standards, indicating generally strong performance in these program areas, but did not perform as well in the Members standard, as demonstrated by a moderate performance score (81 percent), reflecting that additional focus is needed in this area. While 12 of the 64 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 20 measure rates fell below the 50th percentile indicating opportunities for improvement for **Molina Healthcare of Michigan** primarily in the Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization domains.

Molina Healthcare of Michigan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-45—Quality, Timeliness, and Access Performance Impact for MOL

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 100 percent in the Quality standard, indicating that the MHP had an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 94 percent in the MIS standard, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The MHP received a performance score of 100 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider. • Strength: The *Cervical Cancer Screening* measure rate ranked at or above the 75th percentile, indicating many women were screened for this type of cancer which is highly treatable if detected early. • Strength: All three *Chlamydia Screening in Women* indicator rates ranked at or above the 75th percentile, indicating many women were being screened for this sexually transmitted disease. • Strength: The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* and the *Adult BMI Assessment* measure rates ranked at or above the 75th percentile, indicating child, adolescent, and adult BMIs were assessed by a PCP or OB/GYN during a medical appointment, and children received counseling for nutrition and physical activity, which are important to identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate ranked above the 75th percentile, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Strength: The MHP designed a scientifically sound PIP, *Addressing Disparities in Timeliness of Prenatal Care*, supported by using key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. • Weakness: The *Adolescent Well-Care Visits* measure rate fell below the 50th percentile, indicating many adolescents were not seeing their PCPs or OB/GYNs as

Performance Area*	Overall Performance Impact
	often as suggested to ensure timely assessment of their physical, emotional, and social development. • Weakness: The *Appropriate Treatment for Children with Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis* measure rates fell below the 50th percentile, indicating many children diagnosed with an upper respiratory infection were prescribed an antibiotic inappropriately, which can lead to antibiotic-resistant bacteria; and children diagnosed with pharyngitis and dispensed an antibiotic did not receive the appropriate testing, which testing could potentially lead to a reduction in the unnecessary prescribing of antibiotics. • Weakness: Five of the six *Comprehensive Diabetes Care* indicator rates fell below the 50th percentile, indicating opportunities to improve proper diabetes management, which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: Both *Medication Management for People With Asthma* indicator rates and the *Asthma Medication Ratio—Total* measure rate fell below the 50th percentile, indicating that members with asthma were not properly utilizing controller medications to reduce the prevalence of asthma attacks. • Weakness: The *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure rate fell below the 50th percentile, indicating adult members diagnosed with schizophrenia and cardiovascular disease did not receive an LDL-C test and, therefore, did not receive appropriate screening and monitoring to detect any decline in health. • Weakness: One of the three *Annual Monitoring for Patients on Persistent Medications* indicator rates (*Diuretics*) fell below the 50th percentile, indicating many members may be at risk of adverse drug events.
Timeliness	• Strength: The *Immunizations for Adolescents—Combination 1* indicator rate exceeded the 90th percentile, indicating adolescents 13 years of age were receiving recommended vaccinations to prevent diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis, and human papillomavirus. • Strength: Both *Follow-Up Care for Children Prescribed ADHD Medication* indicator rates ranked at or above the 75th percentile, indicating that children prescribed ADHD medication had timely follow-up care to control symptoms of hyperactivity, impulsiveness, and inability to sustain concentration. • Weakness: The MHP received a performance score of 81 percent in the Members standard, indicating some members were not receiving new member information timely and may not have received services as promptly as needed when services were determined to be medically necessary. • Weakness: Four of the nine *Childhood Immunization Status* indicator rates fell below the 50th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator rate fell below the 25th percentile, indicating many women were not

Performance Area*	Overall Performance Impact
	accessing timely prenatal care, which could impact the health of the member and her baby during pregnancy and after delivery. • Weakness: The MHP did not demonstrate statistically significant improvement over the baseline for the PIP study indicators for the Remeasurement 1 measurement period. Both study indicators had a nonstatistical decline over the baseline measurement, indicating opportunities exist for members to access prenatal care timely. The goal of removing the racial disparity was also not achieved.
Access	• Strength: One of the four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates exceeded the 90th percentile, indicating many adults 65 years of age and older were accessing ambulatory or preventive care services from their physicians. • Weakness: One of the four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 50th percentile, indicating children ages 12 to 24 months were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 50th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-46, Table 5-47, and Table 5-48 present the recommendations made by HSAG to **Molina Healthcare of Michigan** during the SFY 2017–2018 EQR, **Molina Healthcare of Michigan**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **Molina Healthcare of Michigan** addressed those recommendations.

Table 5-46—Compliance Monitoring Recommendations—MOL

HSAG's Recommendations
Molina Healthcare of Michigan should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Providers • Members • Quality • Program Integrity

HSAG's Recommendations
Molina Healthcare of Michigan should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies

Summary of MOL's Response
Providers: Issue: When MDHHS conducted secret shopper calls on 17 PCPs listed in **Molina Healthcare of Michigan**'s online provider directory, they noted that five of the providers had correct information listed on the online directory and confirmed they were accepting new patients. They were unable to reach one provider's location and 10 providers stated they were not accepting new patients. Corrective Action: **Molina Healthcare of Michigan** staff reached out to those providers identified from the review and updated records so the information would be correctly reflected in the online provider directory. In addition, the Provider Services Department implemented several updates to the auditing and monitoring process to continue to improve the online provider directory information. <u>Provider Service Representative Visits:</u> At the time of each visit to a provider office, the Provider Service Representative is to verify the following information with each provider and update the system if changes are identified: • Office location address • Office phone • Office fax • Office hours • Americans with Disabilities Act (ADA) accessible • Special experience • Accepting new members • Verify that the provider is a PCP • Languages <u>Weekly Audit:</u> • Each week the Provider Services Department receives a random file with approximately 40 providers, for all lines of business. • Within three business days, an outreach call is made to the provider's office to verify the providers in the practice, service location, address, phone, fax, office hours, and product lines accepted. • Changes to provider information are documented on the audit spreadsheet. • The audit spreadsheet is sent to our Provider Network Administration (PNA) department.

Summary of MOL's Response

- The PNA department processes the audit file to update our internal system and the online directory within 30 calendar days.

Quarterly Audit:

The **Molina Healthcare of Michigan** Provider Data Validation team conducts outreach to contracted primary care and specialty providers on a quarterly basis, except for Physician Organizations that have a delegated credential agreement with a single point of contact (see note below). Those provider groups with 10 or less physicians are contacted by phone and provider groups with over 10 physicians by mail, fax, or email. They verify the following information with each provider:

- Office location address
- Office phone
- Office fax
- Office hours
- ADA accessible
- Special experience
- Accepting new members by line of business
- Verify that the provider is a PCP
- Languages

Note: On a quarterly basis, **Molina Healthcare of Michigan** Provider Service staff will be reaching out to all Physician Organizations with a delegated credentialing contract with single point of contact for credentialing. **Molina Healthcare of Michigan** will provide a full roster and letter requesting an attestation of the accuracy of information we have on file.

Any information identified as incorrect will be sent to our PNA department, who will correct the **Molina Healthcare of Michigan** internal system and directory file. Changes will be made within 30 calendar days.

Provider Newsletter:

Providers were reminded of the importance of reviewing and updating their demographics in an article that was included in the spring Provider Newsletter sent to all providers at the end of May.

Provider Request for Changes:

Providers can contact **Molina Healthcare of Michigan** directly through their Provider Service Representative, fax, or email to make any necessary changes. Also, a Provider Change Form is located on the **Molina Healthcare of Michigan** website under the Provider Section. Changes received in these methods are also logged into the Network Administration system and follow the 30-calendar day time frame for completion.

Members:

Issue: When MDHHS reviewed the **Molina Healthcare of Michigan** Grievance and Appeal Log, it noted that the requirement to resolve non-expedited appeals within 30 days and expedited appeals within 72 hours was not always met.

Summary of MOL's Response
Corrective Action: **Molina Healthcare of Michigan** updated the internal process for resolving appeals to ensure timely responses were being sent to members. Changes included the following: • Updated the internal procedures used by staff • Created a detailed process flow map for appeals • Inventory is being monitored daily by department leadership to identify cases approaching their due date • If an appeal is at risk of going out of compliance, the staff member is notified to the appeal at risk and that it needs to be completed • Ongoing staff training including additional training on systems used by staff to research appeals and how to investigate and document appeals appropriately • Key Performance Indicators (KPIs) are being tracked and provided to Leadership and Compliance monthly **Quality:** Issue: **Molina Healthcare of Michigan** was required to submit a CAP to MDHHS in response to the Performance Measure Report, which indicated late submission of the 4275 provider file. Corrective Action: **Molina Healthcare of Michigan** was late submitting the 4275 provider file in the month of March 2018 due to a system issue. The process in place to create and submit the 4275 file on a timely basis each month was reviewed and validated to ensure that it is being followed appropriately. The file is generated using a script by the Healthcare Analytics team and then uploaded to the State file transfer protocol (FTP) site by our information technology (IT) area each month. The script used to create the 4275 file in the system has built in error validation coding that will catch errors in the file as it is generated. This automated process ensures accurate creation of the file and reduces the amount of time that an individual needs to review the information prior to submission. All errors are being reviewed on a monthly basis to ensure that corrections have occurred and to identify any potential procedural or system-related issues to prevent future delays in submission. **Program Integrity** Issue: During SFY 2017–2018, **Molina Healthcare of Michigan** did not meet the following performance measures for Program Integrity. • Tips and Grievances Form—Errors and/or discrepancies were noted on the form for one quarter. • Data Mining/Algorithm Form—Errors and/or discrepancies were noted on the form for one quarter. • Audits Form—Errors and/or discrepancies were noted on the form for two quarters. • Provider Disenrollments Form—Errors and/or discrepancies were noted on the form for one quarter. • Overpayments Collected Form—Errors and/or discrepancies were noted on the form for one quarter. • Explanation of Benefits (EOB) Requirements—Errors and/or discrepancies were noted on the form for one quarter. Upon review of these deficiencies, the root causes identified were due to: 1) the vast amount of data requiring manual entry and formatting due to system limitations; and 2) the reporting template supplied by MDHHS-Office of Inspector General (OIG) was modified, which caused errors in the previously used process for data entry.

Summary of MOL's Response
Corrective Action: In order to meet the performance measures for Program Integrity, **Molina Healthcare of Michigan** implemented the following corrective actions. • **Molina Healthcare of Michigan** updated an internal procedure, C-02B Medicaid Program Integrity Report, based on issued reporting specifications by MDHHS-OIG, which provides additional guidance on each section of the report including background and helpful tips for completion, and owners of each data set. The effective date of this procedure was 10/01/2018. • **Molina Healthcare of Michigan** updated reporting logic to minimize manual entry and formatting of data into the MDHHS-OIG template. The reporting logic is now primarily auto-populated by internal systems through a data analytics team to help eliminate any manual interventions. In addition, the data are now reviewed for quality assurance by the Payment Integrity and Government Contracts departments prior to final sign-off and submission by the Health Plan Compliance Officer. The effective date of the updated reporting logic was June 2019. Outcomes: To date in 2019, **Molina Healthcare of Michigan** has achieved 100 percent on all Program Integrity-related measures.
HSAG's Assessment of the Degree to Which MOL Addressed the Recommendations
Based on **Molina Healthcare of Michigan**'s response and the SFY 2018–2019 compliance review findings, **Molina Healthcare of Michigan** addressed the prior year's recommendations; however, **Molina Healthcare of Michigan** continues to have opportunities for improvement related to the provider directory and program integrity forms. **Molina Healthcare of Michigan** received deficient findings for *MHP Provider Directory Accuracy* in February and August 2019 and *Program Integrity Forms* in November 2019.

Table 5-47—Performance Measures Recommendations—MOL

HSAG's Recommendations
HSAG recommended that **Molina Healthcare of Michigan** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Pregnancy of Care** • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* **Living With Illness** • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* HSAG further recommended that **Molina Healthcare of Michigan** include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?

HSAG's Recommendations
5. What intervention(s) is **Molina Healthcare of Michigan** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **Molina Healthcare of Michigan** should have included the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement
Summary of MOL's Response
The health plan's 2019 Quality Improvement Work Plan identified *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* as two measures falling below the 25th percentile and outlined the action plan to improve these measures, which included: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies The action plan also included identifying root causes associated with the rates for each measure, how to address unexpected outcomes found in the data, an analysis of the disparities identified, and implementing focused interventions to improve the performance of the measures.
HSAG's Assessment of the Degree to Which MOL Addressed the Recommendations
HSAG recommended that **Molina Healthcare of Michigan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. Based on the results of the SFY 2018–2019 validation, the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure rate improved to rank above the 25th percentile but below the 50th percentile, indicating **Molina Healthcare of Michigan** has opportunities to continue performance improvement efforts.

Table 5-48—PIP Recommendations—MOL

HSAG's Recommendations
Molina Healthcare of Michigan should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **Molina Healthcare of Michigan** should have ensured the following: • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Summary of MOL's Response
Molina Healthcare of Michigan reviewed the PIP recommendations and has taken the following proactive steps to ensure a successful PIP: • Data are reviewed and calculations are performed by the Quality Department's senior analyst who will review and perform all calculations related to the PIP prior to submission. • **Molina Healthcare of Michigan** is conducting cause/barriers analysis throughout the year to identify and implement interventions timelier to provide enough time for the intervention to impact the study indicator rate. • The data analysis results used for the causal/barrier analysis is included in the updated PIP submission. • **Molina Healthcare of Michigan** has included multiple departments and external community partners to design and implement new improvement strategies. These include working directly with OBGYN providers in low performing regions of **Molina Healthcare of Michigan**'s service area. • The process for evaluating the performance of each PIP intervention and its impact on the study indicators allows for continual refinement of improvement strategies. The evaluation process is ongoing and cyclical. **Molina Healthcare of Michigan** has engaged the Quality Department's senior analyst to assist with measuring the impact of each intervention and providing input regarding when and how to measure the interventions.
HSAG's Assessment of the Degree to Which MOL Addressed the Recommendations
For the SFY 2017–2018 validation, **Molina Healthcare of Michigan** designed a PIP that was appropriate for measuring and monitoring PIP outcomes, and reported accurate baseline measurement results and improvement strategies; therefore, HSAG had no required follow-up recommendations. HSAG did provide the following recommendations for **Molina Healthcare of Michigan**'s consideration as it progressed to Remeasurement 1: complete an annual causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner, as interventions implemented late in the Remeasurement 1 study

HSAG's Assessment of the Degree to Which MOL Addressed the Recommendations
period will not have enough time to impact the study indicator rate; implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes; and implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators. In the SFY 2018–2019 validation, **Molina Healthcare of Michigan** addressed some of the recommendations for consideration; however, there were areas in need of improvement.

Recommendations for Program Improvement

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 recommends that **Molina Healthcare of Michigan** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **Molina Healthcare of Michigan** incorporate new improvement efforts as necessary for the following performance measure ranking below the 25th percentile.

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

To meet the above recommendation, **Molina Healthcare of Michigan** should include within its next annual QAPIP review the results of analyses for the performance measure listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Molina Healthcare of Michigan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Molina Healthcare of Michigan** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Molina Healthcare of Michigan** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Members
- MIS

Molina Healthcare of Michigan was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends 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 recommends 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. Additionally, HSAG recommends **Molina Healthcare of Michigan**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **Molina Healthcare of Michigan** should immediately implement internal corrective action.

Molina Healthcare of Michigan should also take proactive steps to ensure a successful PIP. **Molina Healthcare of Michigan** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments* in the *2018–2019 PIP Validation Report Addressing Disparities in Timeliness of Prenatal Care for Molina Healthcare of Michigan* and make the following necessary corrections prior to the next annual submission:

- Describe the process for determining the priority rankings for the identified barriers.
- Use consistent language throughout the PIP submission when describing barriers and interventions.
- Clearly and logically link the identified barriers to the interventions, as the implemented improvement strategies should directly impact the corresponding barrier.
- The PIP has not yet demonstrated significant improvement in the study indicator results nor met the plan-specific goals for both study indicators. The MHP should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.

Finally, as applicable, **Molina Healthcare of Michigan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

Priority Health Choice, Inc. (PRI)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **Priority Health Choice, Inc.**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Priority Health Choice, Inc**.

EQR Activity Results

Compliance Monitoring

Priority Health Choice, Inc. was evaluated in six program areas referred to as "standards." Table 5-49 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-49 also presents **Priority Health Choice, Inc.**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-49—Compliance Review Results for PRI

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	PRI	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	13	1	1	15	90%	91%
3	Members	8	0	0	8	100%	87%
4	Quality	15	0	0	15	100%	98%
5	MIS	8	1	0	9	94%	95%
6	Program Integrity	28	0	0	28	100%	97%
Overall		**77**	**2**	**1**	**80**	**98%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Priority Health Choice, Inc. demonstrated compliance for 77 of 80 elements, with an overall compliance score of 98 percent, which was above the statewide average of 95 percent. **Priority Health Choice, Inc.** demonstrated strong performance, scoring at or above 90 percent in all six standards, with four standards (Administrative, Members, Quality, and Program Integrity) achieving full compliance. The program areas of strength include the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in two of the six standards, which are briefly described below:

- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.
- *Pharmacy/MCO Common Formulary* (April)—Non-compliant NCPDP rejections.
- *MHP Provider Directory Accuracy* (August)—"Accepting new MA pts" and "Phone # and address listed online correct" fell below the 75 percent threshold.

MDHHS required **Priority Health Choice, Inc.** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Priority Health Choice, Inc. was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **Priority Health Choice, Inc.** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **Priority Health Choice, Inc.** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-50 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-7] for **Priority Health Choice, Inc.**

[5-7] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-50—HEDIS 2019 Performance Measure Results for PRI

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	80.05%	★★★★
Combination 3	76.89%	★★★★
Combination 4	76.40%	★★★★
Combination 5	69.10%	★★★★★
Combination 6	51.82%	★★★★
Combination 7	68.86%	★★★★★
Combination 8	51.82%	★★★★
Combination 9	47.93%	★★★★
Combination 10	47.93%	★★★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	77.62%	★★★★★
Lead Screening in Children		
Lead Screening in Children	82.00%	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.86%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	58.39%	★★★
Immunizations for Adolescents		
Combination 1	83.70%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	94.71%	★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	83.29%	★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	26.15%	★
Continuation and Maintenance Phase	26.23%	★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	64.48%	★★★★
Cervical Cancer Screening		
Cervical Cancer Screening	68.61%	★★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	68.22%	★★★★
Ages 21 to 24 Years	70.23%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Total	69.06%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	87.40%	★
Ages 25 Months to 6 Years	78.61%	★
Ages 7 to 11 Years	85.61%	★
Ages 12 to 19 Years	83.59%	★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	81.39%	★★★
Ages 45 to 64 Years	88.98%	★★★
Ages 65+ Years	94.70%	★★★★★
Total	84.69%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	41.06%	★★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	91.48%	★★★★★
Counseling for Nutrition—Total	79.32%	★★★★
Counseling for Physical Activity—Total	79.32%	★★★★★
Adult BMI Assessment		
Adult BMI Assessment	94.16%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	79.32%	★★
Postpartum Care	71.05%	★★★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	93.43%	★★★★★
*HbA1c Poor Control (>9.0%)**	28.47%	★★★★★
HbA1c Control (<8.0%)	61.50%	★★★★★
Eye Exam (Retinal) Performed	69.53%	★★★★★
Medical Attention for Nephropathy	93.80%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	73.91%	★★★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	65.67%	★★★
Medication Compliance 75%—Total	44.12%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Asthma Medication Ratio		
Total	70.40%	★★★★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	73.24%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	81.94%	★★★★
Discussing Cessation Medications	57.42%	★★★
Discussing Cessation Strategies	50.16%	★★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	79.84%	★★★★★
Effective Continuation Phase Treatment	66.67%	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.12%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	54.84%	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.24%	★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	88.25%	★★★
Diuretics	88.76%	★★★
Total	88.46%	★★★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	60.16%	NC
Total—Black or African American	14.30%	NC
Total—American-Indian and Alaska Native	0.53%	NC
Total—Asian	0.77%	NC
Total—Native Hawaiian and Other Pacific Islander	0.05%	NC
Total—Some Other Race	0.00%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	24.18%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	10.53%	NC

Measure	HEDIS 2019	2019 Performance Level
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	0.00%	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	0.00%	NC
Language Preferred for Written Materials—Non-English	0.00%	NC
Language Preferred for Written Materials—Unknown	100.00%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	65.22	★★
Outpatient Visits—Total	368.60	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	6.48	NC
Total Inpatient—Average Length of Stay—Total	3.91	NC
Maternity—Discharges per 1,000 Member Months—Total	2.92	NC
Maternity—Average Length of Stay—Total	2.85	NC
Surgery—Discharges per 1,000 Member Months—Total	1.71	NC
Surgery—Average Length of Stay—Total	5.62	NC
Medicine—Discharges per 1,000 Member Months—Total	2.72	NC
Medicine—Average Length of Stay—Total	3.62	NC
***Use of Opioids From Multiple Providers**[*,2]*		
Multiple Prescribers	21.61%	NC
Multiple Pharmacies	4.24%	NC
Multiple Prescribers and Multiple Pharmacies	2.43%	NC
***Use of Opioids at High Dosage**[*,2]*		
Use of Opioids at High Dosage	1.98%	NC
***Risk of Continued Opioid Use**[*,4]*		
At Least 15 Days Covered—Total	12.41%	NC
At Least 31 Days Covered—Total	5.45%	NC
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	10.78%	★★★★
Index Total Stays—Observed Readmissions—45–54 Years	10.44%	★★★★★

Measure	HEDIS 2019	2019 Performance Level
Index Total Stays—Observed Readmissions—55–64 Years	9.89%	★★★★★
Index Total Stays—Observed Readmissions—Total	10.39%	★★★★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-50 shows **Priority Health Choice, Inc.** ranked at or above the 75th percentile for 41 of the 63 measure rates (65.1 percent), 16 of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care, Access to Care, Obesity, Living With Illness, and Utilization domains. Conversely, nine of 63 measure rates (14.3 percent) fell below the 50th percentile, seven of which fell below the 25th percentile. Opportunities for improvement for **Priority Health Choice, Inc.** include a focus on Child & Adolescent Care, Access to Care, and Living With Illness, where some rates in these domains fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **Priority Health Choice, Inc.** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **Priority Health Choice, Inc.** analyzed historical data to identify potential disparity within its population related to timeliness of prenatal care. However, there was not an existing disparity among **Priority Health Choice, Inc.**'s populations. It was determined, and MDHHS approved, that **Priority Health Choice, Inc.** would focus on improving the timeliness of prenatal care for African-American women as this subpopulation's compliance rate demonstrated an opportunity for improvement.

Table 5-51 outlines the study indicator for the PIP.

Table 5-51—Study Indicator for PRI

PIP Topic	Study Indicator
Improving the Timeliness of Prenatal Care for African-American Women	The percentage of eligible, pregnant African-American women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-52 displays the validation results for **Priority Health Choice, Inc.**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-52 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-52—PIP Validation Results for PRI

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	33% (1/3)	67% (2/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**78% (7/9)**	**22% (2/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**81% (17/21)**		

Overall, 81 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP.

For the first remeasurement period, **Priority Health Choice, Inc.** reported that 36.9 percent of eligible African-American women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The reported rate for the study indicator demonstrated a statistically significant decrease over the baseline and did not meet the goal for the PIP, which was set at 53.7 percent.

Strengths, Weaknesses, and Overall Conclusions

Priority Health Choice, Inc. demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Priority Health Choice, Inc.** received a total compliance score of 98 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **Priority Health Choice, Inc.** scored 90 percent or above in the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards, indicating strong performance in these program areas. While 41 of the 63 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, nine measure rates fell below the 50th percentile, indicating opportunities for improvement for **Priority Health Choice, Inc.** primarily in the Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization domains.

Priority Health Choice, Inc.'s overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-53—Quality, Timeliness, and Access Performance Impact for PRI

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 100 percent in the Quality standard, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 94 percent in the MIS standard, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The MHP received a performance score of 100 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider.

Performance Area*	Overall Performance Impact
	• Strength: The *Well-Child Visits in the First 15 Months of Life* measure rate exceeded the 90th percentile, indicating many children in the first 15 months of life were seeing their PCPs as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Strength: The *Appropriate Treatment for Children With Upper Respiratory Infection* measure rate ranked at or above the 75th percentile, indicating many children diagnosed with upper respiratory infections were not being prescribed antibiotics inappropriately. • Strength: The *Cervical Cancer Screening* and *Breast Cancer Screening* measure rates each ranked at or above the 75th percentile, indicating many women were screened for these types of cancer, which are highly treatable if detected early. • Strength: All three *Chlamydia Screening in Women* indicator rates ranked at or above the 75th percentile, indicating many women ages 16 to 24 years were being screened for this sexually transmitted disease. • Strength: The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate ranked at or above the 75th percentile, indicating many adults diagnosed with acute bronchitis were not dispensed an antibiotic, which helps avoid side effects and possible resistance to antibiotics. • Strength: All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicator rates and the *Adult BMI Assessment* measure rate ranked at or above the 75th percentile, including two rates that exceeded the 90th percentile, indicating many child, adolescent, and adult BMIs were assessed by a PCP or OB/GYN during a medical appointment, and many children received counseling for nutrition and physical activity which are important to identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: All six *Comprehensive Diabetes Care* indicator rates ranked at or above the 75th percentile, including five indicator rates that exceeded the 90th percentile, indicating many adults received proper diabetes management which is essential to control blood glucose and reduce risks for complications. • Strength: One of the two *Medication Management for People With Asthma* indicator rates and the *Asthma Medication Ratio—Total* measure rate ranked at or above the 75th percentile, indicating members received appropriate medication management, which could reduce the need for rescue medication as well as the costs associated with ED visits, inpatient admissions, and missed days of work or school. • Strength: Two of the three *Medical Assistance With Smoking and Tobacco Use Cessation* indicator rates ranked at or above the 75th percentile, indicating many adults who are tobacco smokers or users received cessation advice and discussed cessation medications to help quit tobacco and improve overall health. • Strength: Both *Antidepressant Medication Management* indicator rates exceeded the 90th percentile, indicating adult members diagnosed with major depression received effective medication management, which can improve a person's daily functioning and wellbeing, and reduce the risk of suicide.

Performance Area*	Overall Performance Impact
	• Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate ranked at or above the 75th percentile, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Strength: The MHP designed a scientifically sound PIP, *Improving the Timeliness of Prenatal Care for African-American Women*, supported by using key research principles, meeting 100 percent of the requirements in the Design stage. • Weakness: The *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure rate fell below the 25th percentile, indicating many adult members diagnosed with schizophrenia and diabetes did not always receive an LDL-C and HbA1c test during the year and, therefore, may have an increased risk for declining health.
Timeliness	• Strength: The MHP received a performance score of 100 percent in the Members standard, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: All nine of the *Childhood Immunization Status* indicator rates ranked at or above the 75th percentile, including two indicator rates that exceeded the 90th percentile, indicating many children and adolescents received vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Strength: The *Lead Screening in Children* measure rate ranked at or above the 75th percentile, indicating many children were tested for lead poisoning by 2 years of age. • Strength: The *Prenatal and Postpartum Care—Postpartum Care* indicator rate ranked at or above the 75th percentile, indicating many women were accessing timely postpartum care, which could impact the health of the member and her baby after pregnancy. • Weakness: Both *Follow-Up Care for Children Prescribed ADHD Medication* indicator rates fell below the 25th percentile, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a pediatrician. • Weakness: The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator rate fell below the 50th percentile, indicating many pregnant women were not always accessing timely prenatal care, which could impact the health of the member and her baby before, during, and after pregnancy. • Weakness: The MHP demonstrated a statistically significant decrease over the baseline measurement period and did not meet the plan-specific goal, meeting 33 percent of the requirements in the PIP Outcomes stage, indicating significant opportunities still remain to improve performance associated with timeliness of prenatal care.
Access	• Strength: One of the four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates exceeded the 90th percentile, indicating many adults 65 years of age and older were accessing ambulatory or preventive care services from their physicians. • Weakness: All four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 25th percentile, indicating children ages 12 months to

Performance Area*	Overall Performance Impact
	19 years were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 50th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-54, Table 5-55, and Table 5-56 present the recommendations made by HSAG to **Priority Health Choice, Inc.** during the SFY 2017–2018 EQR, **Priority Health Choice, Inc.**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **Priority Health Choice, Inc.** addressed those recommendations.

Table 5-54—Compliance Monitoring Recommendations—PRI

HSAG's Recommendations
Priority Health Choice, Inc. should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Providers • Program Integrity **Priority Health Choice, Inc.** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies

Summary of PRI's Response
MHP PROVIDER DIRECTORY: MDHHS will conduct secret shopper calls of a sample of open PCPs listed in the online MHP Provider Directory to check for provider availability accuracy. **Priority Health Choice, Inc.** received *Fail* Compliance Review scores for online provider directory accuracy in February and August 2019. The requirement is to achieve 75 percent accuracy for provider directory content matching direct feedback from PCPs during secret shopper calls made by MDHHS. **Priority Health Choice, Inc.** scored below the 75 percent accuracy threshold and submitted CAPs as required by MDHHS. The CAP outlined several action steps to improve accuracy, including increased auditing, analytics and reporting, implementation of Provider Data Management (PDM) system enhancements, provider education, and additional staffing to support provider directory functions. Upon review, the CAPs were deemed acceptable by MDHHS, demonstrating progress toward achieving the 75 percent accuracy goal. **PROGRAM INTEGRITY Authority: Complete and submit Program Integrity form and related reports for April–June** **Priority Health Choice, Inc.** received an *Incomplete* score in August 2019 for the Program Integrity quarterly report. Detail on a case was initially not provided in the submission as the investigation, conducted by a dental partner, was still in the process of validating concerns. A revised quarterly report was provided that included the detail requested by the MDHHS-OIG. The CAP provided in response to the *Incomplete* score noted that in future reports, if a gap or inconsistency in the data is identified, **Priority Health Choice, Inc.** will submit narrative along with the quarterly report for additional background information and explanation. In addition, an email was sent from MDHHS-OIG to **Priority Health Choice, Inc.** requesting additional data on the Program Integrity quarterly report under Tips and Grievances. This email was inadvertently missed, and a response was not made within the expected time frame. **Priority Health Choice, Inc.** acknowledged this oversight in the CAP and developed internal procedures to ensure messages from the MDHHS-OIG are reviewed timely.
HSAG's Assessment of the Degree to Which PRI Addressed the Recommendations
Based on **Priority Health Choice, Inc.**'s response and the SFY 2018–2019 compliance review findings, **Priority Health Choice, Inc.** addressed the prior year's recommendations; however, **Priority Health Choice, Inc.** continues to have opportunities for improvement related to the provider directory. **Priority Health Choice, Inc.** received deficient findings for *MHP Provider Directory Accuracy* in February and August 2019.

Table 5-55—Performance Measures Recommendations—PRI

HSAG's Recommendations
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Priority Health Choice, Inc.** to members, HSAG recommended that **Priority Health Choice, Inc.** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Child & Adolescent Care** • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* **Living With Illness** • *Diabetes Monitoring for People With Diabetes and Schizophrenia* HSAG further recommended that **Priority Health Choice, Inc.** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 1. What unexpected outcomes were found within the data? 2. What disparities were identified in the analyses? 3. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 4. What intervention(s) is **Priority Health Choice, Inc.** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **Priority Health Choice, Inc.** should have included the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement
Summary of PRI's Response
Child & Adolescent Care: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase When **Priority Health Choice, Inc.** looked at 2017 HEDIS and 2018 HEDIS rates for both the initiation phase and maintenance follow-up phase rates, a slight rise in the rates was noticed. **Priority Health Choice, Inc.** believes it was primarily due a change in HEDIS certified vendors. **Priority Health Choice, Inc.**'s pharmacy area also became more engaged in the carve out drug file ingestion to the data warehouse, more timely notifying of a carve out medication fill. No targeted interventions were conducted for these sub-measures, just

Summary of PRI's Response
monitoring of the prescriber and follow-up activity. Other system-level tasks on the QIP for **Priority Health Choice, Inc.** were to optimally manage NCQA HEDIS process by adding supplemental sources previously missing, building infrastructure to capture new supplemental data sources, developing continuous annual HEDS improvement processes per product line. **Living With Illness: Diabetes Monitoring for People With Diabetes and Schizophrenia** When **Priority Health Choice, Inc.** reviewed 2017 and 2018 HEDIS rates for this measure, an increase in denominator size (from 82 up to 93) was noted. With the denominator drop, the rate declined, but not at a statistically significant decline. Interesting to note, this is a fairly straight-forward diabetes measure with a narrowed denominator population and looking at our other diabetic measures, we do very well. This measure was on the QAPIP in 2018 and was not in 2019, it will again be included in the QAPIP in 2020.
HSAG's Assessment of the Degree to Which PRI Addressed the Recommendations
HSAG recommended that **Priority Health Choice, Inc.** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. Based on the results of the SFY 2018–2019 validation, no measure rates that fell below the 25th percentile in 2017–2018 improved to rank above the 25th percentile in 2018–2019, indicating **Priority Health Choice, Inc.** has opportunities to continue performance improvement efforts to improve low performing rates.

Table 5-56—PIP Recommendations—PRI

HSAG's Recommendations
Priority Health Choice, Inc. should take proactive steps to ensure a successful PIP. As the PIP progresses, **Priority Health Choice, Inc.** should ensure the following: • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Summary of PRI's Response
Priority Health Choice, Inc. is taking the following steps to be proactive in a successful PIP: • Reconvening workgroup to conduct another causal/barrier analysis and document the process/meeting • Look at data more frequently, if available, to redirect or pivot active interventions • Continue expanding or building upon interventions with successful outcomes • Monitor outcomes for interventions in beginning stages • Workgroup meetings will evaluate performance of interventions and document detailed minutes
HSAG's Assessment of the Degree to Which PRI Addressed the Recommendations
For the SFY 2017–2018 validation, **Priority Health Choice, Inc.** designed a PIP that was appropriate for measuring and monitoring PIP outcomes, and reported accurate baseline measurement results and improvement strategies; therefore, HSAG had no required follow-up recommendations. HSAG did provide the following recommendations for **Priority Health Choice, Inc.**'s consideration as it progressed to Remeasurement 1: complete an annual causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner, as interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate; implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes; and implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators. In the SFY 2018–2019 validation, **Priority Health Choice, Inc.** addressed all recommendations for consideration within the PIP submission.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Priority Health Choice, Inc.** to members, HSAG recommends that **Priority Health Choice, Inc.** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **Priority Health Choice, Inc.** incorporate new improvement efforts as necessary for the following performance measures ranking below the 25th percentile.

Child & Adolescent Care

- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*

Living With Illness

- *Diabetes Monitoring for People With Diabetes and Schizophrenia*

To meet the above recommendation, **Priority Health Choice, Inc.** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Priority Health Choice, Inc.** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Priority Health Choice, Inc.** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Priority Health Choice, Inc.** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- MIS

Priority Health Choice, Inc. was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends that **Priority Health Choice, Inc.** 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 recommends that **Priority Health Choice, Inc.** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. Additionally, HSAG recommends **Priority Health Choice, Inc.**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **Priority Health Choice, Inc.** should immediately implement internal corrective action.

Priority Health Choice, Inc. should also take proactive steps to ensure a successful PIP. **Priority Health Choice, Inc.** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments in the 2018–2019 PIP Validation Report Improving the Timeliness of Prenatal Care for African-American Women for Priority Health Choice, Inc.* and make the following necessary corrections prior to the next annual submission:

- Recalculate the statistical test to ensure the reported *p*-value is accurate.
- Clearly document the data collection method used and clarify how the identified factors may impact the comparability of the reported data.
- The PIP has not yet demonstrated significant improvement in the study indicator results nor met the plan-specific goals for both study indicators. The MHP should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.

Finally, as applicable, **Priority Health Choice, Inc.** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

Total Health Care, Inc. (THC)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **Total Health Care, Inc.**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Total Health Care, Inc.**

EQR Activity Results

Compliance Monitoring

Total Health Care, Inc. was evaluated in six program areas referred to as "standards." Table 5-57 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-57 also presents **Total Health Care, Inc.**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-57—Compliance Review Results for THC

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	THC	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	14	1	0	15	97%	91%
3	Members	8	0	0	8	100%	87%
4	Quality	15	0	0	15	100%	98%
5	MIS	9	0	0	9	100%	95%
6	Program Integrity	28	0	0	28	100%	97%
Overall		**79**	**1**	**0**	**80**	**99%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Total Health Care, Inc. demonstrated compliance for 79 of 80 elements, with an overall compliance score of 99 percent, which was above the statewide average of 95 percent. **Total Health Care, Inc.** demonstrated strong performance, scoring above 90 percent in all six standards, with five of those standards (Administrative, Members, Quality, MIS, and Program Integrity) achieving full compliance. The program areas of strength include the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards.

An opportunity for improvement was identified in one of the six standards, which is briefly described below:

- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.

MDHHS required **Total Health Care, Inc.** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Total Health Care, Inc. was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **Total Health Care, Inc.** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **Total Health Care, Inc.** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-58 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-8] for **Total Health Care, Inc.**

[5-8] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-58—HEDIS 2019 Performance Measure Results for THC

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	64.46%	★
Combination 3	58.94%	★
Combination 4	58.94%	★
Combination 5	49.23%	★
Combination 6	25.83%	★
Combination 7	49.23%	★
Combination 8	25.83%	★
Combination 9	21.85%	★
Combination 10	21.85%	★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	66.23%	★★★
Lead Screening in Children		
Lead Screening in Children	68.43%	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.61%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	58.50%	★★★
Immunizations for Adolescents		
Combination 1	84.55%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	93.65%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	73.00%	★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	51.78%	★★★★
Continuation and Maintenance Phase	65.45%	★★★★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	54.44%	★★
Cervical Cancer Screening		
Cervical Cancer Screening	60.89%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	67.78%	★★★★
Ages 21 to 24 Years	70.09%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Total	68.69%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	91.13%	★
Ages 25 Months to 6 Years	83.28%	★
Ages 7 to 11 Years	86.66%	★
Ages 12 to 19 Years	86.22%	★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	73.35%	★★
Ages 45 to 64 Years	83.46%	★★
Ages 65+ Years	87.69%	★★
Total	77.65%	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.82%	★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	86.31%	★★★★
Counseling for Nutrition—Total	77.26%	★★★
Counseling for Physical Activity—Total	75.28%	★★★★
Adult BMI Assessment		
Adult BMI Assessment	92.94%	★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	76.50%	★
Postpartum Care	53.22%	★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	88.30%	★★★
*HbA1c Poor Control (>9.0%)**	35.10%	★★★
HbA1c Control (<8.0%)	49.67%	★★
Eye Exam (Retinal) Performed	55.85%	★★
Medical Attention for Nephropathy	91.17%	★★★
Blood Pressure Control (<140/90 mm Hg)	56.73%	★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	82.58%	★★★★★
Medication Compliance 75%—Total	65.46%	★★★★★

Measure	HEDIS 2019	2019 Performance Level
Asthma Medication Ratio		
Total	51.33%	★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	56.29%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	80.43%	★★★
Discussing Cessation Medications	60.11%	★★★★
Discussing Cessation Strategies	47.54%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	69.46%	★★★★★
Effective Continuation Phase Treatment	56.57%	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.68%	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	65.43%	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	57.43%	★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	87.03%	★★
Diuretics	86.72%	★★
Total	86.89%	★★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	30.67%	NC
Total—Black or African American	54.84%	NC
Total—American-Indian and Alaska Native	0.25%	NC
Total—Asian	1.12%	NC
Total—Native Hawaiian and Other Pacific Islander	0.06%	NC
Total—Some Other Race	2.86%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	10.19%	NC
Total—Declined	0.00%	NC
Total—Hispanic or Latino	2.86%	NC

Measure	HEDIS 2019	2019 Performance Level
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	99.10%	NC
Spoken Language Preferred for Health Care—Non-English	0.89%	NC
Spoken Language Preferred for Health Care—Unknown	0.01%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	99.10%	NC
Language Preferred for Written Materials—Non-English	0.89%	NC
Language Preferred for Written Materials—Unknown	0.01%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	99.10%	NC
Other Language Needs—Non-English	0.89%	NC
Other Language Needs—Unknown	0.01%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	68.80	★★
Outpatient Visits—Total	339.74	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	9.33	NC
Total Inpatient—Average Length of Stay—Total	4.41	NC
Maternity—Discharges per 1,000 Member Months—Total	2.32	NC
Maternity—Average Length of Stay—Total	2.71	NC
Surgery—Discharges per 1,000 Member Months—Total	2.12	NC
Surgery—Average Length of Stay—Total	7.82	NC
Medicine—Discharges per 1,000 Member Months—Total	5.44	NC
Medicine—Average Length of Stay—Total	3.63	NC
***Use of Opioids From Multiple Providers**[*,2]		
Multiple Prescribers	16.77%	NC
Multiple Pharmacies	6.23%	NC
Multiple Prescribers and Multiple Pharmacies	3.33%	NC
***Use of Opioids at High Dosage**[*,2]		
Use of Opioids at High Dosage	9.07%	NC
***Risk of Continued Opioid Use**[*,4]		
At Least 15 Days Covered—Total	31.83%	NC
At Least 31 Days Covered—Total	19.28%	NC
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	17.89%	★★
Index Total Stays—Observed Readmissions—45–54 Years	19.17%	★

Measure	HEDIS 2019	2019 Performance Level
Index Total Stays—Observed Readmissions—55–64 Years	18.77%	★
Index Total Stays—Observed Readmissions—Total	18.57%	★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-58 shows **Total Health Care, Inc.** ranked at or above the 75th percentile for 14 of the 63 measure rates (22.2 percent), five of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Living With Illness domain. Conversely, 37 of 63 measure rates (58.7 percent) fell below the 50th percentile, 18 of which fell below the 25th percentile. Opportunities for improvement for **Total Health Care, Inc.** include a focus on Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization, where rates in these domains fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **Total Health Care, Inc.** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **Total Health Care, Inc.** analyzed historical data to identify potential disparity within its population related to timeliness of prenatal care. However, after conducting a thorough analysis of its data, **Total Health Care, Inc.** identified no disparities and determined that the focus of the PIP should be to improve timeliness of prenatal care for women ages 23 to 28. MDHHS approved the MHP's selected topic.

Table 5-59 outlines the study indicator for the PIP.

Table 5-59—Study Indicator for THC

PIP Topic	Study Indicator
Improving Timeliness of Prenatal Care for Women Ages 23 to 28	The percentage of eligible women ages 23 to 28 who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-60 displays the validation results for **Total Health Care, Inc.**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-60 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-60—PIP Validation Results for THC

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	86% (6/7)	14% (1/7)	0% (0/7)
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**94% (16/17)**	**6% (1/17)**	**0% (0/17)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	100% (3/3)	0% (0/3)	0% (0/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**97% (28/29)**		

Overall, 97 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP. The MHP has opportunities for improvement related to documentation and addressing HSAG's validation feedback in the Design stage.

For the first remeasurement period, **Total Health Care, Inc.** reported that 61 percent of eligible women 23 to 28 years of age received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The reported rate for the study indicator met the goal for the PIP, which was set at 42 percent.

Strengths, Weaknesses, and Overall Conclusions

Total Health Care, Inc. demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Total Health Care, Inc.** received a total compliance score of 99 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **Total Health Care, Inc.** scored 97 percent or above in the Administrative, Providers, Members, Quality, MIS, and Program Integrity standards, indicating generally strong performance in these program areas. While 14 of the 63 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 37 measure rates fell below the 50th percentile, indicating opportunities for improvement for **Total Health Care, Inc.** primarily in the Child & Adolescent Care, Women—Adult Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization domains.

Total Health Care, Inc.'s overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-61—Quality, Timeliness, and Access Performance Impact for THC

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 100 percent in the Quality standard, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 100 percent in the MIS standard, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The MHP received a performance score of 100 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider.

Performance Area*	Overall Performance Impact
	• Strength: All three *Chlamydia Screening in Women* indicator rates ranked at or above the 75th percentile, indicating many women ages 16 to 24 years were being screened for this sexually transmitted disease. • Strength: Two of the three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicator rates and the *Adult BMI Assessment* measure rate ranked at or above the 75th percentile, indicating many child, adolescent, and adult BMIs were assessed by a PCP or OB/GYN during a medical appointment, and many children received counseling for nutrition, which are important to identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: Both *Medication Management for People With Asthma* indicator rates exceeded the 90th percentile, indicating adult and child members diagnosed with persistent asthma were dispensed appropriate asthma controller medications and remained on the medications for most of their treatment period. • Strength: One of the three *Medical Assistance With Smoking and Tobacco Use Cessation* indicator rates ranked at or above the 75th percentile, indicating many adults who are tobacco smokers or users discussed cessation medications to help quit tobacco and improve overall health. • Strength: Both *Antidepressant Medication Management* indicator rates exceeded the 90th percentile, indicating adults diagnosed with major depression received effective medication management, which can improve a person's daily functioning and wellbeing, and reduce the risk of suicide. • Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate exceeded the 90th percentile, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Strength: The MHP performed well with data analysis and improvement strategies, with 100 percent of the PIP, *Improving Timeliness of Prenatal Care for Women Ages 23 to 28*, evaluation elements receiving a *Met* score. • Weakness: The *Appropriate Testing for Children With Pharyngitis* measure rate fell below the 50th percentile, indicating many children diagnosed with pharyngitis and dispensed an antibiotic did not receive the appropriate testing, which increases the unnecessary use of antibiotics. • Weakness: The *Breast Cancer Screening* measure rate fell below the 50th percentile, indicating many women were not screened for this type of cancer, which is highly treatable if detected early. • Weakness: Three of the six *Comprehensive Diabetes Care* indicator rates fell below the 50th percentile, indicating many adults did not receive an eye exam or achieve blood pressure or HbA1c control, which are essential to reduce risks for complications. • Weakness: Although the MHP demonstrated strength in its members being dispensed and remaining on asthma controller medications through treatment, the *Asthma Medication Ratio—Total* measure rate fell below the 25th percentile, indicating an

Performance Area*	Overall Performance Impact
	opportunity to improve the ratio of controller medications to total asthma medications and reduce the prevalence of asthma attacks. • Weakness: The *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure rate fell below the 50th percentile, indicating many adult members diagnosed with schizophrenia and diabetes did not always receive an LDL-C and HbA1c test during the year and, therefore, may have an increased risk for declining health. • Weakness: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure rate fell below the 50th percentile, indicating many adults with schizophrenia were dispensed but did not remain on an antipsychotic for most of their treatment period, therefore, increasing the risk of relapse and complications. • Weakness: All three *Annual Monitoring for Patients on Persistent Medications* indicator rates fell below the 50th percentile, indicating many adult members may be at risk of adverse drug events.
Timeliness	• Strength: The MHP received a performance score of 100 percent in the Members standard, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: Both *Follow-Up Care for Children Prescribed ADHD Medication* indicator rates ranked at or above the 75th percentile, indicating prescribed ADHD medications were closely monitored by a practitioner. • Strength: The MHP demonstrated statistically significant improvement over the baseline for the PIP study indicator for the Remeasurement 1 measurement period, suggesting the implemented interventions were improving timeliness to prenatal care rates. • Weakness: All nine *Childhood Immunization Status* indicator rates fell below the 25th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The *Lead Screening in Children* measure rate fell below the 50th percentile, indicating many children were not tested for lead poisoning, which can lead to irrevocable effects on a child's physical and mental health. • Weakness: Both *Prenatal and Postpartum Care* indicator rates fell below the 25th percentile, indicating pregnant women were not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy.
Access	• Weakness: All four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 50th percentile, including three indicator rates falling below the 25th percentile, indicating children 12 months to 19 years of age were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: All four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates fell below the 50th percentile, indicating many adults of all ages were not accessing ambulatory or preventive care services from their physicians.

Performance Area*	Overall Performance Impact
	• Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 50th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-62, Table 5-63, and Table 5-64 present the recommendations made by HSAG to **Total Health Care, Inc.** during the SFY 2017–2018 EQR, **Total Health Care, Inc.**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **Total Health Care, Inc.** addressed those recommendations.

Table 5-62—Compliance Monitoring Recommendations—THC

HSAG's Recommendations
Total Health Care, Inc. should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Providers • Program Integrity **Total Health Care, Inc.** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Summary of THC's Response
Providers: **Narrative of deficiency: Total Health Care, Inc.** has been deficient in the accuracy of the provider directory based on results from secret shopper calls. The 4275 file is used to match against **Total Health Care, Inc.**'s website and providers are called regarding their participation status for **Total Health Care, Inc.** members. In several rounds of this process, **Total Health Care, Inc.** providers have not responded according to our information on file.

Summary of THC's Response
Corrective action: To address this issue, **Total Health Care, Inc.** hired a dedicated worker to perform daily secret shopper calls. This employee cold calls each office asking to make an appointment with a specific PCP. If the office does not respond that they accept **Total Health Care, Inc.**, **Total Health Care, Inc.** informs them that they responded incorrectly and forwards the information to the Provider Relations team for follow up. If the office responds correctly, that person's name is put into a drawing for a $500 gift card. A monthly drawing is held and advertised to reinforce appropriate behavior. Provider Relations follows up with each office to educate them about their participation and validate the physician information. This encourages frequent communication. **Total Health Care, Inc.** also implemented a new provider portal this year. One of the new functions of the portal requires offices to validate their demographic information at least quarterly. This feature is another tool to help ensure the provider directory is as accurate as possible. **Total Health Care, Inc.** also has internal controls that provider updates must be made to our system which feeds the website within 10 business days. In most instances, **Total Health Care, Inc.** exceeds that timeline; however, during the conversion to a new claims system, **Total Health Care, Inc.** did experience some delayed timelines. These have since been rectified. Resources required to resolve deficiency: A dedicated team member was hired to perform secret shopper calls. **Program Integrity:** **Total Health Care, Inc.** was not assigning unique case numbers to each case. Moving forward, **Total Health Care, Inc.** will populate the "Unique Case Number" column with "NO CASE NUMBER ASSIGNED". **Total Health Care, Inc.** had an outstanding CAP for the August 2018 quarterly submission. **Total Health Care, Inc.** had a staff change in the Fraud, Waste, and Abuse (FWA) Coordinator, only weeks before the MDHHS-OIG submission was due. The "File for Change Health" was inadvertently missed, as staff worked together to assist the new FWA Coordinator in completing the log. Errors and/or discrepancies were noted on the Tips and Grievances, Data Mining/Algorithm, Audits, and Overpayments Collected forms. Corrected submissions and explanations were provided to MDHHS-OIG.
HSAG's Assessment of the Degree to Which THC Addressed the Recommendations
Based on **Total Health Care, Inc.**'s response and the SFY 2018–2019 compliance review findings, **Total Health Care, Inc.** addressed the prior year's recommendations; however, **Total Health Care, Inc.** continues to have opportunities for improvement related to the provider directory. **Total Health Care, Inc.** received deficient findings for *MHP Provider Directory Accuracy* in February 2019.

Table 5-63—Performance Measures Recommendations—THC

HSAG's Recommendations
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Total Health Care, Inc.** to members, HSAG recommended that **Total Health Care, Inc.** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Child & Adolescent Care** • *Childhood Immunization Status—Combination 5* **Access to Care** • *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years* • *Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years* **Pregnancy Care** • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* **Living With Illness** • *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%),* and *Blood Pressure Control (<140/90 mm Hg)* • *Asthma Medication Ratio—Total* • *Controlling High Blood Pressure* • *Diabetes Monitoring for People With Diabetes and Schizophrenia* • *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* HSAG further recommended that **Total Health Care, Inc.** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Total Health Care, Inc.** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **Total Health Care, Inc.** should have included the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement

Summary of THC's Response	
Total Health Care, Inc. incorporated improvement efforts for the recommended measures.	
Measure	**Improvement Efforts**
CIS—Combination 5	**Total Health Care, Inc.** created targeted mailings and improved gap reporting related to immunizations.
CAP—Ages 12 to 24 Months and Ages 25 Months to 6 Years	**Total Health Care, Inc.** engaged providers for **Total Health Care, Inc.** days at their offices where they saw only **Total Health Care, Inc.** members to complete well-child visits and access to care visits.
AAP—Ages 65+ Years	**Total Health Care, Inc.** engaged providers for **Total Health Care, Inc.** days at their offices where they saw only **Total Health Care, Inc.** members to complete access to care visits.
PPC—Timeliness of Prenatal Care and Postpartum Care	Improved engagement with MIHPs to increase prenatal and postpartum rates. Updated **Total Health Care, Inc.**'s Destination Motherhood program, which engages mothers in prenatal and postpartum care by offering education and incentives. **Total Health Care, Inc.** also improved its medical records collection process to better capture prenatal and postpartum rates.
CDC—A1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), and Blood Pressure Control (<140/90 mm Hg)	**Total Health Care, Inc.** implemented Diabetic Health Fair days that allowed members to obtain HbA1c testing, blood pressure checks, eye exams, nephropathy tests, and nutrition education. **Total Health Care, Inc.** also improved its medical records collection process to better capture CDC rates.
Asthma Medication Ratio—Total	**Total Health Care, Inc.** is currently working with the Pharmacy Department to conduct outreach to non-complaint members. This has not been implemented yet but is in process.
Controlling High Blood Pressure	**Total Health Care, Inc.** is currently working on an intervention to identify members with high blood pressure who are not being managed by a Cardiologist and provide information to the member and their PCP on the referral process to see one. **Total Health Care, Inc.** hopes that, if blood pressure is not being managed appropriately at the PCP level, engagement with a specialist will assist the member with controlling their high blood pressure.
Diabetes Monitoring for People With Diabetes and Schizophrenia	**Total Health Care, Inc.** is working with its Behavioral Health (BH) subcontractor to increase coordination of care between medical and BH care. Interventions are still under discussion.

Summary of THC's Response	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	**Total Health Care, Inc.** is currently working with the Pharmacy Department to conduct outreach to non-complaint members. This has not been implemented yet.

RECOMMENDATION: HSAG further recommended that **Total Health Care, Inc.** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

RESPONSE: **Total Health Care, Inc.** did not include this information in its most recent QI Evaluation (QAPI). It will, however, be included in the next report submitted.

RECOMMENDATION: Based on the information presented, **Total Health Care, Inc.** should include the following within its QI plan:

RESPONSE:

Recommendations	Included in QI Work Plan
Measurable goals and benchmarks for each measure	Yes
Mechanisms to measure performance	Yes
Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates	Yes
Identified opportunities for improvement	Yes
Ongoing analysis to identify factors that impact adequacy of rates	In process
QI interventions that address the root cause of the deficiency	Yes
A plan to monitor the QI interventions to detect whether they effect improvement	In process

HSAG's Assessment of the Degree to Which THC Addressed the Recommendations

HSAG recommended that **Total Health Care, Inc.** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. Based on the results of the SFY 2018–2019 validation, the *Adults' Access to Preventive/ Ambulatory Health Services—Ages 65+ Years*; *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Control (<8.0%),* and *Blood Pressure Control (<140/90 mm Hg)*; *Diabetes Monitoring for People With Diabetes and Schizophrenia*; and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure rates improved to rank at or above the 50th percentile but below the 75th percentile, and the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* indicator rate improved to rank at or above the 50th percentile but below the 75th percentile. However, the remaining measure rates remained below the 25th percentile, indicating **Total Health Care, Inc.** has opportunities to continue performance improvement efforts.

Table 5-64—PIP Recommendations—THC

HSAG's Recommendations
Total Health Care, Inc. should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **Total Health Care, Inc.** should have ensured the following: • Addressed all validation feedback and make necessary corrections prior to the next annual submission. • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

Summary of THC's Response	
Recommendation	**Addressed in Most Recent Submission**
Address all validation feedback and make necessary corrections prior to the next annual submission.	Yes
Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission.	Yes
To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate.	Yes, this was updated and will continue to be reviewed.
Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.	Yes, this was updated and will continue to be reviewed.
Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.	Yes, this was updated and will continue to be reviewed.
Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.	Yes

HSAG's Assessment of the Degree to Which THC Addressed the Recommendations
For the SFY 2017–2018 validation, **Total Health Care, Inc.** had opportunities for improvement in Step VIII of the Implementation stage. HSAG recommended the MHP ensure all validation feedback was addressed and that necessary corrections were made prior to the next annual submission. In the SFY 2018–2019 validation, **Total Health Care, Inc.** received a 100 percent score on Step VIII, indicating the MHP addressed the prior year's recommendations.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Total Health Care, Inc.** to members, HSAG recommends that **Total Health Care, Inc.** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **Total Health Care, Inc.** incorporate new improvement efforts as necessary for the following performance measures ranking below the 25th percentile.

Child & Adolescent Care

- *Childhood Immunization Status—Combination 2*, *3*, *4*, *5*, *6*, *7*, *8*, *9*, and *10*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, and *Ages 7 to 11 Years*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Living With Illness

- *Asthma Medication Ratio—Total*

Utilization

- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—45–54 Years*, *55–64 Years*, and *Total*

To meet the above recommendation, **Total Health Care, Inc.** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?

2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Total Health Care, Inc.** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Total Health Care, Inc.** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Total Health Care, Inc.** develop meaningful plans of action to bring into compliance the following deficient program area:

- Providers

Total Health Care, Inc. was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends that **Total Health Care, Inc.** 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 recommends that **Total Health Care, Inc.** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. Additionally, HSAG recommends **Total Health Care, Inc.**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **Total Health Care, Inc.** should immediately implement internal corrective action.

Total Health Care, Inc. should also take proactive steps to ensure a successful PIP. **Total Health Care, Inc.** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments* in the *2018–2019 PIP Validation Report Improving Timeliness of Prenatal Care for Women Ages 23 to 28 for Total Health Care, Inc.* and make the following necessary corrections prior to the next annual submission:

- Accurately report the population size for all measurement periods.
- Describe the determination of the reported estimated degree of administrative data completeness percentage.
- Report the percentage point difference between the Remeasurement 1 results and the plan-specific goal.
- Provide additional information on how the developed interventions will improve the study indicator.

Finally, as applicable, **Total Health Care, Inc.** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

Trusted Health Plan (TRU)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **Trusted Health Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Trusted Health Plan**.

EQR Activity Results

Compliance Monitoring

Trusted Health Plan was evaluated in six program areas referred to as "standards." Table 5-65 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-65 also presents **Trusted Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-65—Compliance Review Results for TRU

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	TRU	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	9	5	1	15	77%	91%
3	Members	0	2	6	8	13%	87%
4	Quality	11	4	0	15	87%	98%
5	MIS	7	1	1	9	83%	95%
6	Program Integrity	25	3	0	28	95%	97%
Overall		**57**	**15**	**8**	**80**	**81%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Trusted Health Plan demonstrated compliance for 57 of 80 elements, with an overall compliance score of 81 percent, which was below the statewide average of 95 percent. **Trusted Health Plan** demonstrated strong performance, scoring above 90 percent in two standards, with one of those standards (Administrative) achieving full compliance. The program areas of strength include the Administrative and Program Integrity standards.

Opportunities for improvement were identified in five of the six standards, which are briefly described below:

- *Standard Provider Contract Formats* (January)—Provider Contract Table was submitted; however, the table provided no indication of the date of the Department of Insurance and Financial Services' (DIFS') approval.
- *Provider Subcontracts* (January)—Subcontract Table was not submitted. With the exception of policies and procedures of non-emergency medical transportation (NEMT), none of the requested information was submitted.
- *24/7 Access* (January)—Website did not provide information regarding 24-hour access though policy indicated 24-hour access to clinical staff of network provider. Provision that the MHP will respond to providers within one hour or less for emergent treatment prior authorizations (PAs) for inpatient treatment was not included in the policy.
- *Provider Network* (January)—Network Access Plan and accompanying information was not submitted.
- *Community Health Worker (CHW) Policy and Procedure* (January)—MHP did not maintain a CHW to member ratio of at least one full-time CHW per 15,000 members.
- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" and "Phone AND address same online/4275" fell below the 75 percent threshold.
- *Benefits Monitoring Program* (February)—Assignment of members to a provider/pharmacy and notification requirements.
- *Member Material* (April)—ID Card and Member Handbook Mailed within 10 Days—12-month report documenting that ID cards are mailed first class within 10 business days and that member handbooks were mailed within 10 business days of notification of enrollment not submitted. No indication of whether the mailings of the ID cards and member packets were mailed separately first or third class.
- *Member Handbook Requirements* (April)—Could not access the member handbook on website. Navigation from the homepage to the member handbook not provided.
- *Member Newsletters* (April)—Could not access member newsletters on website. Navigation from the homepage to the newsletters not provided.
- *Website Maintained and Reviewed for Appropriate Content* (April)—Could not access content on website. Navigation from the homepage to the content not provided.
- *Pharmacy/MCO Common Formulary* (April)—Non-compliant NCPDP rejections.
- *Member Grievance and Appeal Resolution* (May)—Grievance and Appeal (GAP) member letter template not originally submitted. When submitted, the templates did not address the requirement content.
- *Written Member Appeal Decisions Rendered* (May)—GAP logs for the current year were not submitted.
- *CSHCS Collaboration* (May)—Could not access information on website regarding educational content and outreach information specifically directed toward CSHCS members with a mechanism for CSHCS members and families to contact specifically trained staff to assist them.
- *Third Party Liability Recovery* (May)—Policies and procedures for third-party liability recovers not submitted.

- *PRM Review* (May)—CAPs for the following measures not submitted: Claims Processing, Transition into CFP Status measure for Cohort 1, and Transition out of CFP Status measure for Cohorts 2 and 3.
- *Program Integrity Forms* (May)—Errors and/or discrepancies were noted on the Tips and Grievances and Data Mining forms.
- *Annual Quality Program Worksheet* (June)—Submitted an outdated worksheet that was missing two new required sections.
- *HEDIS IDSS* (June)—Submitted an incomplete data-filled workbook.
- *MHP Provider Directory Accuracy* (August)—"Phone # and address listed online correct" and "Phone AND address same online/4275" fell below the 75 percent threshold.
- *Program Integrity Forms* (August)—Errors and/or discrepancies were noted on the Overpayments Collected form.

MDHHS required **Trusted Health Plan** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Trusted Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **Trusted Health Plan** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **Trusted Health Plan** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-66 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-9] for **Trusted Health Plan**.

[5-9] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-66—HEDIS 2019 Performance Measure Results for TRU

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	58.00%	★
Combination 3	51.00%	★
Combination 4	50.50%	★
Combination 5	43.00%	★
Combination 6	25.00%	★
Combination 7	42.50%	★
Combination 8	25.00%	★
Combination 9	22.50%	★
Combination 10	22.50%	★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	43.96%	★
Lead Screening in Children		
Lead Screening in Children	64.00%	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.80%	★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	33.58%	★
Immunizations for Adolescents		
Combination 1	68.63%	★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	95.83%	★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NB	NC
Continuation and Maintenance Phase	NB	NC
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	65.83%	★★★★
Cervical Cancer Screening		
Cervical Cancer Screening	50.61%	★
Chlamydia Screening in Women		
Ages 16 to 20 Years	75.00%	★★★★★
Ages 21 to 24 Years	75.53%	★★★★★

Measure	HEDIS 2019	2019 Performance Level
Total	75.29%	★★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	82.08%	★
Ages 25 Months to 6 Years	70.36%	★
Ages 7 to 11 Years	74.88%	★
Ages 12 to 19 Years	66.67%	★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	48.48%	★
Ages 45 to 64 Years	69.07%	★
Ages 65+ Years	NA	NC
Total	56.83%	★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	30.23%	★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	81.02%	★★★
Counseling for Nutrition—Total	73.48%	★★★
Counseling for Physical Activity—Total	63.99%	★★★
Adult BMI Assessment		
Adult BMI Assessment	75.18%	★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	35.56%	★
Postpartum Care	32.22%	★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	81.09%	★
*HbA1c Poor Control (>9.0%)**	54.17%	★
HbA1c Control (<8.0%)	36.22%	★
Eye Exam (Retinal) Performed	51.28%	★★
Medical Attention for Nephropathy	83.65%	★
Blood Pressure Control (<140/90 mm Hg)	44.23%	★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	50.00%	★
Medication Compliance 75%—Total	35.42%	★★

Measure	HEDIS 2019	2019 Performance Level
Asthma Medication Ratio		
Total	42.86%	★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	45.26%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	79.30%	★★★
Discussing Cessation Medications	55.43%	★★★
Discussing Cessation Strategies	46.88%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	NB	NC
Effective Continuation Phase Treatment	NB	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	88.64%	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NC
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	68.57%	★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	85.77%	★
Diuretics	87.15%	★★
Total	86.42%	★★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	26.47%	NC
Total—Black or African American	54.68%	NC
Total—American-Indian and Alaska Native	0.10%	NC
Total—Asian	0.00%	NC
Total—Native Hawaiian and Other Pacific Islander	1.03%	NC
Total—Some Other Race	3.97%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	13.76%	NC
Total—Declined	0.00%	NC

Measure	HEDIS 2019	2019 Performance Level
Total—Hispanic or Latino	3.97%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	98.88%	NC
Spoken Language Preferred for Health Care—Non-English	1.06%	NC
Spoken Language Preferred for Health Care—Unknown	0.06%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	0.00%	NC
Language Preferred for Written Materials—Non-English	0.00%	NC
Language Preferred for Written Materials—Unknown	100.00%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	70.78	★
Outpatient Visits—Total	207.65	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	8.42	NC
Total Inpatient—Average Length of Stay—Total	4.95	NC
Maternity—Discharges per 1,000 Member Months—Total	1.56	NC
Maternity—Average Length of Stay—Total	2.97	NC
Surgery—Discharges per 1,000 Member Months—Total	1.70	NC
Surgery—Average Length of Stay—Total	9.46	NC
Medicine—Discharges per 1,000 Member Months—Total	5.56	NC
Medicine—Average Length of Stay—Total	3.99	NC
***Use of Opioids From Multiple Providers**[*,2]		
Multiple Prescribers	17.89%	NC
Multiple Pharmacies	5.96%	NC
Multiple Prescribers and Multiple Pharmacies	3.86%	NC
***Use of Opioids at High Dosage**[*,2]		
Use of Opioids at High Dosage	0.39%	NC
***Risk of Continued Opioid Use**[*,4]		
At Least 15 Days Covered—Total	27.86%	NC
At Least 31 Days Covered—Total	11.90%	NC

Measure	HEDIS 2019	2019 Performance Level
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	29.01%	★
Index Total Stays—Observed Readmissions—45–54 Years	7.69%	★★★★★
Index Total Stays—Observed Readmissions—55–64 Years	23.74%	★
Index Total Stays—Observed Readmissions—Total	21.12%	★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.
NB indicates that the MHP did not offer the required benefit.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-66 shows **Trusted Health Plan** ranked at or above the 75th percentile for eight of the 56 measure rates (14.3 percent), five of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Women—Adult Care, Living With Illness, and Utilization domains. Conversely, 42 of 56 measure rates (75.0 percent) fell below the 50th percentile, 36 of which fell below the 25th percentile. Opportunities for improvement for **Trusted Health Plan** include a focus on Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, Pregnancy Care, Living With Illness, and Utilization, where rates in these domains fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **Trusted Health Plan** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **Trusted Health Plan** analyzed historical data to identify disparity within its population related to timeliness of prenatal care. However, after thorough analysis, it was determined that **Trusted Health Plan** did not have an identified disparity. MDHHS approved **Trusted Health Plan** to focus on improving timeliness of prenatal care as defined by the HEDIS *Prenatal and Postpartum Care* measure.

Table 5-67 outlines the study indicator for the PIP.

Table 5-67—Study Indicator for TRU

PIP Topic	Study Indicator
Improving the Timeliness of Prenatal Care	The percentage of eligible women who receive a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment during the measurement period.

Table 5-68 displays the validation results for **Trusted Health Plan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-68 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-68—PIP Validation Results for TRU

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	75% (3/4)	25% (1/4)	0% (0/4)
Design Total			**89% (8/9)**	**11% (1/9)**	**0% (0/9)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**86% (18/21)**		

Overall, 86 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP.

For the first remeasurement period, **Trusted Health Plan** reported that 35.6 percent of eligible women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The reported rate for the study indicator did not meet the goal for Remeasurement 1, which was set at 83.6 percent.

Strengths, Weaknesses, and Overall Conclusions

Trusted Health Plan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Trusted Health Plan** received a total compliance score of 81 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **Trusted Health Plan** scored 95 percent or above in the Administrative and Program Integrity standards, indicating generally strong performance in these program areas, but did not perform as well in the Providers, Members, Quality, and MIS standards, as demonstrated by low to moderate performance scores (77 percent, 13 percent, 87 percent, and 83 percent, respectively), reflecting that additional focus is needed in these areas. While eight of the 56 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 42 measure rates fell below the 50th percentile, indicating opportunities for

improvement for **Trusted Health Plan** primarily in the Child & Adolescent Care, Women—Adult Care, Access to Care, Pregnancy Care, Obesity, Living With Illness, and Utilization domains.

Trusted Health Plan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-69—Quality, Timeliness, and Access Performance Impact for TRU

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 95 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were mostly compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider. • Strength: The *Appropriate Treatment for Children With Upper Respiratory Infection* measure rate ranked at or above the 75th percentile, indicating many children diagnosed with an upper respiratory infection were appropriately prescribed an antibiotic. • Strength: The *Breast Cancer Screening* measure rate ranked at or above the 75th percentile, indicating many women were screened for this type of cancer, which is highly treatable if detected early. • Strength: All three *Chlamydia Screening in Women* indicator rates exceeded the 90th percentile, indicating many women were being screened for this sexually transmitted disease. • Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate exceeded the 90th percentile, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Strength: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure rate ranked at or above the 75th percentile, indicating many members were dispensed an antipsychotic medication and remained on the medication for most of their treatment period, which reduces the risk of relapse and hospitalization. • Weakness: The *Well-Child Visits in the First 15 Months of Life—Six of More Visits*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Adolescent Well-Care Visits* measure rates each fell below the 25th percentile, indicating that children and adolescents were not seeing their PCPs or OB/GYNs as often as suggested to ensure timely assessment of their health and development.

Performance Area*	Overall Performance Impact
	• Weakness: The *Cervical Cancer Screening* measure rate fell below the 25th percentile, indicating many women were not screened for this type of cancer, which is highly treatable if detected early. • Weakness: The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate fell below the 50th percentile, indicating many adults diagnosed with acute bronchitis were dispensed an antibiotic, which could cause harmful side effects and lead to possible resistance to antibiotics. • Weakness: The *Adult BMI Assessment* measure rate fell below the 25th percentile, indicating opportunities to improve BMI screening, which helps providers identify members who are at risk and provide suggestions and services to assist them in obtaining a healthier weight. • Weakness: All six *Comprehensive Diabetes Care* indicator rates fell below the 50th percentile, including five indicator rates that fell below the 25th percentile, indicating opportunities to improve proper diabetes management, which is essential to control blood glucose, reduce risks for complications, and prolong life. • Weakness: Both *Medication Management for People With Asthma* indicator rates fell below the 50th percentile, including one indicator rate (*Medication Compliance 50%—Total*) that fell below the 25th percentile, and the *Asthma Medication Ratio—Total* measure rate fell below the 25th percentile. This indicates that members with asthma were not properly utilizing controller medications to reduce the prevalence of asthma attacks. • Weakness: All three *Annual Monitoring for Patients on Persistent Medications* indicator rates fell below the 50th percentile, including one indicator rate (*ACE Inhibitors or ARBs*) falling below the 25th percentile, indicating members may be at risk for adverse drug events.
Timeliness	• Weakness: The MHP received a performance score of 13 percent in the Members standard, indicating members were not receiving ID cards and new member information timely, and may not have received adequate written resolution of grievances and appeals. • Weakness: All nine *Childhood Immunization Status* indicator rates and the *Immunizations for Adolescents—Combination 1* measure rate fell below the 25th percentile, indicating children and adolescents were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: The *Lead Screening in Children* measure rate fell below the 50th percentile, indicating many children were not tested for lead poisoning, which can lead to irrevocable effects on a child's physical and mental health. • Weakness: Both *Prenatal and Postpartum Care* indicator rates fell below the 25th percentile, indicating pregnant women were not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy. • Weakness: For the first remeasurement period of the PIP, *Improving the Timeliness of Prenatal Care*, the MHP reported that 35.6 percent of eligible women received a

Performance Area*	Overall Performance Impact
	prenatal visit timely, which was below the goal that had been set at 83.6 percent, indicating opportunities for women to access prenatal care services earlier.
Access	• Weakness: Although the MHP received a moderate performance score of 77 percent in the Providers standard, findings suggest that members may experience potential challenges locating and accessing providers to obtain treatment as indicated by deficient findings in both the current and prior year's compliance reviews. • Weakness: All four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates and all three reportable *Adults' Access to Preventive/Ambulatory Health Services* indicator rates fell below the 25th percentile, indicating children, adolescents, and adults were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 25th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-70, Table 5-71, and Table 5-72 present the recommendations made by HSAG to **Trusted Health Plan** during the SFY 2017–2018 EQR, **Trusted Health Plan**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **Trusted Health Plan** addressed those recommendations.

Table 5-70—Compliance Monitoring Recommendations—TRU

HSAG's Recommendations
Trusted Health Plan should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Administrative • Providers • Members • MIS • Program Integrity **Trusted Health Plan** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency

HSAG's Recommendations
• Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies

Summary of TRU's Response
Administrative: • *Administrative Position*—**Trusted Health Plan** did not submit the change in personnel for its chief financial officer (CFO) and MIS director within the allotted seven-day time frame according to the contract. – **Trusted Health Plan addressed the deficiency. The Medicaid liaison implemented a notification process.** • *Standard Provider Contract Format Table*—**Trusted Health Plan** did not complete the Provider Contract table or submit an attestation indicating that there was no change in the contract. – **Trusted Health Plan addressed the deficiency and submitted the required format. The Medicaid liaison implemented a compliance monitoring timeline and quality check process.** • *Pharmacy Contracts*—**Trusted Health Plan** did not submit its policy and procedure for this criterion. – **Trusted Health Plan was in the process of contracting with a new pharmacy vendor and overlooked this requirement. Since the occurrence, the Medicaid liaison implemented a compliance monitoring timeline and quality check process.** • *MHP Provider Directory*—MDHHS conducted a random sample of calls to PCPs to check for accurate provider availability. The findings, as reported by MDHHS, are summarized below: <u>February 2018</u> • 50 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients <u>August</u> • 21 percent of providers had the correct information listed in the online directory and confirmed they were accepting new patients • 37 percent of providers matched what was submitted on the 4275 for "accepting new patients" • 29 percent of providers appeared to have matching contact information online and on the 4275 • 2 providers were unable to be reached • *Provider Network—MHP demonstrates that covered services are available and accessible*—**Trusted Health Plan** did not submit the Network Access Plan. – **Since the occurrence, the Medicaid liaison implemented a compliance monitoring timeline and quality check process.**

Summary of TRU's Response
• *Written Member Appeal Decisions Rendered*—**Trusted Health Plan** submitted logs with none of the requested information. • *MIS Health Plan maintains an Information System that collects, analyzes, integrates, and reports data as required by MDHHS*—The operational plans did not include provider enrollment, the newborn tracking and enrollment, or the quality report for tracking EPSDT, immunization, and members satisfaction related to access. • *Tips and Grievances Form*—Errors and/or discrepancies were noted on the form for one quarter. • *Data Mining/Algorithms Form*—Errors and/or discrepancies were noted on the form for two quarters. • *Audits Form*—Errors and/or discrepancies were noted on the form for two quarters. • *Provider Disenrollments Form*—Errors and/or discrepancies were noted on the form for one quarter. – **For all the items identified, new or revised processes were implemented. Since the occurrence, the Medicaid liaison implemented a compliance monitoring timeline and quality check process. There were several barriers identified including staff/vendor lack of knowledge related to the requirements; new data vendor contracted in 2017 with lack of clear understanding of Michigan requirements (there were several meetings with the vendor to identify and implement improvement processes).** – **The MIS/EPSDT quality report was not submitted due to new staff not realizing the report was required. Since the occurrence, the Medicaid liaison implemented a compliance monitoring timeline and quality check process.** – **The 'tips and grievance' form was corrected and staff education completed.**
HSAG's Assessment of the Degree to Which TRU Addressed the Recommendations
Based on **Trusted Health Plan**'s response and the SFY 2018–2019 compliance review findings, **Trusted Health Plan** addressed the prior year's recommendations; however, **Trusted Health Plan** continues to have opportunities for improvement related to the provider directory. **Trusted Health Plan** received deficient findings for *MHP Provider Directory Accuracy* in February and August 2019, and *Program Integrity Forms* in May and August 2019.

Table 5-71—Performance Measures Recommendations—TRU

HSAG's Recommendations
As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Trusted Health Plan** to members, HSAG recommended that **Trusted Health Plan** incorporate improvement efforts for the following performance measures rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Child & Adolescent Care** • *Childhood Immunization Status—Combination 2, 3, 4, 5, 6, 7, 8, 9, and 10* • *Well-Child Visits in the First 15 Months of Life—Six or More Visits* • *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* • *Adolescent Well-Care Visits* **Women—Adult Care** • *Cervical Cancer Screening* **Access to Care** • *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years* • *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 45 to 64 Years, and Total* **Obesity** • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* • *Adult BMI Assessment* **Pregnancy Care** • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* **Living With Illness** • *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy,* and *Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure* • *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics* HSAG further recommended that **Trusted Health Plan** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?

HSAG's Recommendations
5. What intervention(s) is **Trusted Health Plan** considering or has already implemented to improve rates and performance for each identified measure? Based on the information presented, **Trusted Health Plan** should include the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement
Summary of TRU's Response
Applying the Plan-Do-Check-Act (PDCA) process, **Trusted Health Plan** completed the following for several measures—e.g., HEDIS, Access, Satisfaction: • Established appropriate data/measures to monitor • Established goals for each measure • Reviewed results • Evaluated measure rate to goal • Evaluated patterns/trends • Assessed current best practices; NCQA Annual Quality Compass percentiles • Identified opportunities for improvement • Performed a barrier analysis • Identified interventions to improve The following is one example taken from the QI evaluation: <u>EPSDT</u> Federal regulations require state Medicaid programs to offer EPSDT services to Medicaid eligible beneficiaries younger than 21 years of age; however, member participation is voluntary. The intent of EPSDT is to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services. Providers are responsible for providing well-child visits, including immunizations and developmental screening, at specified intervals as defined in the periodicity schedule by the American Academy of Pediatrics (AAP). To encourage providers to perform member outreach and provide the age appropriate services, **Trusted Health Plan** offers PCP and members EPSDT financial incentives. <u>Well-Child Visits</u> Well-child visits provide an opportunity for the PCP to obtain an initial history or interval history, promote healthy lifestyle choices, monitor children's physical and behavioral health, and provide age-appropriate anticipatory guidance and education. It is during these well-child visits that potential health problems may be detected and prevented or treated in the early stages, thereby reducing the negative effects of these problems.

Summary of TRU's Response

Components of a well-child visit include measurements, a physical examination, various screenings—sensory, developmental, behavioral—oral health, and various blood tests.

Trusted Health Plan monitors progress for these measures through annual HEDIS and monthly gaps in care reports through the software vendor. The following are results for several childhood preventive health measures.

Measure/Data Elements	HEDIS 2016	HEDIS 2017	HEDIS 2018	50th Percentile	75th Percentile	90th Percentile
Weight Assessment/Counseling for Children/Adolescents						
BMI Percentile	73.97%	79.08%	70.32%	75.55%	82.63%	87.98%
Counseling for Nutrition	69.83%	79.81%	66.67%	69.57%	77.91%	83.45%
Counseling for Physical Activity	57.66%	57.91%	46.96%	65.33%	73.31%	79.17%
Childhood Immunization Status						
Combination #3	44.29%	50.00%	52.94%	70.80%	74.70%	79.56%
Combination #10	17.46%	16.07%	18.95%	35.28%	40.88%	48.42%
Immunizations for Adolescents (Ima)	58.33%	68.42%	75.00%	79.81%	85.64%	88.08%
Combination #1	48.57%	15.79%	25.00%	31.87%	37.71%	46.72%
Combination #2	10.53%	15.79%	28.13%	33.82%	40.63%	49.88%
HPV	71.43%	67.86%	72.55%	73.13%	80.08%	85.64%
Lead Screening in Children	71.43%	67.86%	72.55%	73.13%	80.08%	85.64%
Children and Adolescents' Access to Primary Care Practitioners						
12–24 Months	82.35%	86.05%	82.46%	95.66%	97.03%	97.71%
25 Months–6 Years	73.16%	76.97%	69.86%	87.47%	90.47%	92.88%
7–11 Years	71.65%	79.14%	77.50%	90.69%	93.04%	96.18%
12–19 Years	67.02%	65.25%	69.13%	89.56%	92.05%	94.75%
Well Child Visits in the First 15 months of Life—6+ Visits	64.29%	55.17%	43.86%	66.23%	71.29%	75.43%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.89%	69.68%	61.31%	73.89%	79.33%	83.70%
Adolescent Well-Care Visits	35.51%	42.82%	30.41%	54.57%	61.99%	66.80%

Summary of Findings

The results in green font demonstrate areas of improvement from the previous year. The areas in the table shaded in green represent a measure reaching the 50th, 75th, or 90th percentile. The preventive care measures demonstrate several areas for improvement:

- Weight assessment and counseling for children and adolescents
- Childhood immunizations
- Adolescents immunizations—combo
- Lead screening
- Well-child visits 0–15 months

Summary of TRU's Response
• Well-child visits—3rd–6th years • Adolescent well-care visits • Child and adolescent access to primary care: 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years **Barriers** **Trusted Health Plan** has completed a geographic analysis of the HEDIS gaps in care for several of the children's measures. This analysis has identified significant disparity in Region 10, specifically the city of Detroit. In the preliminary analysis, six ZIP Codes in the city are noted to have higher gaps in care. **Trusted Health Plan** will continue to analyze the data while we focus improvement efforts in these 'hot-spot' geographic areas. Factors affecting the preventive care rates include ineffective outreach from physicians and **Trusted Health Plan**, members having transportation issues, members needing childcare for other children, members not wanting to take their children to the doctor unless they are sick, member/provider knowledge deficit regarding incentives, and member knowledge deficit regarding the importance of preventive screening and/or the existence of transportation assistance. Barriers related to lead screening in children include: parental opposition (unwillingness to have their child undergo the trauma of a blood draw or capillary stick), lack of blood draws or capillary sticks in the physician office, and failure of parents to follow up on a lead screening order. Additional barriers include the social determinants of health (housing status, food security, income, type of employment, poverty, and education). **Improvement Activities** **Trusted Health Plan** continues implementation of previous initiatives and has implemented new strategies to address the above barriers, including: • Continue incentivizing members and providers for completing lead screening, well child visits/access visits, immunizations • Partner with a vendor to deploy a home-visit initiative aimed at educating members/parents about their gaps in care, connecting them with primary care appointments and healthcare services, and further aligning them with community resources, including transportation • Providing gaps in care information to providers to assist them in performing outreach to their members and implementing member gaps in care via the provider portal • In conjunction with Provider Services, analyze provider practice and billing awareness, provide interventions including provider education regarding billing the appropriate code (96110) when developmental screening is performed • Continue to employ Alternative Payment Models and Value-Based Payments

HSAG's Assessment of the Degree to Which TRU Addressed the Recommendations
HSAG recommended that **Trusted Health Plan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. Based on the results of the SFY 2018–2019 validation, the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Annual Monitoring for Patients on Persistent Medications—Diuretics* indicator rates improved to rank at or above the 25th percentile but below the 50th percentile, and the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* indicator rate improved to rank at or above the 50th percentile but below the 75th percentile. However, the remaining performance measure rates with an appropriate comparison and benchmark remained below the 25th percentile, indicating **Trusted Health Plan** has opportunities to continue performance improvement efforts to address the lower performing measures.

Table 5-72—PIP Recommendations—TRU

HSAG's Recommendations
Trusted Health Plan should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **Trusted Health Plan** should have ensured the following: • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Summary of TRU's Response
• Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission. – **Trusted Health Plan followed HSAG's recommendations** • To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate. – The following is taken from **Trusted Health Plan**'s PIP submission: There were a total of 146 members identified for Maternity Case Management and outreached to by the Case Manager. Of the 146 members that were identified a total of 49 (33.6 percent) of the members were included in the HEDIS 2019 population. It is not unusual for the Maternity Case Management Program to have more members than the HEDIS population as there are a number of women who enroll with the Plan to

Summary of TRU's Response

deliver and then immediately dis-enroll, meaning that these members do not meet continuous enrollment criteria. Additionally, members who deliver a non-live birth are excluded from the Timeliness of Prenatal Care measure. 18 of the members who were in both the HEDIS measure and Maternity Case Management received their Prenatal Care timely. This is a 36.7 percent success rate for Maternity Case Management. Further drilldown showed that Maternity Case Management had 56.5 percent (18 out of 32) of the HEDIS numerator positives for this measure.
Additionally, of the 49 members who were in both the HEDIS 2019 population and Maternity Case Management, 14 members (28.6 percent) were referred and enrolled in an MIHP. However, these members were identified and referred to MIHPs after the HEDIS specification date for the prenatal visit. In an effort to better understand the process for Maternity Case Management and barriers that the Case Manager may have, the Quality Improvement Analyst conducted an interview with the Case Manager and used the information gathered to compile a Key Driver Diagram. The following items were identified:

- Although the Case Manager is now a full-time employee, more cases from other programs have been added to their workload. This has decreased time spent on the Maternity Case Management Program. These additional cases are also more complex and time consuming as they are the Children with Special Healthcare Services (CSHCS) members
- The Case Manager uses multiple methods to identify pregnant members quickly. This quick identification helps the Case Manager work with the member to get them into their prenatal appointment within the NCQA required timeframe. These methods include:
  - 834 File—Identifies members that reported to MDHHS that they are pregnant and includes the member's estimated delivery date
  - Claims Data—Identifies members who had a pregnancy test or pregnancy related procedure done
  - Pharmacy Data—Identifies members who received prenatal vitamins and may be pregnant

  Currently, the Case Manager is having to review this information separately which has been time consuming and has resulted in a lack of timely identification.
- The Case Manager has prioritized their case load to focus on new infant and not the mother
- Maternity Case Management are focusing on members that are already identified as being pregnant via a medical and/or pharmacy claim for a prenatal service/medication; or the State indicated the member was pregnant on the 834 File. There is not a plan-wide focus on identifying members who may be pregnant and who may not have received any prenatal services/medications. Therefore, these members are not being case managed or receiving their prenatal visits.
- Members have complained to the Case Manager about the lack of female OB/GYNs in the network
- There is a culture barrier, especially in the Hamtramck area as the members need to wait for their husbands/partners to take them to their appointments which tend to be outside of normal business hours

- Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
  - **The following attachment includes key driver notes from the meeting with Care Management and Quality Improvement**

Summary of TRU's Response		
Primary Driver	**Secondary Driver**	**Change Ideas**
Timeliness of Identification	Multiple sources	Creation of comprehensive report
	Using sources that indicate member already had service	Education for member-facing staff to identify members who are pregnant and schedule PN appointment
	Lack of linkage for the HMP HRA to CM	Develop coordination between rest of Plan and CM
	Lack of plan-wide focus	
Timeline of Outreach/Maternity Case Management	Resources	Staff
	Competing priorities	
Engagement of Members	Wrong Demographics	
	Incentive	
Appointment No Shows	Language Barriers	Home Visiting Program
	Culture Barriers	Advertise importance of Prenatal Care
	Lack of Female OBs	Increase Provider Network so it meets member needs
	Lower Rate in Hamtramck	

- Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.

To address the above recommendations, the MHP provided its SFY 2018–2019 PIP Summary Form for the remeasurement period.

HSAG's Assessment of the Degree to Which TRU Addressed the Recommendations

For the SFY 2017–2018 validation, **Trusted Health Plan** had opportunities for improvement in Steps VI, VII, and VIII in the Design and Implementation stages. HSAG recommended the MHP clearly document the type of sampling method, if utilized; document the staff members that made up the QI team; and describe and submit the QI tools used to conduct a causal/barrier analysis. In the SFY 2018–2019 validation, **Trusted Health Plan** addressed some of the recommendations; however, **Trusted Health Plan** received similar recommendations for the sampling methods, indicating the MHP partially addressed the prior year's recommendations.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **Trusted Health Plan** to members, HSAG recommends that **Trusted Health Plan** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **Trusted Health Plan** incorporate new improvement efforts as necessary for the following performance measures ranking below the 25th percentile.

Child & Adolescent Care

- *Childhood Immunization Status—Combination 2*, *3*, *4*, *5*, *6*, *7*, *8*, *9*, and *10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Immunizations for Adolescents—Combination 1*

Women—Adult Care

- *Cervical Cancer Screening*

Access to Care

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 45 to 64 Years*, and *Total*

Obesity

- *Adult BMI Assessment*

Pregnancy Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Living With Illness

- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Asthma Medication Ratio—Total*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*

Utilization

- *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total*
- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—18–44 Years, 55–64 Years,* and *Total*

To meet the above recommendation, **Trusted Health Plan** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Trusted Health Plan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Trusted Health Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Trusted Health Plan** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Members
- Quality
- MIS
- Program Integrity

Trusted Health Plan was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends that **Trusted 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 recommends that **Trusted Health Plan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. Additionally, HSAG recommends **Trusted Health Plan**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **Trusted Health Plan** should immediately implement internal corrective action.

Trusted Health Plan should also take proactive steps to ensure a successful PIP. **Trusted Health Plan** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments* in the *2018–2019 PIP Validation Report Improving the Timeliness of Prenatal Care for Trusted Health Plan* and make the following necessary corrections prior to the next annual submission:

- Provide a description of how the study indicators were calculated or provide a copy of the plan's Final Audit Report (FAR) with the appropriate passing performance measure included.
- The PIP has not yet demonstrated significant improvement in the study indicator results nor met the plan-specific goals for both study indicators. The MHP should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.

Finally, as applicable, **Trusted Health Plan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

UnitedHealthcare Community Plan (UNI)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **UnitedHealthcare Community Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **UnitedHealthcare Community Plan**.

EQR Activity Results

Compliance Monitoring

UnitedHealthcare Community Plan was evaluated in six program areas referred to as "standards." Table 5-73 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-73 presents **UnitedHealthcare Community Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-73—Compliance Review Results for UNI

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	UNI	Statewide
1	Administrative	4	1	0	5	90%	99%
2	Providers	12	2	1	15	87%	91%
3	Members	6	2	0	8	88%	87%
4	Quality	15	0	0	15	100%	98%
5	MIS	8	1	0	9	94%	95%
6	Program Integrity	28	0	0	28	100%	97%
Overall		**73**	**6**	**1**	**80**	**95%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

UnitedHealthcare Community Plan demonstrated compliance for 73 of 80 elements, with an overall compliance score of 95 percent, which was equal to the statewide average. **UnitedHealthcare Community Plan** demonstrated strong performance, scoring at or above 90 percent in four standards, with two standards (Quality and Program Integrity) achieving full compliance. The program areas of strength include the Administrative, Quality, MIS, and Program Integrity standards.

Opportunities for improvement were identified in four of the six standards, which are briefly described below:

- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.
- *MAC Pricing* (March)—Information identifying three national drug codes not received.
- *Pharmacy/MCO Common Formulary* (April)—Non-compliant NCPDP rejections.
- *MHP Provider Directory Accuracy* (August)—"Accepting new MA pts" and "Accepting new patients as PCP on 4275?" fell below the 75 percent threshold.
- *Governing Body* (August)—Board meeting dates originally not submitted.

MDHHS required **UnitedHealthcare Community Plan** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

UnitedHealthcare Community Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **UnitedHealthcare Community Plan** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **UnitedHealthcare Community Plan** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-74 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-10] for **UnitedHealthcare Community Plan**.

[5-10] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-74—HEDIS 2019 Performance Measure Results for UNI

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	71.05%	★★
Combination 3	66.42%	★★
Combination 4	63.99%	★★
Combination 5	58.15%	★★
Combination 6	33.58%	★★
Combination 7	56.20%	★★
Combination 8	32.36%	★
Combination 9	30.41%	★★
Combination 10	29.44%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	64.48%	★★
Lead Screening in Children		
Lead Screening in Children	75.91%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.26%	★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	58.15%	★★★
Immunizations for Adolescents		
Combination 1	85.16%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	91.69%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	79.21%	★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	42.41%	★★
Continuation and Maintenance Phase	57.02%	★★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	61.31%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	64.48%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	67.63%	★★★★
Ages 21 to 24 Years	71.25%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Total	69.09%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	94.54%	★★
Ages 25 Months to 6 Years	87.87%	★★★
Ages 7 to 11 Years	90.92%	★★★
Ages 12 to 19 Years	90.70%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	77.98%	★★★
Ages 45 to 64 Years	87.95%	★★★
Ages 65+ Years	95.08%	★★★★★
Total	81.97%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	32.57%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	86.37%	★★★★
Counseling for Nutrition—Total	81.27%	★★★★
Counseling for Physical Activity—Total	77.13%	★★★★
Adult BMI Assessment		
Adult BMI Assessment	91.97%	★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	79.32%	★★
Postpartum Care	62.53%	★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	91.51%	★★★★
*HbA1c Poor Control (>9.0%)**	29.63%	★★★★★
HbA1c Control (<8.0%)	60.80%	★★★★★
Eye Exam (Retinal) Performed	61.27%	★★★
Medical Attention for Nephropathy	94.29%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	64.81%	★★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	58.10%	★★
Medication Compliance 75%—Total	34.05%	★★

Measure	HEDIS 2019	2019 Performance Level
Asthma Medication Ratio		
Total	62.94%	★★★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	64.72%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	84.33%	★★★★★
Discussing Cessation Medications	63.16%	★★★★★
Discussing Cessation Strategies	55.30%	★★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	52.99%	★★★
Effective Continuation Phase Treatment	36.51%	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.71%	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	74.24%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	79.69%	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	60.25%	★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	89.54%	★★★
Diuretics	89.29%	★★★
Total	89.44%	★★★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	51.15%	NC
Total—Black or African American	30.36%	NC
Total—American-Indian and Alaska Native	0.28%	NC
Total—Asian	1.89%	NC
Total—Native Hawaiian and Other Pacific Islander	0.08%	NC
Total—Some Other Race	0.00%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	16.24%	NC
Total—Declined	0.00%	NC

Measure	HEDIS 2019	2019 Performance Level
Total—Hispanic or Latino	5.90%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	95.23%	NC
Spoken Language Preferred for Health Care—Non-English	4.71%	NC
Spoken Language Preferred for Health Care—Unknown	0.06%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	95.23%	NC
Language Preferred for Written Materials—Non-English	4.71%	NC
Language Preferred for Written Materials—Unknown	0.06%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	95.23%	NC
Other Language Needs—Non-English	4.71%	NC
Other Language Needs—Unknown	0.06%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	66.48	★★
Outpatient Visits—Total	371.07	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	5.62	NC
Total Inpatient—Average Length of Stay—Total	4.56	NC
Maternity—Discharges per 1,000 Member Months—Total	2.51	NC
Maternity—Average Length of Stay—Total	2.63	NC
Surgery—Discharges per 1,000 Member Months—Total	1.30	NC
Surgery—Average Length of Stay—Total	7.42	NC
Medicine—Discharges per 1,000 Member Months—Total	2.50	NC
Medicine—Average Length of Stay—Total	4.46	NC
***Use of Opioids From Multiple Providers**[*,2]		
Multiple Prescribers	18.82%	NC
Multiple Pharmacies	4.88%	NC
Multiple Prescribers and Multiple Pharmacies	2.58%	NC
***Use of Opioids at High Dosage**[*,2]		
Use of Opioids at High Dosage	2.56%	NC
***Risk of Continued Opioid Use**[*,4]		
At Least 15 Days Covered—Total	20.54%	NC
At Least 31 Days Covered—Total	7.88%	NC
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	12.53%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Index Total Stays—Observed Readmissions—45–54 Years	11.33%	★★★★★
Index Total Stays—Observed Readmissions—55–64 Years	13.72%	★★★
Index Total Stays—Observed Readmissions—Total	12.66%	★★★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-74 shows **UnitedHealthcare Community Plan** ranked at or above the 75th percentile for 18 of the 64 measure rates (28.1 percent), seven of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Access to Care, Living With Illness, and Utilization domains. Conversely, 20 of 64 measure rates (31.3 percent) fell below the 50th percentile, one of which fell below the 25th percentile. Opportunities for improvement for **UnitedHealthcare Community Plan** include a focus on Child & Adolescent Care, Access to Care, Pregnancy Care, Living With Illness, and Utilization, where several rates in each domain fell below the 50th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **UnitedHealthcare Community Plan** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **UnitedHealthcare Community Plan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its African-American/Black and White populations. The goal of the PIP is to improve the timeliness of prenatal care for the African-American/Black population and eliminate the identified disparity without a decline in performance for the White population.

Table 5-75 outlines the study indicators for the PIP.

Table 5-75—Study Indicators for UNI

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible African-American or Black women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible White women who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-76 displays the validation results for **UnitedHealthcare Community Plan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-76 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-76—PIP Validation Results for UNI

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	67% (2/3)	33% (1/3)	0% (0/3)
Design Total			**89% (8/9)**	**11% (1/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	33% (1/3)	67% (2/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**78% (7/9)**	**22% (2/9)**	**0% (0/9)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total*			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**76% (16/21)**		

* Percentage totals may not equal 100 due to rounding.

Overall, 76 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP. The technical design of the PIP was sufficient to measure and monitor PIP outcomes; however, opportunities for improvement exist related to the MHP's documentation and omission of requirements in Step VI, Accurate/Complete Data Collection and Step VII, Sufficient Data Analysis and Interpretation of Results.

For the first remeasurement period, **UnitedHealthcare Community Plan** reported that 57.8 percent of eligible African-American/Black women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 66.2 percent of eligible White women received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The reported rates for both study indicators did not meet the goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

UnitedHealthcare Community Plan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **UnitedHealthcare Community Plan** received a total compliance score of 95 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **UnitedHealthcare Community Plan** scored 90 percent or above in the Administrative, Quality, MIS, and Program Integrity standards, indicating strong performance in these program areas, but did not perform as well in the Providers and Members standards, as demonstrated by moderate performance scores (87 and 88 percent, respectively), reflecting that additional focus is needed in these program areas. While 18 of the 64 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 20 measure rates fell below the 50th percentile, indicating opportunities for improvement for **UnitedHealthcare Community Plan** primarily in the Child & Adolescent Care and Pregnancy Care domains.

UnitedHealthcare Community Plan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-77—Quality, Timeliness, and Access Performance Impact for UNI

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 90 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 100 percent in the Quality standard, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 94 percent in the MIS standard, indicating that the MHP maintained a health information system that is capable of collecting, analyzing, integrating, and reporting data to meet the obligations under its contract with MDHHS and, therefore, the ability to appropriately monitor the quality of services being provided to members. • Strength: The MHP received a performance score of 100 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider. • Strength: All three *Chlamydia Screening in Women* indicator rates ranked at or above the 75th percentile, indicating many women ages 16 to 24 years were being screened for this sexually transmitted disease. • Strength: All three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicator rates ranked at or above the 75th percentile, indicating children and adolescents had their BMIs assessed and received counseling for nutrition and physical activity by a PCP or OB/GYN during a medical appointment, which can help providers identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: Four of the six *Comprehensive Diabetes Care* indicator rates ranked at or above the 75th percentile, including three indicator rates that exceeded the 90th percentile, indicating many adults received proper diabetes management, which is essential to control blood glucose and reduce risks for complications. • Strength: All three *Medical Assistance With Smoking and Tobacco Use Cessation* indicator rates ranked at or above the 75th percentile, including two indicator rates that exceeded the 90th percentile, indicating many adults who are tobacco smokers or users received cessation advice and discussed cessation medications and strategies to help quit tobacco and improve overall health. • Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate ranked at or above the 75th

Performance Area*	Overall Performance Impact
	percentile, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Weakness: The *Well-Child Visits in the First 15 Months of Life—Six of More Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates each fell below the 50th percentile, indicating that children were not seeing their PCPs as often as suggested to ensure timely assessment of their health and development. • Weakness: The *Appropriate Testing for Children With Pharyngitis* measure rate fell below the 50th percentile, indicating many children diagnosed with pharyngitis and dispensed an antibiotic did not receive the appropriate testing to potentially reduce the unnecessary use of antibiotics. • Weakness: Both *Medication Management for People With Asthma* indicator rates fell below the 50th percentile, indicating adult and child members diagnosed with persistent asthma were not always dispensed appropriate asthma controller medications and did not always remain on the medications for most of their treatment period.
Timeliness	• Weakness: All nine *Childhood Immunization Status* indicator rates fell below the 50th percentile, including one indicator rate that fell below the 25th percentile, indicating children were not always receiving vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: Both *Follow-Up Care for Children Prescribed ADHD Medication* indicator rates fell below the 50th percentile, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a practitioner. • Weakness: Both *Prenatal and Postpartum Care* indicator rates fell below the 50th percentile, indicating pregnant women were not always accessing timely prenatal care and/or having a timely postpartum visit after delivery, which could impact the health of the member and her baby before, during, and after pregnancy. • Weakness: The MHP's reported rates for the PIP, *Addressing Disparities in Timeliness of Prenatal Care*, study indicators did not meet the goal to no longer have a statistically significant rate difference between African-American/Black and White women accessing prenatal care, indicating opportunities to improve the percentage of African-American/Black women receiving timely services.
Access	• Strength: One of the four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates ranked at or above the 90th percentile, indicating many adults 65 years of age and older were accessing ambulatory or preventive care services from their physicians. • Weakness: One of the four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 50th percentile, indicating many children between the ages of 12 and 24 months were not always accessing primary care services for appropriate screenings, treatment, and preventive services. • Weakness: The *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure rate fell below the 50th percentile, indicating potential inadequate access to care resulting in preventable ED visits.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-78, Table 5-79, and Table 5-80 present the recommendations made by HSAG to **UnitedHealthcare Community Plan** during the SFY 2017–2018 EQR, **UnitedHealthcare Community Plan**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **UnitedHealthcare Community Plan** addressed those recommendations.

Table 5-78—Compliance Monitoring Recommendations—UNI

HSAG's Recommendations
UnitedHealthcare Community Plan should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Providers • Program Integrity **UnitedHealthcare Community Plan** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Summary of UNI's Response
Providers: • Detailed narrative of the deficiency Response: The February compliance review resulted in **UnitedHealthcare Community Plan** not meeting compliance requirement 2.6 Provider Directory. 18 PCPs were called and of the 18 PCPs: – 60% reflected accurate information based on outreach to the provider. The minimum threshold to pass this requirement is 75%. The August compliance review resulted in **UnitedHealthcare Community Plan** not meeting compliance requirement 2.6 Provider Directory. 19 PCPs were called and of the 19 PCPs – 64% reflected accurate information based on outreach to the provider. The minimum threshold to pass this requirement is 75%. • Detailed corrective action steps to resolve each deficiency Response: Outreach to each provider was conducted to validate the State's results. Updates were made to the system based on this outreach. Further, providers were educated on **UnitedHealthcare Community Plan**'s process to update provider information. The importance of getting timely updates was emphasized

Summary of UNI's Response
with each provider. In addition, **UnitedHealthcare Community Plan** works to ensure our provider data are as accurate as possible throughout the year using the following initiatives: – Outreach to delegated providers to ensure we received monthly delegated roster updates – Outreach to delegated providers to ensure we receive at least one full roster annually – Annual outreach to all independent providers to validate information on file (example A attached) – Monthly and/or quarterly advocates visits to PCP offices; these visits include demographic validation – Ongoing provider data audits to identify and remediate data entry errors – Our Primary Care contract also encourages open access as the monthly care management fee is only available to providers open and accepting UNI members – Monthly faxes to Primary Care offices reminding them that the care management fee is dependent on being open and accepting members • Any resources required to resolve the deficiency Response: Internal **UnitedHealthcare Community Plan** staff dedicated to providers and provider data were used to resolve the deficiency. • Due dates for completing each action step Response: Staff was asked to resolve each deficiency as soon as possible. Much of our ability to resolve is dependent on feedback from the provider. • Assigned party responsible for completing each action step Response: **UnitedHealthcare Community Plan** Provider Advocate staff as well as provider data team that are responsible for system updates. • Any required deliverables to show that a deficiency has been resolved Response: System validation is performed based on the providers' validation of demographic information. • Any dependencies to resolve deficiencies Response: **UnitedHealthcare Community Plan** is dependent on verification from the provider to resolve the deficiency. **Program Integrity:** • Detailed narrative of the deficiency 6.1 Tips and Grievances • Column AD "CASE STATUS DETAILS" remains blank for line 25. ➢ Per the guidance document, this field must contain the status of the case as of the last day of the reporting period. • Column R "OVERPAYMENT IDENTIFIED (Y/N)" and Column S "DATE INITIAL REVIEW COMPLETED/OVERPAYMENT IDENTIFIED" remain blank for lines 66 and 67 ➢ Per the guidance document, this field must be completed.

Summary of UNI's Response
6.3 Audits • The Activity Report tab shows: Column AC "SUMMARY OF RESOLUTION/FINDINGS" remains blank for lines 295-349 despite having a designation of "Closed-Recovery" or "Closed-No Further Action Necessary" in column AD "CASE STATUS DETAILS." ➢ Per the guidance document, this field cannot be left blank. 6.2 Data Mining/Algorithms: • The Activity Report tab shows: Column AC "SUMMARY OF RESOLUTION/FINDINGS" remains blank for lines 90-294 despite having a designation of "Closed-Recovery" or "Closed-No Further Action Necessary" in column AD "CASE STATUS DETAILS." ➢ Per the guidance document, this field cannot be left blank. • Column AD "CASE STATUS DETAILS" remains blank for lines 350-364. ➢ Per the guidance document, this field must contain the status of the case as of the last day of the reporting period. • Detailed corrective action steps to resolve each deficiency – A QA process is now being utilized by the reporting team to address each of the deficiencies above. All MI Medicaid reports flow through that QA process prior to being sent to the MI Health Plan for submission to the state. Compliance also maintains line of sight of all reports and reviews thoroughly before submission to the state. • Any resources required to resolve the deficiency – No resources required. • Due dates for completing each action step – QA process implemented 10/22/2018. • Assigned party responsible for completing each action step – Reporting team and Compliance Officer. • Any required deliverables to show that a deficiency has been resolved – These new QA processes have enabled UNI to be compliant with our MI Medicaid reporting requirements. Since being placed on the CAP, we have not had any issues with the quality of our reporting. • Any dependencies to resolve deficiencies – None
HSAG's Assessment of the Degree to Which UNI Addressed the Recommendations
Based on **UnitedHealthcare Community Plan**'s response and the SFY 2018–2019 compliance review findings, **UnitedHealthcare Community Plan** addressed the prior year's recommendations; however, **UnitedHealthcare Community Plan** continues to have opportunities for improvement related to the provider directory. **UnitedHealthcare Community Plan** received deficient findings for *MHP Provider Directory Accuracy* in February and August 2019.

Table 5-79—Performance Measures Recommendations—UNI

HSAG's Recommendations
HSAG recommended that **UnitedHealthcare Community Plan** prioritize its efforts for improvement on those measure rates below the national Medicaid 50th percentile and focus particularly on those measure rates within the Access to Care and Pregnancy Care domains. **UnitedHealthcare Community Plan** should incorporate these efforts as part of its QI strategy within the QAPIP and consider answering the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **UnitedHealthcare Community Plan** considering or has already implemented to improve rates and performance for each identified measure? HSAG further recommended that **UnitedHealthcare Community Plan** should include the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement
Summary of UNI's Response
UnitedHealthcare Community Plan provided a detailed analysis of its lower performing measure rates, as recommended in the SFY 2017–2018 technical report. **UnitedHealthcare Community Plan** also indicated: The most significant area of focus for **Child Access to Care 12–24 months** is to support large providers with on-site scheduling or remote scheduling for members as allowed. The significant area of focus for **Adult Access to Care ages 20–44** is to develop layers of communication geared toward the age group, educate on how members can access and use information on benefits, accessing primary care, and the benefit of prevent care/screening. The significant area of focus for the **prenatal and postpartum moms** is to include community resources on our website for pre-pregnancy or new pregnancy registration with Healthy First Steps/Baby Blocks. In addition, community partnerships in Wayne County are the key to closing the disparity gap, improving understanding of early prenatal and postpartum care from peers. Through additionally locally based health plan telephonic outreach to identified members through the Healthy First Steps Program, there will be identification of staff at the local health plan, both Ob Care Coordinators as well as Quality Department staff, that can assist members with barriers, questions, problems, etc. around their Ob care/postpartum period. This will allow the plan to develop relationships with the OB members and also assist with additional identification, information, and referrals to the MIHP if needed. All members are referred to MIHP by the plan but engagement by the members varies. It will also allow the local plan staff to provide referrals for local resources regarding social determinants of health (SDOH) that members may need thus adding a layer of possible intervention around this area. MHP staff will have talking points and attempt to establish a relationship with the

Summary of UNI's Response
member so that they feel that they can approach the plan if obstacles/needs occur during the pregnancy or postpartum period. During the call, the MHP staff will provide information on the importance of prenatal care/assess provider satisfaction/assist with linkage if needed including alternative models of prenatal care such as Centering Pregnancy; instruct on importance of taking prenatal vitamins; ask about problems/barriers getting to prenatal visits including SDOH needs and give referrals as needed; ask about WIC and give referrals as needed, etc. Members will also receive a letter from the health plan with information such as WIC, Tobacco Quit Line, Mental Health and Substance Use Assistance, and dental services as well as specific linkage to their local community resources through the Great Start Collaborative-Parent Coalitions and parenting hotlines if they are available within their county of residence. The local linkage is important so that members can garner support from those in their area as well as becoming familiar with local community resources that address SDOH issues that they may be currently experiencing. Members are contacted during the postpartum period. Interventions in place for **Child Access to Care 12–24** months include live and mail incentive outreach, educating on 0–15 well-visit schedule, PCP scheduling assistance on-site at two large provider sites. Quality outreach staff currently stagger work hours to overlap into evening hours for greater accessibility for busy working families. PCP intervention includes providing member list for gaps in care along with money left on the table reports. Interventions related to **Access Ages 20–44** include end of year notification by mail for provider and mailing to member with lack of care in previous CY. Educational mailing will include risk factors for age group and PCP preventive services covered by the health plan. Texting is also an option being explored to assist with access to care utilizing health links, apps etc. An initiative is also being developed to target prosperity regions 4, 5, and 8 that has the highest ED visits for ages 20–44 that involves follow-up care in evening hours, education on how to control blood pressure, and other more convenient sources of primary care. Additionally, contacts are currently being made to African-American members in Wayne, Oakland, and Macomb counties during the postpartum period and education is being provided regarding the importance of the postpartum checkup, helping to schedule the checkup with the provider or offering a home visit for the postpartum checkup through the plan's home visiting agency if the member prefers or if the member has barriers in getting back to the provider for the visit. The MHP indicated they are also linking members to Medicaid enrollment for their infants, breastfeeding assistance/obtaining breast pumps, and any other expressed need by the member. In addition to the information previously provided, the MHP is exploring the use of alternative prenatal care delivery models such as Centering as well as the use of Doulas with the African-American population. The MHP is also working on better linkage of women to breastfeeding resources within their local communities in addition to WIC and is researching the culturally appropriate resources available so that women can receive culturally competent services that will hopefully increase their engagement with these resources. Additionally, the MHP is working on educating its OB providers regarding health plan services available for its members, the PPC measure itself, and billing practices around the measure as well as the importance of referring to evidence-based home visiting programs, dental care, smoking cessation, WIC, mental health, and substance abuse resources. The MHP is also planning on expanding that education to other women's health measures as OB/GYN providers are often the only healthcare providers that women consistently see. The MHP will also be working with providers on transitioning members following the postpartum period back to PCPs if desired as well as mental health/substance use providers and educating the providers around FQHC services available if the member will no longer have Medicaid after the postpartum period so that they can receive a continuous source of healthcare outside of ER usage.

Summary of UNI's Response
The following recommendations have been included in the **UnitedHealthcare Community Plan** QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement • Measurable goals and benchmarks for each measure—Measurable goals and benchmarks for each measure are listed in UNI 2019 QI Work Plan under each measure worksheet. • Mechanisms to measure performance—Mechanisms to measure performance are included in Strategic Interventions in UNI 2019 QI Work Plan. • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates—Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates are listed in Admin Interventions in UNI 2019 QI Work Plan. • Identified opportunities for improvement—Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates are listed in Admin Interventions in UNI 2019 QI Work Plan. • Ongoing analysis to identify factors that impact adequacy of rates—Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates are listed in Admin Interventions in UNI 2019 QI Work Plan. • QI interventions that address the root cause of the deficiency—Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates are listed in Admin Interventions in UNI 2019 QI Work Plan. • A plan to monitor the QI interventions to detect whether they effect improvement—Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates are listed in Admin Interventions in UNI 2019 QI Work Plan.
HSAG's Assessment of the Degree to Which UNI Addressed the Recommendations
The 2017–2018 validation of performance measures for **UnitedHealthcare Community Plan** determined that no measure rates fell below the 25th percentile. HSAG recommended that **UnitedHealthcare Community Plan** focus on improving measure rates that fell below the 50th percentile. Based on the results of the SFY 2018–2019 validation, the *Childhood Immunization Status—Combination 8* indicator rate fell below the 25th percentile. Additionally, more measure rates fell below the 50th percentile in SFY 2018–2019 than in SFY 2017–2018, indicating that **UnitedHealthcare Community Plan** has opportunities to continue improvement efforts to prevent a decline in performance.

Table 5-80—PIP Recommendations—UNI

HSAG's Recommendations
UnitedHealthcare Community Plan should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **UnitedHealthcare Community Plan** should have ensured the following: • Addressed all validation feedback and made necessary corrections prior to the next annual submission, including those recommendations for improvement related to documentation and omission of requirements in Step VI, Reliably Collect Data and Step VII, Sufficient Data Analysis and Interpretation of Results. Validation feedback provided on Step VI, Reliably Collect Data, is being addressed with our QSD team to be appropriately addressed for next submission. The FAR was provided in the August 2019 submission and it did include PPC in auditor approval.
Summary of UNI's Response
• The MHP's Plan-Do-Study-Act (PDSA) Worksheet was included in the response and provided an analysis for the time period of 11/06/2017–11/05/2018. • The MHP developed and implemented additional interventions targeted to the two subgroups for the PIP that include internal changes to include live outreach to low-risk members that do not become part of the Healthy First/Baby Blocks program. In addition, women often go to the emergency room prior to ascribing to traditional care for pregnancy and those data are reviewed to capture timely outreach to members. The MHP is encouraging PCPs that service children of women of childbearing age to discuss caring for themselves if they become pregnant and prior to acquiring Medicaid coverage for pregnancy care. • Follow the approved PIP methodology to calculate and report data accurately in next year's annual submission: The MHP will address this issue in advance utilizing technical support for confirmation. • To impact the Remeasurement 1 study indicator rate, 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 will not have enough time to impact the study indicator rate: The MHP noted the recommendations and changed the process to include reliance on data available to health plan via providers, and ED visits. • Document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis: The MHP noted the recommendation and the bi-weekly leadership meeting has notes that reflect efforts towards supporting the goal. • Implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes: The MHP indicated it has strongly considered limitation with external partners and inability to cross reference individually captured data and lack of impact on either side. Major changes have to come from within the health plan strategies while continuing to utilize external partners as additional support. • Implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical: The MHP noted the recommendation and put into action steps that are brought during the bi-weekly leadership meeting review of PPC measures. • Seek technical assistance throughout the PIP process to address any questions or concerns: The MHP noted the recommendation and indicated it will seek technical assistance throughout the PIP process.

HSAG's Assessment of the Degree to Which UNI Addressed the Recommendations
For the SFY 2017–2018 validation, **UnitedHealthcare Community Plan** had opportunities for improvement in Steps VI and VII in the Design and Implementation stages. HSAG provided recommendations to address Steps VI and VII prior to the next validation activity. In the SFY 2018–2019 validation, **UnitedHealthcare Community Plan** addressed some of HSAG's recommendations; however, **UnitedHealthcare Community Plan** received similar findings, indicating the MHP did not completely address the prior year's recommendations.

Recommendations for Program Improvement

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by **UnitedHealthcare Community Plan** to members, HSAG recommends that **UnitedHealthcare Community Plan** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **UnitedHealthcare Community Plan** incorporate new improvement efforts as necessary for the following performance measure ranking below the 25th percentile.

Child & Adolescent Care

- *Childhood Immunization Status—Combination 8*

To meet the above recommendation, **UnitedHealthcare Community Plan** should include within its next annual QAPIP review the results of analyses for the performance measure listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **UnitedHealthcare Community Plan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **UnitedHealthcare Community Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement

- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **UnitedHealthcare Community Plan** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Administrative
- Providers
- Members
- MIS

UnitedHealthcare Community Plan was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends that **UnitedHealthcare Community 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 recommends that **UnitedHealthcare Community Plan** conduct an internal audit of each deficient program requirement to ensure the plans of action were successfully implemented and resolved each deficiency. Additionally, HSAG recommends **UnitedHealthcare Community Plan**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **UnitedHealthcare Community Plan** should immediately implement internal corrective action.

UnitedHealthcare Community Plan should also take proactive steps to ensure a successful PIP. **UnitedHealthcare Community Plan** should address all feedback provided in *Partially Met* and *Not Met* validation scores as well as any *General Comments* in the *2018–2019 PIP Validation Report Addressing Disparities in Timeliness of Prenatal Care for UnitedHealthcare Community Plan* and make the following necessary corrections prior to the next annual submission:

- Accurately calculate and report the study indicator *p*-values.
- Include a clear description of the data analysis process and provide a comparison of the results to the State-developed goals or benchmarks.
- Describe the potential impact of the all factors that may threaten the comparability of the study indicator results.

- The decision to continue, discontinue, or modify an intervention should be data-driven and accurately documented within the submission.
- The PIP has not yet demonstrated significant improvement in the study indicator results nor met the plan-specific goals for both study indicators. The MHP should identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.

Finally, as applicable, **UnitedHealthcare Community Plan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

Upper Peninsula Health Plan (UPP)

To conduct the SFY 2018–2019 EQR, HSAG reviewed **Upper Peninsula Health Plan**'s results for mandatory EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by **Upper Peninsula Health Plan**.

EQR Activity Results

Compliance Monitoring

Upper Peninsula Health Plan was evaluated in six program areas referred to as "standards." Table 5-81 presents the total number of criteria for each standard as well as the number of criteria for each standard that received a score of *Pass*, *Incomplete*, or *Fail*. Table 5-81 presents **Upper Peninsula Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages.

Table 5-81—Compliance Review Results for UPP

Standard		Number of Scores				Compliance Score	
		Pass	*Incomplete*	*Fail*	*Total Applicable*	UPP	Statewide
1	Administrative	5	0	0	5	100%	99%
2	Providers	14	1	0	15	97%	91%
3	Members	8	0	0	8	100%	87%
4	Quality	15	0	0	15	100%	98%
5	MIS	7	2	0	9	89%	95%
6	Program Integrity	25	3	0	28	95%	97%
Overall		**74**	**6**	**0**	**80**	**96%**	**95%**

The overall compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), or *Fail* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Upper Peninsula Health Plan demonstrated compliance for 74 out 80 elements, with an overall compliance score of 96 percent, which was above the statewide average of 95 percent. **Upper Peninsula Health Plan** demonstrated strong performance, scoring above 90 percent in five standards, with three standards (Administrative, Members, and Quality) achieving full compliance. The program areas of strength include the Administrative, Providers, Members, Quality, and Program Integrity standards.

Opportunities for improvement were identified in three of the six standards, which are briefly described below:

- *Program Integrity Forms* (November)—Errors and/or discrepancies were noted on the Tips and Grievances, Data Mining, and Audits forms.
- *MHP Provider Directory Accuracy* (February)—"Accepting new MA pts" fell below the 75 percent threshold.
- *Pharmacy/MCO Common Formulary* (April)—Non-compliant NCPDP rejections.
- *Written Procedure to Electronically Process Enrollments/Disenrollments* (June)—Group composition information not originally submitted.

MDHHS required **Upper Peninsula Health Plan** to develop and implement a CAP for applicable requirements within all program areas that received an *Incomplete* or a *Fail* finding.

Validation of Performance Measures

Upper Peninsula Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the 2019 HEDIS Compliance Audit Report findings, **Upper Peninsula Health Plan** was fully compliant with all seven IS standards, including:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support Measure HEDIS Reporting Integrity

According to the auditors' review, **Upper Peninsula Health Plan** followed the NCQA HEDIS 2019 technical specifications and produced a Reportable rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 5-82 displays the HEDIS 2019 performance measure rates and 2019 performance levels based on comparisons to national percentiles[5-11] for **Upper Peninsula Health Plan**.

[5-11] HEDIS 2019 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles" throughout this section of the report).

Table 5-82—HEDIS 2019 Performance Measure Results for UPP

Measure	HEDIS 2019	2019 Performance Level
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	71.93%	★★
Combination 3	69.23%	★★
Combination 4	67.78%	★★
Combination 5	55.30%	★★
Combination 6	44.91%	★★★
Combination 7	54.68%	★★
Combination 8	44.70%	★★★
Combination 9	37.94%	★★★
Combination 10	37.84%	★★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	79.56%	★★★★★
Lead Screening in Children		
Lead Screening in Children	82.00%	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.16%	★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	43.77%	★
Immunizations for Adolescents		
Combination 1	80.97%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	93.78%	★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	84.99%	★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	49.62%	★★★
Continuation and Maintenance Phase	53.92%	★★
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	65.42%	★★★★
Cervical Cancer Screening		
Cervical Cancer Screening	65.21%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	43.19%	★
Ages 21 to 24 Years	53.78%	★

Measure	HEDIS 2019	2019 Performance Level
Total	47.86%	★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	96.79%	★★★
Ages 25 Months to 6 Years	87.93%	★★★
Ages 7 to 11 Years	90.67%	★★
Ages 12 to 19 Years	91.61%	★★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	82.16%	★★★
Ages 45 to 64 Years	88.60%	★★★
Ages 65+ Years	94.91%	★★★★★
Total	85.65%	★★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.44%	★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	92.21%	★★★★★
Counseling for Nutrition—Total	69.83%	★★★
Counseling for Physical Activity—Total	66.42%	★★★
Adult BMI Assessment		
Adult BMI Assessment	96.84%	★★★★★
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	91.48%	★★★★★
Postpartum Care	73.97%	★★★★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	92.21%	★★★★
*HbA1c Poor Control (>9.0%)**	21.90%	★★★★★
HbA1c Control (<8.0%)	63.50%	★★★★★
Eye Exam (Retinal) Performed	70.32%	★★★★★
Medical Attention for Nephropathy	94.16%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	78.35%	★★★★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total[1]	70.36%	★★★★
Medication Compliance 75%—Total	50.90%	★★★★

Measure	HEDIS 2019	2019 Performance Level
Asthma Medication Ratio		
Total	63.06%	★★★
Controlling High Blood Pressure[2]		
Controlling High Blood Pressure	76.89%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	77.22%	★★
Discussing Cessation Medications	56.42%	★★★
Discussing Cessation Strategies	49.09%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	59.54%	★★★★
Effective Continuation Phase Treatment	44.15%	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	88.87%	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	84.15%	★★★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	83.38%	★★★★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	89.92%	★★★
Diuretics	91.62%	★★★★
Total	90.63%	★★★
Health Plan Diversity[3]		
Race/Ethnicity Diversity of Membership		
Total—White	87.85%	NC
Total—Black or African American	1.48%	NC
Total—American-Indian and Alaska Native	2.43%	NC
Total—Asian	0.24%	NC
Total—Native Hawaiian and Other Pacific Islander	0.07%	NC
Total—Some Other Race	1.68%	NC
Total—Two or More Races	0.00%	NC
Total—Unknown	0.00%	NC
Total—Declined	6.25%	NC

Measure	HEDIS 2019	2019 Performance Level
Total—Hispanic or Latino	1.68%	NC
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	99.93%	NC
Spoken Language Preferred for Health Care—Non-English	0.04%	NC
Spoken Language Preferred for Health Care—Unknown	0.02%	NC
Spoken Language Preferred for Health Care—Declined	0.00%	NC
Language Preferred for Written Materials—English	99.93%	NC
Language Preferred for Written Materials—Non-English	0.04%	NC
Language Preferred for Written Materials—Unknown	0.02%	NC
Language Preferred for Written Materials—Declined	0.00%	NC
Other Language Needs—English	0.00%	NC
Other Language Needs—Non-English	0.00%	NC
Other Language Needs—Unknown	100.00%	NC
Other Language Needs—Declined	0.00%	NC
Utilization[3]		
Ambulatory Care—Total (Per 1,000 Member Months)		
*ED Visits—Total**	52.04	★★★
Outpatient Visits—Total	307.10	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	5.34	NC
Total Inpatient—Average Length of Stay—Total	3.80	NC
Maternity—Discharges per 1,000 Member Months—Total	2.22	NC
Maternity—Average Length of Stay—Total	2.93	NC
Surgery—Discharges per 1,000 Member Months—Total	1.65	NC
Surgery—Average Length of Stay—Total	5.60	NC
Medicine—Discharges per 1,000 Member Months—Total	2.08	NC
Medicine—Average Length of Stay—Total	3.05	NC
***Use of Opioids From Multiple Providers**[*,2]		
Multiple Prescribers	15.85%	NC
Multiple Pharmacies	6.53%	NC
Multiple Prescribers and Multiple Pharmacies	4.16%	NC
***Use of Opioids at High Dosage**[*,2]		
Use of Opioids at High Dosage	3.81%	NC
***Risk of Continued Opioid Use**[*,4]		
At Least 15 Days Covered—Total	13.07%	NC
At Least 31 Days Covered—Total	5.72%	NC

Measure	HEDIS 2019	2019 Performance Level
Plan All-Cause Readmissions*		
Index Total Stays—Observed Readmissions—18–44 Years	8.21%	★★★★★
Index Total Stays—Observed Readmissions—45–54 Years	12.11%	★★★★
Index Total Stays—Observed Readmissions—55–64 Years	11.38%	★★★★
Index Total Stays—Observed Readmissions—Total	10.35%	★★★★★

[1] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate and Plan All-Cause Readmissions indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[3] These measure indicator rates and any comparisons to benchmarks for these measures are provided for informational purposes only.
[4] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.
2019 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 5-82 shows **Upper Peninsula Health Plan** ranked at or above the 75th percentile for 28 of the 63 measure rates (44.4 percent), 16 of which exceeded the 90th percentile. Measure rates that exceeded the 90th percentile were in the Child & Adolescent Care, Access to Care, Obesity, Pregnancy Care, Living With Illness, and Utilization domains. Conversely, 14 of 63 measure rates (22.2 percent) fell below the 50th percentile, five of which fell below the 25th percentile. Opportunities for improvement for **Upper Peninsula Health Plan** include a focus on Child & Adolescent Care, Women—Adult Care, and Access to Care, where rates in these domains fell below the 25th percentile.

Validation of Performance Improvement Projects

For the SFY 2018–2019 PIP, **Upper Peninsula Health Plan** submitted Remeasurement 1 data for the State-mandated topic, *Addressing Disparities in Timeliness of Prenatal Care*. **Upper Peninsula Health Plan** analyzed historical data and identified a disparity related to timeliness of prenatal care among its counties. The goal of the PIP is to improve the timeliness of prenatal care for women residing in Marquette County and eliminate the identified disparity without a decline in performance for women residing in all other counties served by **Upper Peninsula Health Plan**.

Table 5-83 outlines the study indicators for the PIP.

Table 5-83—Study Indicators for UPP

PIP Topic	Study Indicators
Addressing Disparities in Timeliness of Prenatal Care	1. The percentage of eligible pregnant women residing in Marquette County who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year. 2. The percentage of eligible pregnant women residing in all other counties served by **Upper Peninsula Health Plan** who received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment in the health plan during the measurement year.

Table 5-84 displays the validation results for **Upper Peninsula Health Plan**'s PIP. This table illustrates the MHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-84 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-84—PIP Validation Results for UPP

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	100% (3/3)	0% (0/3)	0% (0/3)
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (21/21)**		

Overall, 100 percent of all applicable evaluation elements received a score of *Met* for the Design, Implementation, and Outcomes stages of the PIP.

For the first remeasurement period, **Upper Peninsula Health Plan** reported that 54.2 percent of eligible women residing in Marquette County received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment, and 57.8 percent of eligible women residing in all other counties served by **Upper Peninsula Health Plan** received a prenatal visit during the first trimester, on the enrollment date, or within 42 days of enrollment. The reported rates for both study indicators met the goal for the PIP, which is that there will no longer be a statistically significant rate difference between the two subgroups.

Strengths, Weaknesses, and Overall Conclusions

Upper Peninsula Health Plan demonstrated both strengths and weaknesses based on the results of the SFY 2018–2019 EQR activities. **Upper Peninsula Health Plan** received a total compliance score of 96 percent across all program areas reviewed during the SFY 2018–2019 compliance review. **Upper Peninsula Health Plan** scored 95 percent or above in the Administrative, Providers, Members, Quality, and Program Integrity standards, indicating strong performance in these program areas, but did not perform as well in the MIS standard as demonstrated by a moderate performance score (89 percent),

reflecting that additional focus is needed in this area. While 28 of the 63 HEDIS measure rates ranked at or above the 75th percentile, indicating strengths in these areas, 14 measure rates fell below the 50th percentile, indicating opportunities for improvement for **Upper Peninsula Health Plan** primarily in the Child & Adolescent Care, Women—Adult Care, Access to Care, and Living With Illness domains.

Upper Peninsula Health Plan's overall performance demonstrates the following impact to the Medicaid population's quality of, timeliness of, and access to care and services:

Table 5-85—Quality, Timeliness, and Access Performance Impact for UPP

Performance Area*	Overall Performance Impact
Quality	• Strength: The MHP received a performance score of 100 percent in the Administrative standard, indicating that the MHP had adequate staffing and oversight mechanisms in place to ensure the delivery of quality services to its members. • Strength: The MHP received a performance score of 100 percent in the Quality standard, indicating that the MHP had the components of an effective QAPIP in place to assess and improve the quality of services provided to members. • Strength: The MHP received a performance score of 95 percent in the Program Integrity standard during the compliance review, indicating the MHP's program integrity processes were compliant with federal and State regulations, and contracted providers had been appropriately screened and met the MHP's expectations for a quality provider. • Strength: The *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure rate exceeded the 90th percentile, indicating many children in the first 15 months of life were seeing their PCPs as often as suggested to ensure timely assessment of their physical and mental development. • Strength: The *Appropriate Treatment for Children With Upper Respiratory Infection* measure rate ranked at or above the 75th percentile, indicating many children diagnosed with upper respiratory infections were not being prescribed antibiotics inappropriately. • Strength: The *Breast Cancer Screening* measure rate ranked at or above the 75th percentile, indicating many women were screened for this type of cancer, which is highly treatable if detected early. • Strength: The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* indicator rate and the *Adult BMI Assessment* measure rate exceeded the 90th percentile, indicating child, adolescent, and adult BMIs were assessed, which can help providers identify at-risk members and provide suggestions and services to assist them in obtaining and maintaining a healthier weight. • Strength: All six *Comprehensive Diabetes Care* indicator rates ranked at or above the 75th percentile, including five indicator rates that exceeded the 90th percentile, indicating many adults received proper diabetes management, which is essential to control blood glucose and reduce risks for complications.

Performance Area*	Overall Performance Impact
	• Strength: Both *Medication Management for People With Asthma* indicator rates ranked at or above the 75th percentile, indicating adult and child members diagnosed with persistent asthma were dispensed appropriate asthma controller medications and remained on the medications for most of their treatment period. • Strength: Both *Antidepressant Medication Management* indicator rates ranked at or above the 75th percentile, indicating adults diagnosed with major depression received effective medication management, which can improve a person's daily functioning and wellbeing, and reduce the risk of suicide. • Strength: The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate exceeded the 90th percentile, indicating many adults diagnosed with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication had a diabetes screening. • Strength: The *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure rate exceeded the 90th percentile, indicating many adult members diagnosed with schizophrenia and diabetes received an LDL-C and HbA1c test during the year. • Strength: The *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure rate exceeded the 90th percentile, indicating many members were dispensed an antipsychotic medication and remained on the medication for most of their treatment period, which reduces the risk of relapse and hospitalization. • Strength: The *Annual Monitoring for Patients on Persistent Medications—Diuretics* indicator rate ranked at or above the 75th percentile, indicating many adult members were appropriately monitored for potential adverse drug events. • Strength: The MHP designed a scientifically sound PIP, *Addressing Disparities in Timeliness of Prenatal Care*, supported by using key research principals, meeting 100 percent of the requirements in the Design, Implementation, and Outcomes stages. • Weakness: The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rate fell below the 50th percentile, and the *Adolescent Well-Care Visits* measure rate fell below the 25th percentile, indicating many members 3 to 21 years of age were not seeing their PCPs or OB/GYNs as often as suggested to ensure timely assessment of their physical, emotional, and social development. • Weakness: All three *Chlamydia Screening in Women* indicator rates fell below the 25th percentile, indicating many women were not being screened for this sexually transmitted disease, which can lead to serious and irreversible complications if left untreated. • Weakness: The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure rate fell below the 25th percentile, indicating many adults diagnosed with bronchitis were dispensed an antibiotic, which can lead to side effects and possible resistance to antibiotics. • Weakness: One of the three *Medical Assistance With Smoking and Tobacco Use Cessation* indicator rates fell below the 50th percentile, indicating many adults who are tobacco smokers or users did not receive cessation advice to help quit tobacco and improve overall health.

Performance Area*	Overall Performance Impact
Timeliness	• Strength: The MHP received a performance score of 100 percent in the Members standard, indicating members received member materials, including an ID card, in a timely manner, to have information available to access services as soon as needed. • Strength: The *Lead Screening in Children* measure rate ranked at or above the 75th percentile, indicating many children were tested for lead poisoning by 2 years of age. • Strength: Both *Prenatal and Postpartum Care* indicator rates exceeded the 90th percentile, indicating many women were accessing timely prenatal and/or postpartum care, which could positively impact the health of the member and her baby before, during, and after pregnancy. • Strength: The MHP's reported rates for the study indicators within the PIP met the goal that there will no longer be a statistically significant rate difference between women residing in Marquette County and other counties within the region receiving timely prenatal care services. • Weakness: Five of the nine *Childhood Immunization Status* indicator rates fell below the 50th percentile, indicating children were not always receiving these vaccines in a timely manner to protect them from serious and potentially life-threatening illnesses. • Weakness: One of the two *Follow-Up Care for Children Prescribed ADHD Medication* indicator rates fell below the 50th percentile, indicating additional opportunities for prescribed ADHD medications to be more closely monitored by a pediatrician.
Access	• Strength: Two of the four *Adults' Access to Preventive/Ambulatory Health Services* indicator rates ranked at or above the 75th percentile, including one indicator rate that exceeded the 90th percentile, indicating many adults were accessing ambulatory or preventive care services from their physicians. • Weakness: One of the four *Children and Adolescents' Access to Primary Care Practitioners* indicator rates fell below the 50th percentile, indicating some children between the ages of 7 and 11 years were not accessing primary care services for appropriate screenings, treatment, and preventive services.

* Performance impacts may be applicable to one or more performance areas; however, for this report they were aligned to either quality, timeliness, or access.

Follow-Up on Prior EQR Recommendations

CMS requires that EQROs report annually the degree to which MHPs addressed the EQR recommendations made from the prior year's technical report. Table 5-86, Table 5-87, and Table 5-88 present the recommendations made by HSAG to **Upper Peninsula Health Plan** during the SFY 2017–2018 EQR, **Upper Peninsula Health Plan**'s response as to how those recommendations were addressed, and HSAG's assessment of the degree to which **Upper Peninsula Health Plan** addressed those recommendations.

Table 5-86—Compliance Monitoring Recommendations—UPP

HSAG's Recommendations
Upper Peninsula Health Plan should have developed meaningful plans of action to bring into compliance each of the following deficient program areas: • Providers • Program Integrity **Upper Peninsula Health Plan** should have included the following in each of its plans of action, and the plans of action should be provided to MDHHS as requested: • Detailed narrative of the deficiency • Detailed corrective action steps to resolve each deficiency • Any resources required to resolve the deficiency • Due dates for completing each action step • Assigned party responsible for completing each action step • Any required deliverables to show that a deficiency has been resolved • Any dependencies to resolve deficiencies
Summary of UPP's Response
Providers: The MHP submitted a CAP as required prior to the due date of April 24, 2018. In April of 2018, the MHP's Provider Relations team researched and identified inconsistencies to ensure all provider information was accurate. Beginning in May of 2018, the Provider Relations Manager began educating and training network provider offices about office updates and expectations through newsletters, in-service, and a quarterly outreach process. The Quality Review Specialist in the Provider Relations Department began internal provider network and directory audits. **Program Integrity:** The MHP received a CAP on February's Program Integrity report due to values in the spreadsheet not reconciling. The MHP submitted a corrected report as requested on April 2, 2018. The MDHHS-OIG now offers the option to submit the report for a preliminary review to ensure accuracy and the MHP utilizes this option to ensure the Program Integrity report is correct with no deficiencies.
HSAG's Assessment of the Degree to Which UPP Addressed the Recommendations
Based on **Upper Peninsula Health Plan**'s response and the SFY 2018–2019 compliance review findings, **Upper Peninsula Health Plan** addressed the prior year's recommendations; however, **Upper Peninsula Health Plan** continues to have opportunities for improvement related to the provider directory. **Upper Peninsula Health Plan** received deficient findings for *MHP Provider Directory Accuracy* in February 2019, and *Program Integrity Forms* in November 2018.

Table 5-87—Performance Measures Recommendations—UPP

HSAG's Recommendations
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 improvement efforts for the following performance measure rating below the national Medicaid 25th percentile as part of its QI strategy within the QAPIP: **Women—Adult Care** • *Chlamydia Screening in Women—Ages 16 to 20 Years* HSAG further recommended that **Upper Peninsula Health Plan** should include within its next annual QAPIP review the results of analyses for the performance measure listed above that answers the following questions: 1. What were the root causes associated with rates indicating low performance? 2. What unexpected outcomes were found within the data? 3. What disparities were identified in the analyses? 4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)? 5. What intervention(s) is **Upper Peninsula Health Plan** considering or has already implemented to improve rates and performance for each identified measure? HSAG further recommended that **Upper Peninsula Health Plan** should include the following within its QI plan: • Measurable goals and benchmarks for each measure • Mechanisms to measure performance • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates • Identified opportunities for improvement • Ongoing analysis to identify factors that impact adequacy of rates • QI interventions that address the root cause of the deficiency • A plan to monitor the QI interventions to detect whether they effect improvement
Summary of UPP's Response
• Measurable goals and benchmarks for each measure: Objective—Increase member education regarding chlamydia screening and provider completion of chlamydia screening. Benchmark Goal—HEDIS 2020: 50th percentile. • Mechanisms to measure performance: Cotiviti Quality Reporter HEDIS engine monthly proactive data, annual HEDIS rates, and clinic-specific rates. • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates: Cotiviti Quality Reporter HEDIS engine monthly proactive data, annual HEDIS rates, clinic-specific rates, and MDHHS Performance Monitoring Report. • Identified opportunities for improvement: Increase testing for 16–20-year-old cohort, White, and American-Indian/Alaskan Native cohort through member and provider education and provider quality linked incentives.

Summary of UPP's Response
• QI interventions that address the root cause of the deficiency: Provider incentives and member/provider education on why screening is important. • A plan to monitor the QI interventions to detect whether they effect improvement: **Upper Peninsula Health Plan** monitors the Cotiviti Quality Reporter HEDIS Engine proactive builds monthly. Analysis of the Chlamydia Screening population showed that the 16–20-year-old cohort has a significantly lower rate than the 21–24-year-old cohort. American-Indian/Alaskan Native and White women show the lowest rates for completion of chlamydia testing. **Upper Peninsula Health Plan** will focus on White women as this composes the majority of **Upper Peninsula Health Plan** membership. **Upper Peninsula Health Plan** has included this measure in the Value-Based Payment (VBP) program since CY 2014. **Upper Peninsula Health Plan** also implemented a process improvement incentive for select providers to incorporate standardized workflows to test all eligible members for chlamydia. In 2017, **Upper Peninsula Health Plan** attempted to initiate collaborative efforts to improve chlamydia screening with the American-Indian/Alaskan Native population. In 2019, **Upper Peninsula Health Plan** added a second provider incentive opportunity in addition to the VBP, which awards $15 for each HEDIS eligible member that receives a chlamydia test. No quality benchmark threshold is required to qualify for this incentive. In 2020, **Upper Peninsula Health Plan** plans to implement a member education campaign on sexually transmitted diseases, including chlamydia. **Upper Peninsula Health Plan** will continue to include chlamydia testing in the VBP program and plans to continue to offer the additional $15 testing incentive in 2020. Based on the information presented, **Upper Peninsula Health Plan** will ensure the following are incorporated within its QI Program Plan: • Measurable goals and benchmarks for each measure: *Increase member education regarding chlamydia screening and provider completion of chlamydia screening. Benchmark Goal—HEDIS 2020: 50th percentile.* • Mechanisms to measure performance: *Cotiviti Quality Reporter HEDIS engine monthly proactive data, annual HEDIS rates, and clinic-specific rates.* • Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates: *Cotiviti Quality Reporter HEDIS engine monthly proactive data, annual HEDIS rates, clinic-specific rates, and MDHHS Performance Monitoring Report.* • Identified opportunities for improvement: *Increase testing for 16–20-year-old cohort, White, and American-Indian/Alaskan Native cohort through member and provider education and provider quality linked incentives.* • QI interventions that address the root cause of the deficiency: *Provider incentives and member/provider education on why screening is important.* • A plan to monitor the QI interventions to detect whether they effect improvement: ***Upper Peninsula Health Plan** monitors the Cotiviti Quality Reporter HEDIS Engine proactive builds monthly.*
HSAG's Assessment of the Degree to Which UPP Addressed the Recommendations
HSAG recommended that **Upper Peninsula Health Plan** focus on ensuring the completeness and accuracy of data used for calculating all HEDIS measures, and specifically on improving the rates for measures that fell below the 25th percentile. Based on the results of the SFY 2018–2019 validation, the *Chlamydia Screening in Women—Ages 16 to 20 Years* measure rate remained below the 25th percentile, indicating **Upper Peninsula Health Plan** has opportunities to continue performance improvement efforts to improve the low performing rate.

Table 5-88—PIP Recommendations—UPP

HSAG's Recommendations
Upper Peninsula Health Plan should have taken proactive steps to ensure a successful PIP. As the PIP progressed, **Upper Peninsula Health Plan** should have ensured the following: • Addressed feedback provided in *Points of Clarification* associated with *Met* validation scores. • Followed the approved PIP methodology to calculate and report data accurately in next year's annual submission. • To impact the Remeasurement 1 study indicator rate, completed 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 will not have enough time to impact the study indicator rate. • Documented the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • Implemented active, innovative improvement strategies with the potential to directly impact study indicator outcomes. • Implemented a process for evaluating the performance of each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
Summary of UPP's Response
Upper Peninsula Health Plan scored 100% for the 2019 Prenatal Timeliness PIP. No feedback to address was noted.
HSAG's Assessment of the Degree to Which UPP Addressed the Recommendations
For the SFY 2017–2018 validation, **Upper Peninsula Health Plan** designed a PIP that was appropriate for measuring and monitoring PIP outcomes, and reported accurate baseline measurement results and improvement strategies; therefore, HSAG had no required follow-up recommendations. HSAG did provide the following recommendations for **Upper Peninsula Health Plan**'s consideration as it progressed to Remeasurement 1: complete an annual causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner, as interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate; implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes; and implement a process for evaluating the performance of each PIP intervention and its impact on the study indicators. In the SFY 2018–2019 validation, **Upper Peninsula Health Plan** addressed all recommendations for consideration within the PIP submission.

Recommendations for Program Improvement

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 recommends that **Upper Peninsula Health Plan** evaluate the impact of previously implemented QI initiatives to determine whether those initiatives were effective in improving lower performing HEDIS measures. As a result of that evaluation, and the most current HEDIS performance rates, HSAG further recommends that **Upper**

Peninsula Health Plan incorporate new improvement efforts as necessary for the following performance measures ranking below the 25th percentile.

Child & Adolescent Care

- *Adolescent Well-Care Visits*

Women—Adult Care

- *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total*

Access to Care

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

To meet the above recommendation, **Upper Peninsula Health Plan** should include within its next annual QAPIP review the results of analyses for the performance measures listed above that answer the following questions:

1. What were the root causes associated with rates indicating low performance?
2. What unexpected outcomes were found within the data?
3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is **Upper Peninsula Health Plan** considering or has already implemented to improve rates and performance for each identified measure?

Based on the information presented, **Upper Peninsula Health Plan** should include the following within its QI plan:

- Measurable goals and benchmarks for each measure
- Mechanisms to measure performance
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates
- Identified opportunities for improvement
- Ongoing analysis to identify factors that impact adequacy of rates
- QI interventions that address the root cause of the deficiency
- A plan to monitor the QI interventions to detect whether they effect improvement

HSAG also recommends that **Upper Peninsula Health Plan** develop meaningful plans of action to bring into compliance each of the following deficient program areas:

- Providers
- Program Integrity

Upper Peninsula Health Plan was required to complete plans of action to address each deficiency identified during the compliance monitoring activity. HSAG recommends 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 recommends 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. Additionally, HSAG recommends **Upper Peninsula Health Plan**'s annual monitoring and auditing plan within its compliance program include a comprehensive administrative review of its program areas to ensure MHP compliance with the federal requirements under 42 CFR 438—Managed Care, and specifically each of the federal and associated State requirements under 42 CFR 438 Subpart D and 42 CFR 438.330 under Subpart E. For any requirement found deficient, **Upper Peninsula Health Plan** should immediately implement internal corrective action.

Upper Peninsula Health Plan should also take proactive steps to ensure a successful PIP. **Upper Peninsula Health Plan** should consider the following recommendations prior to the next annual submission:

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Continue to evaluate the effectiveness of each individual intervention and report the findings of the evaluation analysis in the next annual submission.

Finally, as applicable, **Upper Peninsula Health Plan** should align its QI efforts with the *Quality Strategy Recommendations for Michigan* outlined in ***Section 6***.

6. MHP Comparative Information With Recommendations for MDHHS

In addition to performing a comprehensive assessment of the performance of each MHP, HSAG compared the findings and conclusions established for each MHP to assess the Michigan Medicaid managed care program. The overall findings of the 11 MHPs were used to identify the overall strengths and weaknesses of the Michigan Medicaid managed care program and to identify areas in which MDHHS could leverage or modify Michigan's Quality Strategy to promote improvement.

EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the 11 MHPs.

Compliance Monitoring

Table 6-1 presents a summary of performance results for the Medicaid programs of the MHPs, as well as statewide aggregated performance. The percentage of requirements that were met for each of the six compliance standards reviewed during the SFY 2018–2019 compliance monitoring review are provided.

Table 6-1—Compliance Monitoring Comparative Results

Standard		AET	BCC	HAP	MCL	MER	MOL	PRI	THC	TRU	UNI	UPP	Statewide
1	Administrative	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	100%	**99%**
2	Providers	90%	97%	87%	93%	97%	90%	90%	97%	77%	87%	97%	**91%**
3	Members	88%	94%	100%	100%	94%	81%	100%	100%	13%	88%	100%	**87%**
4	Quality	97%	97%	93%	100%	100%	100%	100%	100%	87%	100%	100%	**98%**
5	MIS	89%	100%	100%	100%	100%	94%	94%	100%	83%	94%	89%	**95%**
6	Program Integrity	98%	100%	88%	98%	95%	100%	100%	100%	95%	100%	95%	**97%**
Overall Totals/Score		**94%**	**98%**	**92%**	**98%**	**97%**	**96%**	**98%**	**99%**	**81%**	**95%**	**96%**	**95%**

Total Health Care, Inc. was the highest performing MHP, with an overall compliance score of 99 percent. **Blue Cross Complete of Michigan**, **McLaren Health Plan**, **Meridian Health Plan**, **Molina Healthcare of Michigan**, **Priority Health Choice, Inc.**, **UnitedHealthcare Community Plan**, and **Upper Peninsula Health Plan** also demonstrated strong performance with overall compliance scores at or above the statewide average of 95 percent.

Aetna Better Health of Michigan and **HAP Empowered** demonstrated moderately strong performance, with overall compliance scores above 90 percent but below the statewide average of 95 percent. **Trusted Health Plan** demonstrated moderate performance and was the overall lowest performing MHP, with an overall compliance score below 90 percent (81 percent).

Five of the six program areas demonstrated compliance above 90 percent, with scores ranging between 91 percent to 99 percent. These program areas were the Administrative, Providers, Quality, MIS, and Program Integrity standards. The lowest scoring program area was the Members standard with a statewide score of 87 percent. **Trusted Health Plan** demonstrated significant opportunities for improvement in this program area with a compliance score of only 13 percent. Five other MHPs also had one to three findings in the Members standard.

The second lowest performing program area was the Providers standard. Consistent with the last two years' compliance reviews, MDHHS conducted a random sample of calls to PCPs to check for accuracy in provider availability. Specifically, these calls were to confirm whether the provider was accepting new patients and to verify whether this information along with the provider's contact information matched the MHP's provider directory and the 4275 Provider Network File. All 11 MHPs received one or more *Incomplete* or *Fail* findings in the *MHP Provider Directory* category within the Providers standard, indicating a statewide opportunity for improvement remains in this program area.

Additionally, while the MIS standard demonstrated overall strong performance, eight of the 11 MHPs received findings in the category *Pharmacy/MCO Common Formulary* related to accurate NCPDP 831 rejections and NCPDP 71 rejections. These MHPs did not have less than 0.5 percent non-compliant claims for NCPDP 831 rejections and/or less than 0.1 percent non-complaint claims for products covered on the Common Formulary.

Table 6-2 presents—for each standard and overall across all standards—the statewide compliance scores for the SFY 2017–2018 and SFY 2018–2019 compliance reviews.

Table 6-2—Comparison of Results From the Compliance Reviews: Previous Results for SFY 2017–2018 and Current Results for SFY 2018–2019

Standard		Statewide Compliance Score	
		SFY 2017–2018	SFY 2018–2019
1	Administrative	97%	99%
2	Providers	87%	91%
3	Members	98%	87%
4	Quality	99%	98%
5	MIS	99%	95%
6	Program Integrity	92%	97%
Overall Score/Total		**94%**	**95%**

The current year's overall statewide compliance score across all standards and all MHPs was 95 percent, which was comparable to the previous year's statewide score of 94 percent. The Administrative, Providers, Quality, and MIS standards remained relatively consistent (less than a 5-percentage point increase or decrease). The Program Integrity standard demonstrated a positive trend with a 5-percentage point increase in statewide performance. The greatest decline was in the Members standard, with an 11-percentage point difference between SFY 2017–2018 and SFY 2018–2019. The deficiencies in this standard primarily related to the benefits monitoring program (program to identify and monitor members overutilizing or misusing services), timely delivery of member materials, and member grievance and appeal resolution and notification timeliness.

Performance Measures

Table 6-3 displays the HEDIS 2019 performance levels. Table 6-4 displays the HEDIS 2018 and 2019 Michigan Medicaid weighted averages, comparison of performance between 2018 and 2019, and the performance level for 2019. Statewide weighted averages were calculated and compared from HEDIS 2018 to HEDIS 2019, and comparisons were based on a Chi-square test of statistical significance with a *p*-value of <0.01 considered statistically significant due to large denominators. Of note, 2018 to 2019 comparison values are based on comparisons of the exact HEDIS 2018 and HEDIS 2019 statewide weighted averages rather than on rounded values.

For most measures in Table 6-4, the performance levels compare the HEDIS 2019 statewide weighted average to the NCQA Quality Compass national Medicaid HMO percentiles for HEDIS 2018 (referred to as "percentiles"), as displayed in Table 6-3.[6-1]

Table 6-3—HEDIS 2019 Performance Levels

Performance Levels	Percentile
★★★★★	90th percentile and above
★★★★	75th to 89th percentile
★★★	50th to 74th percentile
★★	25th to 49th percentile
★	Below 25th percentile

For certain measures, such as *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*, where lower rates indicate better performance, the 10th percentile (rather than the 90th percentile) represents excellent performance and the 75th percentile (rather than the 25th percentile) represents below-average performance.

[6-1] 2019 performance levels were based on comparisons to national Medicaid HMO Quality Compass HEDIS 2018 benchmarks, with the exception of the *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Plan All-Cause Readmissions* indicators, which were compared to national Medicaid HMO NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.

Of note, measures in the Health Plan Diversity and Utilization domains are provided within this section for informational purposes only as they assess the MHPs' use of services and/or describe health plan characteristics and are not related to performance. Therefore, most of these rates were not evaluated in comparison to national benchmarks and were not analyzed for statistical significance.

Table 6-4—Overall Statewide Averages for HEDIS 2018 and HEDIS 2019 Performance Measures

Measure	HEDIS 2018	HEDIS 2019	2018–2019 Comparison[1]	2019 Performance Level[2]
Child & Adolescent Care				
Childhood Immunization Status[3]				
Combination 2	76.35%	72.51%	**-3.84**$^{++}$	★★
Combination 3	72.28%	67.93%	**-4.35**$^{++}$	★★
Combination 4	70.75%	67.00%	**-3.75**$^{++}$	★★
Combination 5	62.63%	57.79%	**-4.84**$^{++}$	★★
Combination 6	39.93%	38.40%	**-1.53**$^{++}$	★★
Combination 7	61.53%	57.07%	**-4.46**$^{++}$	★★
Combination 8	39.56%	38.20%	**-1.36**$^{++}$	★★
Combination 9	35.85%	33.40%	**-2.45**$^{++}$	★★
Combination 10	35.55%	33.24%	**-2.31**$^{++}$	★★
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	71.89%	70.92%	-0.97	★★★
Lead Screening in Children				
Lead Screening in Children	80.55%	78.40%	**-2.15**$^{++}$	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.19%	75.90%	**+0.71**$^{+}$	★★★
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	56.75%	55.93%	**-0.82**$^{++}$	★★★
Immunizations for Adolescents				
Combination 1	85.14%	85.66%	+0.52	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	88.83%	90.62%	**+1.79**$^{+}$	★★★
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	79.20%	80.65%	**+1.45**$^{+}$	★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	43.86%	46.59%	**+2.73**$^{+}$	★★★
Continuation and Maintenance Phase	53.56%	58.80%	**+5.24**$^{+}$	★★★

Measure	HEDIS 2018	HEDIS 2019	2018–2019 Comparison[1]	2019 Performance Level[2]
Women—Adult Care				
Breast Cancer Screening[3]				
Breast Cancer Screening	62.13%	61.37%	**-0.76**$^{++}$	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	66.19%	65.76%	**-0.43**$^{++}$	★★★
Chlamydia Screening in Women				
Ages 16 to 20 Years	63.28%	63.98%	+0.70	★★★★
Ages 21 to 24 Years	68.65%	69.17%	+0.52	★★★
Total	65.65%	66.28%	+0.63	★★★★
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	95.16%	94.65%	**-0.51**$^{++}$	★★
Ages 25 Months to 6 Years	87.89%	87.11%	**-0.78**$^{++}$	★★
Ages 7 to 11 Years	91.13%	90.23%	**-0.90**$^{++}$	★★
Ages 12 to 19 Years	90.42%	89.52%	**-0.90**$^{++}$	★★
Adults' Access to Preventive/Ambulatory Health Services[3]				
Ages 20 to 44 Years	78.64%	78.26%	**-0.38**$^{++}$	★★★
Ages 45 to 64 Years	87.57%	87.05%	**-0.52**$^{++}$	★★★
Ages 65+ Years	91.79%	92.99%	**+1.20**$^{+}$	★★★★
Total	82.25%	81.95%	**-0.30**$^{++}$	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	32.20%	34.46%	**+2.26**$^{+}$	★★★
Obesity				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total[3]	84.40%	84.18%	**-0.22**$^{++}$	★★★★
Counseling for Nutrition—Total	74.50%	75.19%	**+0.69**$^{+}$	★★★
Counseling for Physical Activity—Total	67.49%	72.04%	**+4.55**$^{+}$	★★★★
Adult BMI Assessment[3]				
Adult BMI Assessment	94.47%	93.37%	**-1.10**$^{++}$	★★★★
Pregnancy Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	80.23%	77.95%	**-2.28**$^{++}$	★★
Postpartum Care	67.27%	66.36%	-0.91	★★★

Measure	HEDIS 2018	HEDIS 2019	2018–2019 Comparison[1]	2019 Performance Level[2]
Living With Illness				
Comprehensive Diabetes Care[3]				
HbA1c Testing	88.81%	88.35%	**-0.46++**	★★★
*HbA1c Poor Control (>9.0%)**	36.88%	38.37%	**+1.49++**	★★
HbA1c Control (<8.0%)	52.73%	51.41%	**-1.32++**	★★★
Eye Exam (Retinal) Performed	64.18%	62.24%	**-1.94++**	★★★
Medical Attention for Nephropathy	91.94%	91.48%	**-0.46++**	★★★
Blood Pressure Control (<140/90 mm Hg)	62.23%	63.95%	**+1.72+**	★★★
Medication Management for People With Asthma				
Medication Compliance 50%—Total	70.74%	63.81%	**-6.93++**	★★★
Medication Compliance 75%—Total	49.83%	40.70%	**-9.13++**	★★★
Asthma Medication Ratio[3]				
Total	62.06%	62.57%	+0.51	★★★
Controlling High Blood Pressure[4]				
Controlling High Blood Pressure	—	60.19%	—	NC
Medical Assistance With Smoking and Tobacco Use Cessation[5]				
Advising Smokers and Tobacco Users to Quit	80.59%	81.34%	**+0.75+**	★★★★
Discussing Cessation Medications	57.14%	58.38%	**+1.24+**	★★★★
Discussing Cessation Strategies	47.32%	48.98%	**+1.66+**	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	58.27%	55.75%	**-2.52++**	★★★
Effective Continuation Phase Treatment	41.25%	39.46%	**-1.79++**	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[3]				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.31%	84.22%	-0.09	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia[3]				
Diabetes Monitoring for People With Diabetes and Schizophrenia	69.97%	70.56%	+0.59	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia[3]				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	76.86%	76.26%	-0.60	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	63.18%	64.91%	+1.73	★★★

Measure	HEDIS 2018	HEDIS 2019	2018–2019 Comparison[1]	2019 Performance Level[2]
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	86.60%	86.98%	+0.38	★★
Diuretics	86.64%	87.06%	+0.42	★★
Total	86.62%	87.02%	**+0.40⁺**	★★
Utilization[6]				
Ambulatory Care—Total (Per 1,000 Member Months)				
*ED Visits—Total**	70.86	66.87	-3.99	★★
Outpatient Visits—Total[3]	386.18	389.77	+3.59	NC
Inpatient Utilization—General Hospital/Acute Care—Total[3]				
Total Inpatient—Discharges per 1,000 Member Months—Total	8.10	7.93	-0.17	NC
Total Inpatient—Average Length of Stay—Total	4.38	4.33	-0.05	NC
Maternity—Discharges per 1,000 Member Months—Total	2.38	2.36	-0.02	NC
Maternity—Average Length of Stay—Total	2.62	2.66	+0.04	NC
Surgery—Discharges per 1,000 Member Months—Total	1.91	1.92	+0.01	NC
Surgery—Average Length of Stay—Total	6.44	6.89	+0.45	NC
Medicine—Discharges per 1,000 Member Months—Total	4.40	4.29	-0.11	NC
Medicine—Average Length of Stay—Total	4.17	3.87	-0.30	NC
Use of Opioids From Multiple Providers*[,4]				
Multiple Prescribers	—	18.67%	—	NC
Multiple Pharmacies	—	6.16%	—	NC
Multiple Prescribers and Multiple Pharmacies	—	3.30%	—	NC
Use of Opioids at High Dosage*[,4]				
Use of Opioids at High Dosage	—	2.36%	—	NC
Risk of Continued Opioid Use*[,7]				
At Least 15 Days Covered—Total	—	17.31%	—	NC
At Least 31 Days Covered—Total	—	7.43%	—	NC
Plan All-Cause Readmissions*[,3]				
Index Total Stays—Observed Readmissions—18–44 Years	15.72%	14.87%	-0.85	★★★
Index Total Stays—Observed Readmissions—45–54 Years	15.47%	12.25%	-3.22	★★★★

Measure	HEDIS 2018	HEDIS 2019	2018–2019 Comparison[1]	2019 Performance Level[2]
Index Total Stays—Observed Readmissions—55–64 Years	14.57%	15.01%	+0.44	★★★
Index Total Stays—Observed Readmissions—Total	15.28%	14.40%	-0.88	★★★

[1] Weighted averages were calculated and compared from HEDIS 2018 to HEDIS 2019, and comparisons were based on a Chi-square test of statistical significance with a p-value of <0.01 due to large denominators. Rates shaded green with one cross (+) indicate statistically significant improvement from the previous year. Rates shaded red with two crosses (++) indicate statistically significant decline in performance from the previous year. Of note, 2018–2019 comparison values are based on comparisons of the exact HEDIS 2018 and HEDIS 2019 statewide weighted averages, not rounded values.

[2] Performance Levels for 2019 were based on comparisons of the HEDIS 2019 measure indicator rates to national Medicaid Quality Compass HEDIS 2018 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total and Plan All-Cause Readmissions measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2018 benchmarks.

[3] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

[4] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.

[5] The weighted averages for this measure were based on the eligible population for the survey, rather than only the number of people who responded to the survey as being a smoker.

[6] Significance testing was not performed for Utilization-based measure indicator rates and any performance levels for 2019 or 2018–2019 comparisons provided for these measures are for informational purposes only.

[7] This measure is a first-year measure; therefore, the measure does not have an applicable benchmark.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as the measure is a first-year measure; therefore, no trending information is available. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

2019 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Of the 64 measure rates with national benchmarks available and appropriate for comparison, 28 statewide rates (43.8 percent) demonstrated improvement from HEDIS 2018 to HEDIS 2019. Furthermore, 14 measure rates from HEDIS 2018 to HEDIS 2019 indicated a statistically significant improvement.

Statewide performance that demonstrated a statistically significant increase spanned multiple domains including:

- **Child & Adolescent Care** (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Appropriate Treatment for Children With Upper Respiratory Infection*; *Appropriate Testing for Children With Pharyngitis*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*).
- **Access to Care** (*Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*).

- **Obesity** (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*).
- **Living With Illness** (*Comprehensive Diabetes Care—Blood Pressure Control [<140/90 mm Hg]*; *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications*, and *Discussing Cessation Strategies*; and *Annual Monitoring for Patients on Persistent Medications—Total*).

Conversely, 36 statewide rates (56.3 percent) demonstrated a decline in performance from HEDIS 2018 to HEDIS 2019. Of note, 32 measure rates showed a statistically significant decline in performance from HEDIS 2018 to HEDIS 2019.

Statewide performance that demonstrated a statistically significant decline and ranked below the 50th percentile spanned multiple domains including:

- **Child & Adolescent Care** (*Childhood Immunization Status—Combination 2*, *3*, *4*, *5*, *6*, *7*, *8*, *9*, and *10*)
- **Access to Care** (*Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*)
- **Pregnancy Care** (*Prenatal and Postpartum Care—Timeliness of Prenatal Care*)
- **Living With Illness** (*Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*)

Table 6-5 presents, by measure, the number of MHPs that performed at each performance level. The counts include only measures with a valid, reportable rate that could be compared to percentiles. Therefore, not all row totals will equal 11 MHPs.

Table 6-5—Count of MHPs by Performance Level

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	4	5	1	1	0
Combination 3	5	4	1	1	0
Combination 4	5	4	1	1	0
Combination 5	6	3	1	0	1
Combination 6	4	4	2	1	0
Combination 7	6	3	1	0	1
Combination 8	5	3	2	1	0
Combination 9	5	4	1	1	0
Combination 10	4	5	1	1	0

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	2	1	4	0	3
Lead Screening in Children					
Lead Screening in Children	0	3	5	3	0
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	2	4	4	1	0
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	3	3	5	0	0
Immunizations for Adolescents					
Combination 1	1	0	6	1	2
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	1	3	4	3	0
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	1	3	4	1	0
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	2	3	2	2	0
Continuation and Maintenance Phase	2	4	1	2	0
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	0	3	5	3	0
Cervical Cancer Screening					
Cervical Cancer Screening	1	1	6	3	0
Chlamydia Screening in Women					
Ages 16 to 20 Years	1	0	1	7	1
Ages 21 to 24 Years	2	0	1	7	1
Total	2	0	1	7	1
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	5	4	2	0	0
Ages 25 Months to 6 Years	5	2	4	0	0
Ages 7 to 11 Years	5	3	3	0	0
Ages 12 to 19 Years	4	3	4	0	0
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	2	4	5	0	0

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Ages 45 to 64 Years	1	3	7	0	0
Ages 65+ Years	0	3	2	0	5
Total	1	4	5	1	0
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	1	2	6	2	0
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation—Total	0	0	3	6	2
Counseling for Nutrition—Total	0	2	5	4	0
Counseling for Physical Activity—Total	0	2	3	4	2
Adult BMI Assessment					
Adult BMI Assessment	2	0	2	6	1
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	6	3	1	0	1
Postpartum Care	4	2	2	2	1
Living With Illness					
Comprehensive Diabetes Care					
HbA1c Testing	3	2	3	2	1
*HbA1c Poor Control (>9.0%)**	1	6	1	0	3
HbA1c Control (<8.0%)	2	5	1	0	3
Eye Exam (Retinal) Performed	0	4	4	1	2
Medical Attention for Nephropathy	1	2	4	0	4
Blood Pressure Control (<140/90 mm Hg)	3	3	3	1	1
Medication Management for People With Asthma					
Medication Compliance 50%—Total	2	2	3	2	2
Medication Compliance 75%—Total	0	4	2	3	2
Asthma Medication Ratio					
Total	4	1	5	1	0
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	0	1	5	3	2
Discussing Cessation Medications	0	0	5	3	3
Discussing Cessation Strategies	0	0	6	5	0
Antidepressant Medication Management					
Effective Acute Phase Treatment	0	0	7	1	2
Effective Continuation Phase Treatment	0	1	6	1	2

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1	2	0	5	3
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	3	2	4	0	1
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	1	1	2	0	0
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	0	2	4	4	1
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	4	3	4	0	0
Diuretics	4	4	2	1	0
Total	3	4	4	0	0
Utilization[1]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	2	8	1	0	0
Plan All-Cause Readmissions*					
Index Total Stays—Observed Readmissions—18–44 Years	1	3	3	3	1
Index Total Stays—Observed Readmissions—45–54 Years	1	1	3	2	4
Index Total Stays—Observed Readmissions—55–64 Years	2	1	6	1	1
Index Total Stays—Observed Readmissions—Total	2	2	3	2	2
Total	**140**	**164**	**205**	**113**	**62**

[1] Utilization-based measure rates and any performance levels for 2019 comparisons provided for these measures are for informational purposes only.

** For this indicator, a lower rate indicates better performance.*

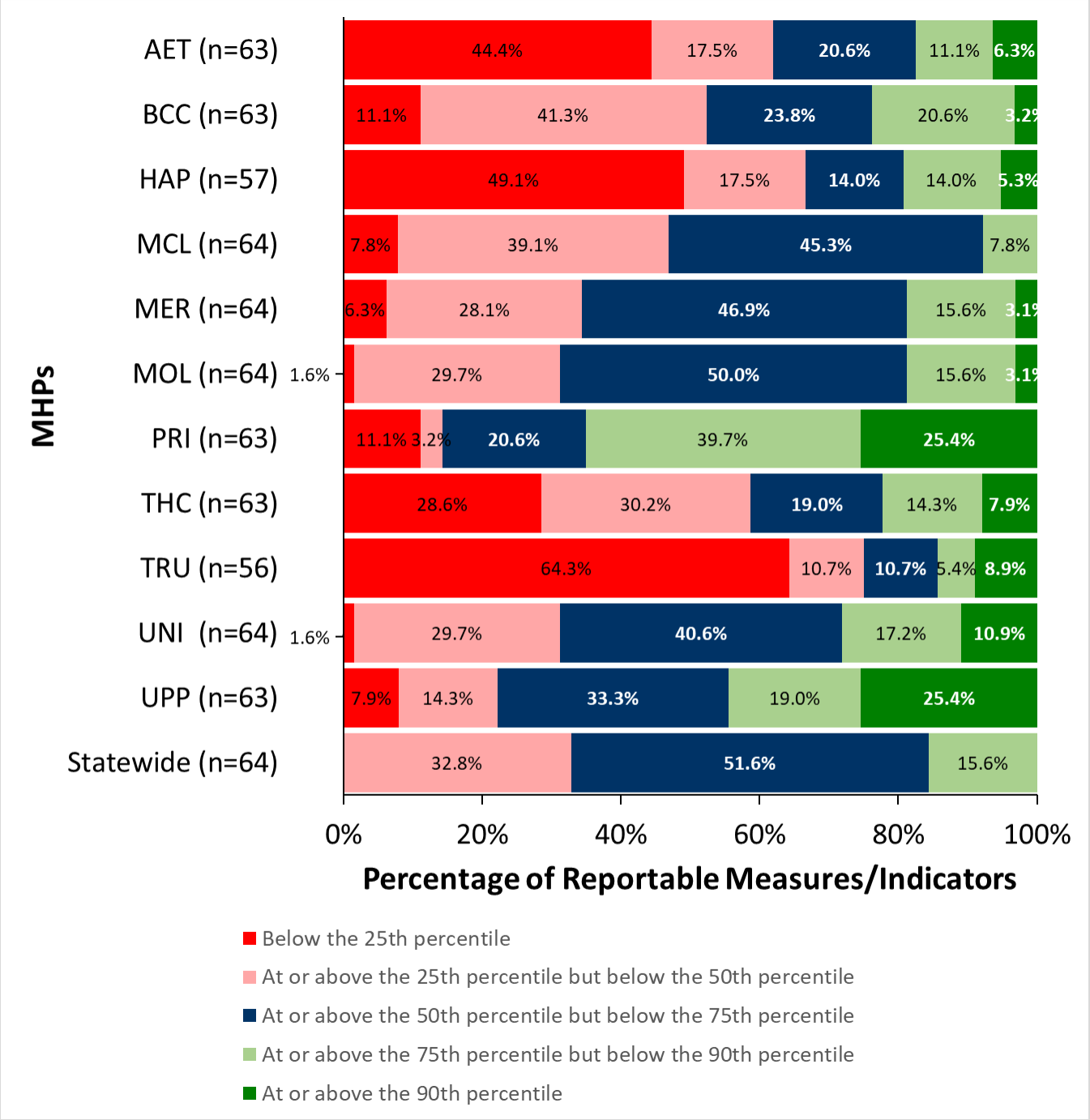
Performance Levels for 2019 represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table 6-5 shows that 205 of 684 performance measure rates (approximately 30.0 percent) reported by the MHPs fell in the average (★★★) range relative to percentiles. When comparing to percentiles, at least half of the plans ranked at or above the 75th percentile for the following measure rates: all three *Chlamydia Screening in Women* indicators; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Physical Activity—Total*; *Adult BMI Assessment*; *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications*; *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*; and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—45–54 Years*. Conversely, at least half of the plans fell below the 25th percentile for the *Childhood Immunization Status—Combination 5* and *7* indicators and the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator.

Figure 6-1 displays the percentage of MHP-specific and statewide rates by percentile ranking for the performance measure rates displayed in this report. Measure rates in the health plan diversity and utilization domains are not included in the counts (with the exception of the *Ambulatory Care—Total [Per 1,000 Member Months]—ED Visits—Total* measure and all four *Plan All-Cause Readmissions* measure indicators) as these types of measures in isolation may not be indicative of quality of services received.

Figure 6-1—Percentage of Reportable Measures/Indicators*

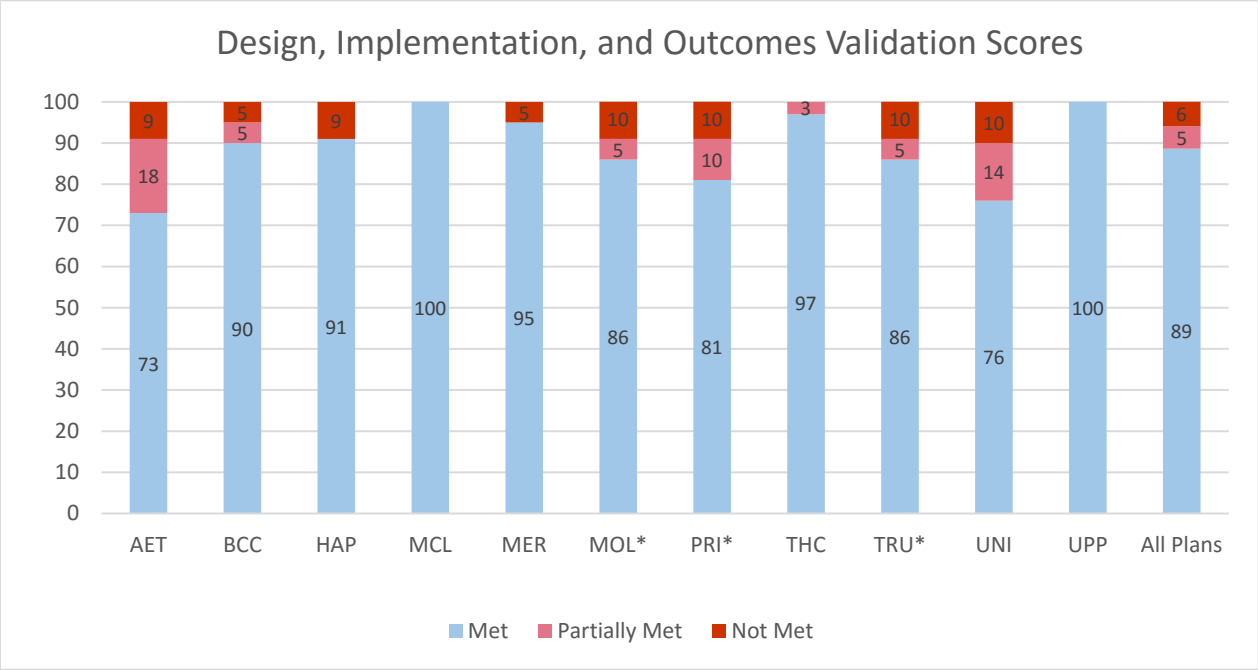


* Rates that had a small denominator (NA) as a result of the MHP's HEDIS audit are not included in this analysis.
"n" indicates the number of rates that were included in this analysis by MHP.
Note: Due to rounding, the percentage of total rates may not equal 100 percent for some MHPs.

Performance Improvement Project

For the SFY 2018–2019 validation, the MHPs provided Remeasurement 1 data and completed Steps I through IX for their ongoing State-mandated PIP topic: *Addressing Disparities in Timeliness of Prenatal Care*. Figure 6-2 provides a comparison of the validation scores, by MHP. Table 6-6 provides a comparison of the overall validation status, by MHP.

Figure 6-2—Comparison of Validation Scores by MHP



* Percentage totals may not equal 100 due to rounding.

Table 6-6—Comparison of Overall Validation Status by MHP

Overall PIP Validation Status by MHP	
AET	*Not Met*
BCC	*Not Met*
HAP	*Not Met*
MCL	*Met*
MER	*Not Met*
MOL	*Not Met*
PRI	*Not Met*
THC	*Met*
TRU	*Not Met*
UNI	*Not Met*
UPP	*Met*

The results from the SFY 2018–2019 validation reflected opportunities for improvement for most of the MHPs, as demonstrated through an overall *Not Met* validation status. Three MHPs, **McLaren Health Plan**, **Total Health Care, Inc.**, and **Upper Peninsula Health Plan**, achieved an overall *Met* validation status. The validation statuses for the MHPs 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. **Aetna Better Health of Michigan** had the lowest validation scores for the Design, Implementation, and Outcomes stages (Steps I through IX). The MHPs can improve their validation scores by ensuring all documentation requirements and HSAG's feedback are addressed in the next annual submission and the study indicators meet the plan-specific goal for each study indicator.

Summary, Conclusions, and Recommendations

HSAG performed a comprehensive assessment of the performance of each MHP and of the overall strengths and weaknesses of the Michigan Medicaid managed care 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 Michigan Medicaid managed care program.

Strengths and Associated Conclusions

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

Compliance Monitoring

Through the SFY 2018–2019 compliance monitoring review, overall, the Michigan Medicaid managed care program demonstrated areas of strength in managing and adhering to expectations established for the Medicaid program through State and federal requirements. Most of these requirements relate to or impact the quality of, timeliness of, and access to care and services provided by each MHP to its members. Statewide average scores in each of the following standards were at 95 percent or above, demonstrating strong program performance in these areas:

- **Administrative**—The MHPs had an effective governing body with adequate staffing and oversight mechanisms in place to support its obligations under its contract with MDHHS.
- **Quality**—The MHPs were accredited organizations with effective QAPIPs in place that included QI and UM policies and procedures to ensure consistency in processes, clinical practice guidelines to support decisions related to medical necessity, QI evaluations and workplans to evaluate and track QI initiatives and progress, PIPs to target improvement in clinical and/or nonclinical performance areas, initiatives for addressing health disparities, and reporting to monitor performance with MDHHS-established performance measures and minimum standards.
- **MIS**—The MHPs maintained sufficient health IS that collect, analyze, integrate, and report data, ensuring expectations and obligations under their contracts with MDHHS can be met, including

submission of accurate and complete medical and pharmacy claims encounters and maintenance of adequate member enrollment and disenrollment processes.

- **Program Integrity**—The MHPs had effective compliance plans in place with mechanisms to detect and prevent fraud, waste, and abuse; staff training programs; open communication channels; auditing practices; and monitoring processes including those that ensure providers are appropriately enrolled and screened, and employees and providers are not excluded from providing services under federal programs.

Performance Measures

The individual MHPs were evaluated against national benchmarks for measures related to quality of, access to, and timeliness of services. When the individual MHP scores were aggregated, 14 of the 64 measure rates (21.9 percent) demonstrated a statistically significant improvement over the prior year's performance. Additionally, multiple domains included statewide rates that performed at or above the 75th percentile, indicating many members were receiving these recommended services, which can positively impact their overall health and wellbeing. The following statewide measure rates performed at or above the 75th percentile:

Child & Adolescent Care—Vaccines can protect adolescents against potentially deadly diseases, such as meningococcal meningitis, tetanus, diphtheria, and pertussis.

- *Immunizations for Adolescents—Combination 1*

Women—Adult Care—Screenings and subsequent treatment of chlamydia can reduce the potential for serious and irreversible complications such as pelvic inflammatory disease and infertility.

- *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Total*

Access to Care—Doctor visits provide an opportunity for members to receive preventive services and counseling and can help members detect and treat health conditions sooner.

- *Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years*

Obesity—Weight assessments are an important tool for providers to identify at-risk members and provide counseling and services to assist them in obtaining and maintaining a healthier weight, which can mitigate risks for developing weight-related diseases.

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Physical Activity—Total*
- *Adult BMI Assessment*

Living With Illness—Quitting tobacco can lead to better health outcomes for members.

- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*

Utilization—Appropriate healthcare utilization is important in ensuring that members receive care in appropriate settings and preventing unnecessary hospitalizations and inpatient readmissions.

- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—45–54 Years*

Performance Improvement Project

Through their participation in the PIP, the MHPs are focusing their efforts on improving the timeliness of prenatal care and eliminating disparities related to timely receipt of prenatal care. Through implementation of this PIP, the MHPs are implementing initiatives and interventions to support improvement in the health of pregnant women and their infants before, during, and after pregnancy.

Weaknesses and Associated Conclusions

HSAG's comprehensive assessment of the MHPs and the Michigan Medicaid managed care program also identified two areas of focus that represent significant opportunities for improvement within the program. These primary areas of focus, identified through the EQR activities, are access to care, with an emphasis on children's access to PCPs and preventive services; and pregnancy care, specifically timely prenatal care. These same areas, Access to Care and Pregnancy Care, were also identified as prevalent focus areas in the SFY 2017–2018 annual assessment.

Access to Care—Children's Preventive Services

Accessibility to quality healthcare is important for a child's cognitive, physical, behavioral, and emotional development. Doctor visits provide an opportunity for members to receive preventive services and counseling and help with detecting and treating health conditions sooner. These visits provide doctors with the opportunity to determine that a child is growing and developing normally—physically, behaviorally, and emotionally. Additionally, vaccines given as part of preventive services protect young children against potentially deadly diseases, such as diphtheria, tetanus, acellular pertussis, polio, measles, mumps, rubella, haemophilus influenza type B, hepatitis B, chicken pox, pneumococcal conjugate, hepatitis A, rotavirus, and influenza. Regular visits with a pediatrician or PCP also promote relationship building and trust and may promote visit compliance as the child ages and moves into adulthood. Regular primary care services have also been found to significantly reduce children's non-urgent ED visits.[6-2] Members' accessibility to care is a priority for MDHHS, as evident from the initiatives included as part of Michigan's Quality Strategy; however, conclusions drawn from HSAG's comprehensive assessment of the MHPs and the Michigan Medicaid managed care program indicate significant opportunities remain for improving members', especially children's, accessibility to care.

[6-2] Bloom, B., R.A. Cohen, G Freeman. 2012. "Summary health statistics for U.S. children: National Health Interview Survey, 2011." National Center for Health Statistics. Vital Health Statistics 10(254). Available at: http://www.cdc.gov/nchs/data/series/sr_10/sr10_254.pdf. Accessed on: Feb 25, 2020.

Low statewide performance compared to national benchmarks on several HEDIS performance measure rates within the Access to Care domain indicate that access to care and services should be addressed to ensure Medicaid members ages 12 months through 19 years are visiting their PCPs regularly and getting checkups at least annually. Specifically, the statewide averages for these Access to Care HEDIS performance measure rates were below the national Medicaid 50th percentile: *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years.* Additionally, all four of the measure rates within the *Children and Adolescents' Access to Primary Care Practitioners* measure demonstrated a statistically significant decline in performance from the prior year. Within the Child & Adolescent Care domain, the *Childhood Immunization Status* measure rates for *Combination 2* through *Combination 10* performed below the national Medicaid 50th percentile and all nine rates demonstrated a statistically significant decline in performance from the prior year, suggesting children and adolescents are not receiving recommended vaccinations, which can negatively impact their health and may lead to them acquiring a preventable disease.

Ten out of the 11 MHPs also scored below the national Medicaid 50th percentile for the *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* measure within the Utilization domain, indicating a large percentage of members may be going to the ED for preventable or treatable conditions due to potential network deficiencies or other barriers to receiving timely access to services.

As demonstrated through the compliance monitoring review, the Providers standard was the second lowest scoring area statewide and continues to be one of the lowest performing areas year over year. For the SFY 2017–2018 and SFY 2018–2019 reviews, specifically, MDHHS identified data discrepancies in all 11 MHPs' provider directories during PCP telephone surveys, suggesting members' access to care is being impeded by inaccurate provider information. Since data in the Provider Network File (4275) are a replication of the data maintained by the MHPs and used by members to select providers, inconsistencies within the data, such as with invalid telephone numbers or accepting new patient status, may limit members' ability to choose providers that are easily accessible and meet the healthcare needs of members and their families, including children. Additionally, since MDHHS uses the 4275 to monitor network adequacy, the data may not be an accurate reflection of the providers available to see members.

Pregnancy Care—Prenatal Services

Appropriate and timely prenatal services and education, both before and during pregnancy, can have a significant impact on the health and wellness of women and their infants. Timely prenatal visits with a PCP, OB/GYN, or nurse midwife ensures that members and their newborn children receive appropriate medical care that can prevent poor birth outcomes. As stated by the Office of Disease Prevention and Health Promotion in Healthy People 2020, "the risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy), prenatal (during pregnancy), and interconception (between pregnancies) care. Healthy birth outcomes and early identification and treatment of developmental delays and disabilities and other health conditions among infants can prevent death or disability and enable children to reach their full

potential."[6-3] Maternal and infant health has been identified as a key priority area of MDHHS leadership and the Michigan Governor. MDHHS has placed significant emphasis on pregnancy care through several quality initiatives, including implementation of the *Addressing Disparities in Timeliness of Prenatal Care* PIP and most recently through implementation of a Statewide Perinatal Quality Collaborative and introduction of the 2020–2023 Mother Infant Health & Equity Improvement Plan. Although Michigan has reduced its pregnancy-related and infant mortality rates from 2011, there remains a significant opportunity to improve performance in this area as indicated by statewide performance determined through this annual assessment.

The rate under the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* HEDIS performance measure experienced a statistically significant decline in performance from the SFY 2017–2018 review period. Additionally, this measure rate was below the national Medicaid 50th percentile. Nine out of 11 MHPs performed below the national Medicaid 50th percentile for the percentage of deliveries that received a timely prenatal care visit, with six MHPs performing below the national Medicaid 25th percentile. Low performance in this area continued even with implementation of the State-mandated PIP, Addressing *Disparities in Timeliness of Prenatal Care*, in SFY 2016–2017. Of the 11 MHPs, only three met their goal to reduce disparities and/or improve the timeliness of prenatal care for its pregnant members. Additionally, two of the MHPs experienced a decline over baseline data from SFY 2016–2017.

Quality Strategy Recommendations for Michigan

Based on a comprehensive assessment of the MHPs' performance in providing quality, timely, and accessible healthcare services to Michigan's Medicaid managed care members, HSAG concludes that the following prevalent areas of the program demonstrate the most opportunities for improvement:

- Access to Care—Children's Preventive Services
- Pregnancy Care—Prenatal Services

Michigan's Quality Strategy is designed to improve the health outcomes of its Medicaid members by measuring access, efficiency, and outcomes through standardized performance measures; initiating PIPs that can be expected to have a positive effect on health outcomes and member satisfaction; and close monitoring of provider networks, affiliates, and subcontractors to ensure that quality healthcare and services are being provided to Michigan residents receiving Medicaid benefits. In consideration of the goals of Michigan's Quality Strategy and the comparative review of findings for all activities, HSAG recommends the following QI initiatives, which target the identified specific areas of opportunity.

[6-3] Office of Disease Prevention and Health Promotion. Healthy People 2020: Maternal, Infant, and Child Health, updated March 3, 2020. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health. Accessed on: Feb 25, 2020.

Access to Care—Children's Preventive Services

Complete and accurate provider directories and provider information are imperative to provide members with adequate information to help them choose a provider, allow for timely access to providers when needed, and increase satisfaction with their provider and the Michigan Medicaid managed care program. Inaccuracies in provider information maintained and published by the MHPs could potentially contribute to access issues being experienced by members. Resolving these inaccuracies could improve member satisfaction and address some of the factors impeding children's access to PCPs for preventive care visits, which in turn, should result in improved HEDIS rates and reduce the number of avoidable ED visits. To improve the accuracy of provider data, HSAG recommends MDHHS expand the scope of existing provider data validation activities within the compliance monitoring review by conducting an evaluation of each MHP's provider data systems and published provider directories. This review could include:

- A focused review and assessment of each MHP's collection, maintenance, and publication of provider data.
- An evaluation of provider data accuracy on a statistically significant sample of in-network providers enrolled with each MHP through a provider survey or other method deemed appropriate by MDHHS. This evaluation should include high-volume specialists, in addition to PCPs.
- An evaluation of provider data accuracy on a sample of in-network providers enrolled with multiple MHPs to allow controlled comparisons of key data elements (e.g., Is the provider accepting new patients from only one MHP or all contracted MHPs? Is the provider listed with the same specialty in multiple networks or are they listed differently?).
- Implementation of a time-limited workgroup consisting of MDHHS and the MHPs to:
  - Identify best practices for collecting, maintaining, and producing accurate provider data.
  - Evaluate MCP procedures for capturing provider network changes and determine how to limit gaps or deficiencies in data submitted to MDHHS or published to members.
  - Address the refinement or development of guidelines defining expectations for providers and MHPs regarding the collection and maintenance of up-to-date provider information, including updating the time frame allowed for making directory changes (e.g., revise from 30 days to 7 days upon receipt of provider updates).

To increase the percentage of children receiving regular preventive care from their pediatricians or PCPs, HSAG recommends MDHHS initiate a State-mandated PIP to specifically target this issue. The PIP could include the following activities:

- Leverage claims data to identify which children and adolescents between the ages of 12 months through 19 years have not seen a pediatrician or PCP within the past 12 months.
- Identification of key characteristics among children who are not seeing their pediatricians or PCPs and not receiving regular preventive services, including visits that would fall under the *Children and Adolescents' Access to Primary Care Practitioners* HEDIS measure. These characteristics may include such factors as geographical location, ethnicity, and/or primary language.
- Selection of one disparate child population that is less likely to see a pediatrician or PCP and focus efforts to improve this group's access to preventive services.

- Development of one or more targeted interventions to test for improvement in children's access to their pediatricians or PCPs and receipt of preventive services. These interventions might include providing targeted education to identified families; and implementing alternative means to facilitate visits, such as inviting families to mobile clinics, using visiting nurse practitioners to conduct preventive services, or providing additional transportation services.

Pregnancy Care—Prenatal Services

For every 1,000 Michigan live births, nearly seven infants die before reaching their first birthday. In 2017, 762 infants under the age of 1 year died, resulting in an infant mortality rate of 6.8 per 1,000 live births. Women receiving inadequate prenatal care experienced infant mortality rates three times as high as those women receiving adequate prenatal care. Additionally, in 2017, there were 2.8 Black babies who died before their first birthday for every White baby that died.[6-4] In alignment with Michigan's vision to have zero preventable maternal and infant deaths and zero health disparities, MDHHS in partnership with the Maternal Infant Strategy Group implemented the 2020–2023 Mother Infant Health & Equity Improvement Plan with a goal to improve the infant mortality Black/White ratio by 15 percent by 2023. To help accomplish this goal, HSAG recommends MDHHS leverage this existing initiative and strategies through the following:

- Develop a P4P Bonus Program that focuses on the MHPs' expectations for partnering with MDHHS to achieve the goals of the 2020–2023 Mother Infant Health & Equity Improvement Plan.
- The P4P Bonus Program could include the following:
  - Mandatory attendance at regular Mother Infant Health & Equity Improvement Plan workgroup sessions
  - Collection of information through a survey process that helps to answer specific areas of interest or specific questions such as the following:
    1. How can MHPs partner with other stakeholders to identify and reach women as soon as they become pregnant?
    2. How can MHPs partner with other stakeholders to shorten the time period between when a woman becomes pregnant and receives approval for Medicaid benefits?
    3. How can MHPs assist in improving the trust between Medicaid women and their providers? Between women and the MHP?
    4. How can MHPs assist with or partner with other stakeholders to address social determinants of health that prevent women from accessing healthcare services, including prenatal services?
  - Pilot study that includes collaboration between MHP care managers/community health workers, MI Bridges Navigators, providers, and a select sample of at-risk pregnant women through all stages of the pregnancy and 12 months postpartum to identify best practices and appropriate interventions to ensure optimal health of the child and mother both during and after pregnancy.
  - Sharing of MHP resources to focus efforts on specific geographic regions throughout the State with the highest prevalence of infant mortality regardless of where the MHP is located.

[6-4] Michigan Department of Health and Human Services. Mother Infant Health & Equity Improvement Plan 2020–2023. Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_96967_97025---,00.html. Accessed on: Feb 25, 2020.