MICHIGAN MEDICAID QUALITY ASSESSMENT AND IMPROVEMENT STRATEGY 2015

Michigan Department of Health and Human Services
Bureau of Medicaid Care Management and Quality Assurance
Section I: INTRODUCTION

Federal regulations¹ require all states contracting with managed care organizations to have a State Quality Strategy (QS). The QS is a written document detailing how the state assesses and improves the quality of managed care services offered within the state. States are also required to resubmit the QS whenever significant revisions are made.

Michigan’s State Quality Strategy (QS) is a population-based, comprehensive and continuous effort to monitor, assess, and improve the performance of all care and services provided to Michigan Medicaid beneficiaries by contracted Medicaid Health Plans. The QS provides a detailed description of Michigan’s Medicaid quality improvement program. The QS includes detailed information on the methods used to improve care and service delivery to continually improve Michigan’s Medicaid program and addresses how Michigan has integrated the Healthy Michigan Plan (Medicaid expansion) population throughout the QI program.

Michigan is using the National Quality Strategy (NQS) as a platform to broaden and strengthen the state’s QS strategy. To do so, Michigan is:
- conducting an ongoing gap analysis to identify areas where the state QS does not align with NQS aims and priorities
- using the quality improvement process (Plan-Do-Study-Act, or PDSA)² to assess the need for additional QI initiatives, measures, and data
- assessing quality improvement integration with state Medicaid policy, and
- developing QI activities to close identified gaps.

As a result, Michigan’s QS has been revised to further emphasize:
- health equity
- quality, safety, and coordination of care delivered to special populations
- enhanced health delivery models
- payment transformation
- patient and community engagement, and
- effective population management to improve prevention and treatment of care for leading causes of mortality

The QS is the vehicle to integrate programs targeting the Medicaid and Medicaid expansion populations, align activities impacting Medicaid beneficiaries throughout the state, and use the quality improvement process to measure and improve program outcomes.

¹ 42 C.F.R. §438.200 et seq.
² Institute for Healthcare Improvement (2013), retrieved 12-3-13 from http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx
Organization of Michigan’s Medicaid Quality Strategy
Michigan’s QS is organized into the following areas:
- Introduction
  - Managed care goals, objectives and overview
  - Development and review of QS
- Assessment
  - Quality and appropriateness of care
  - National performance measures
  - Monitoring and compliance
  - External Quality Review (EQR)
- State Standards
  - Access standards
  - Structure and operations standards
  - Measurement and improvement standards
- Improvement and interventions
  - Quality of care and service
  - Emergency Department utilization
  - Health information technology
- Delivery System Reforms
- Conclusions and Opportunities
- Implications for integration with National Quality Strategy

Results of improvement efforts and analyses are performed on an annual basis and are summarized in the Michigan Medicaid Quality Strategy Annual Review.

Managed Care Goals, Objectives, and Overview

Brief History and Current Description of Michigan Medicaid Managed Care
In 1996, Michigan conducted an analysis and confirmed that increasing Medicaid expenditures were outpacing available state revenue. In addition, there was a lack of provider accountability for both health care delivery and medical utilization, coupled with an absence of reliable data to measure program impact on health care quality and access. As a result, Michigan received a Section 1915(b) waiver to adopt full-risk capitated managed care for the majority of Medicaid beneficiaries. Under the waiver, Medicaid services were provided through contracted Medicaid Health Plans (MHPs) in counties with at least two participating health plans, and the Comprehensive Health Care Program (CHCP) was implemented in July 1997. The program was based on a value purchasing approach driven by accountability. Implementation activities included developing Medicaid policies to meet
Federal rules, creating a competitive bidding process, contracting with Medicaid managed care plans, designating a beneficiary enrollment agency, and developing processes for oversight and reporting.

Under the Michigan waiver, Medicaid managed care enrollees are required to obtain services from specified MHPs based on the county of residence. Payment to health plans is made monthly on a capitated basis. Medicaid managed care is available in all counties. As of January 1, 2016, MDHHS will contract with 11 health plans in a targeted geographical service area comprised of 83 counties (divided into 10 regions) and provides services to approximately 1.7 million managed care beneficiaries.

**Population Health Framework**

In FY 2015, the Michigan Department of Health and Human Services (MDHHS) conducted a competitive request for proposal (RFP) for the Comprehensive Health Care Program (CHCP) services for Medicaid beneficiaries in the state of Michigan. As a result, MDHHS is in the process of preparing a new Medicaid Health Plan contract effective January 1, 2016. References to the current MHP contract are noted throughout the document as the new contract has not been finalized.

Michigan’s vision was to employ a population health management framework, which included contracting with high-performing health plans to build a Medicaid managed care delivery system that *maximizes the health status of beneficiaries, improves beneficiary experience, and lowers cost.* MDHHS will support the MHPs in achieving these goals through evidence and value-based care delivery models, supported by health information technology/health information exchange and a robust quality strategy. (Refer to Table 1.)

Within the population health framework, MHPs must provide a broad 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 well-being. Effective utilization of these principles will maintain or improve the physical and psychosocial well-being of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. Population health management includes an overarching emphasis on health promotion as well as disease prevention. It also incorporates community-based health and wellness strategies focusing on the social determinants of health, creating health equity, and supporting efforts to build more resilient communities.

Medicaid Health Plans must fully participate with MDHHS-directed payment reform initiatives implemented throughout the term of the Contract, which may include, but are not limited to episodic payment, participation with Accountable Systems of Care including partial and global capitation, and the expansion of patient-centered medical homes (PCMH). Contractors must also fully participate with MDHHS-directed initiatives to integrate systems of care and ensure all Medicaid beneficiaries, particularly those with complex physical, behavioral, and social service needs are served by person-centered models across all health care domains. Contractors are encouraged to propose and pilot innovative projects.

Paying for value in the Medicaid population requires moving away from fee-for-service (FFS) models and embracing accountable and transparent payment structures that reward and penalize based on defined metrics.
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<th><strong>Focus</strong></th>
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| Health outcomes across the total population and within specific subgroups | - Population management (identification, analysis, stratification, assessment, and tracking)  
- Outcome metrics drive quality and value (clinical/health status, psychosocial, quality of life, financial)  
- Emphasis on health promotion and disease prevention  
- Tailored interventions for condition-specific conditions and sub-populations  
- Person-centered care, personal engagement and responsibility  
- Focus on social determinants of health, equity and disparities  
- Active support of efforts to build resilient communities |
| Align payment around improving population health outcomes, member experience, and controlling cost | - Value (health outcome per dollar of cost expended)  
- Move away from fee-for-service  
- Performance bonuses linked to outcomes  
- Common performance metrics (physical and behavioral health)  
- Value-based strategies including Patient Centered Medical Homes, shared savings, accountable systems of care/accountable care organizations, episodes of care, value purchasing  
- Payment and delivery system reform at the provider level |
| Ensure that enrollees with complex physical, behavioral, and social service needs are served by person-centered models of care | - Integration and coordination across all health care domains to improve care for individuals  
- Improve health for populations and reduce per capita cost  
- Clear expectations for behavioral health in primary care  
- Coordination with community hubs and other human services entities  
- Establish partnerships/delegation arrangements (MiPCT, health homes)  
- Establish new providers (e.g., Community Health Workers)  
- Support and integrate principles from Michigan’s health system transformation efforts (Healthy Michigan Plan, State Innovation Model) |
| Design and implement structural changes to Michigan’s care delivery system that drive integration, value, and efficiency | - Strong emphasis on health information technology (health information exchange, moving toward a singular system, and clinical predictive modeling)  
- Program driven by a robust quality strategy integrating National Quality Strategy Aims and Priorities  
- Community as the health home  
- Contracted Plans serving entire region (Community Health Innovation Regions/Prosperity Regions)  
- Including services to support behavioral health, oral health, Maternal Infant Health Program  
- Single drug formulary across all managed care plans |
The MDHHS Medical Services Administration (MSA) administers the Medicaid program in Michigan. Eligibility is determined by the State with the sole authority to determine whether individuals or families meet eligibility requirements as specified for enrollment in the Comprehensive Health Care Program (CHCP) and other State assistance programs.

Medicaid Eligible Groups *Mandatorily* Enrolled in the CHCP:
1. Children in foster care
2. Families with children receiving assistance under the Financial Independence Program (FIP)
3. Persons enrolled in Children’s Special Health Care Services (CSHCS)
4. Persons under age 21 who are receiving Medicaid
5. Persons receiving Medicaid for the aged
6. Persons receiving Medicaid for the blind or disabled
7. Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
8. Pregnant women
9. Medicaid eligible persons enrolled under the Healthy Michigan Plan/Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare

Medicaid Eligible Groups Who May *Voluntarily* Enroll in the CHCP:
1. Migrants
2. Native Americans
3. Persons with both Medicare and Medicaid eligibility

Medicaid Eligible Groups *Excluded* From Enrollment in the CHCP:
1. Children in Child Care Institutions
2. Deductible clients (also known as Spenddown)
3. Persons without full Medicaid coverage
4. Persons with Medicaid who reside in an Intermediate Care Facilities for the Mentally Retarded (ICF/MR) or a State psychiatric hospital
5. Persons receiving long-term care (custodial care) in a nursing facility
6. Persons authorized to receive private duty nursing services
7. Persons being served under the Home & Community Based Elderly Waiver
8. Most persons with commercial HMO/PPO coverage
9. Persons in PACE (Program for All-inclusive Care for the Elderly)
10. Persons in the Refugee Assistance Program
11. Persons in the Repatriate Assistance Program
12. Persons in the Traumatic Brain Injury program
13. Persons diagnosed with inherited disease of metabolism who are authorized to receive metabolic formula
14. Persons disenrolled due to Special Disenrollment or Medical Exception for the time period covered by the Disenrollment or Medical Exception
15. Persons residing in a nursing home or enrolled in a hospice program on the effective date of enrollment in the Contractor’s plan
16. Persons incarcerated in a city, county, State, or federal correctional facility
17. Persons participating in the MI Health Link Demonstration

Section 1.022(E)(1) of the Medicaid Health Plan contract requires plans to cover most Medicaid ambulatory and inpatient services. The exceptions to plan services are dental (except for Healthy Michigan Plan beneficiaries), substance abuse, behavioral health beyond 20 outpatient mental health visits, school-based services provided by a school district, custodial care in a nursing facility, and certain classes of psychotropic and HIV/AIDS drugs.

The State uses a 12-month lock-in period for managed care. The enrollment broker, MI Enrolls, provides enrollment and counseling services to beneficiaries during the time of enrollment in the Medicaid program. Since adopting managed care, Michigan has realized improved quality of care and service (e.g., improved HEDIS® and CAHPS® performance), as well as cost savings associated with increased oversight and accountability of health plans, practitioners, and providers serving Medicaid beneficiaries.

**Healthy Michigan Plan (Medicaid Expansion)**

Michigan’s Medicaid Centers for Medicare and Medicaid (CMS) Expansion program, the Healthy Michigan Plan (HMP) was approved by CMS on December 30, 2013. The HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment.

The central features of the HMP are to extend health care coverage to low-income Michigan citizens who are uninsured or underinsured and to implement systemic innovations to improve quality and stabilize health care costs through a continued emphasis on value-based services. Other key features include incentives for healthy behaviors to encourage personal responsibility; encouraging use of high-value services; and promoting overall health and well-being.

The State began accepting applications for the Healthy Michigan Plan on April 1, 2014. Michigan residents may enroll at any time online at [www.michigan.gov/mibridges](http://www.michigan.gov/mibridges), by phone, or in person. Michigan experienced higher than anticipated enrollment in HMP during the first year. As of November 2015, enrollment for the HMP population is 592,564.

HMP enrollees receive benefits required under the Affordable Care Act and all of the Essential Health Benefits required by federal law and regulation. Enrollees will also receive three benefits not covered through the current State Plan: habilitative services, hearing aids, and the full complement of preventive health services. All HMP beneficiaries will be mandatorily enrolled into a Medicaid Health Plan (with the exception of those meeting plan enrollment exemption or voluntary enrollment criteria).

As required by State law, in September 2015 MDHHS submitted a CMS waiver to modify the “Healthy Michigan Plan” to maintain coverage for individuals currently enrolled in the program. State law, MCL 400.105d(20), directs the Department to seek a waiver that would allow individuals who are between 100% and 133% of the federal poverty level and have had Healthy
Michigan Plan coverage for 48 cumulative months to choose one of the following options: (1) Change their medical assistance program eligibility status to be considered eligible for federal advance premium tax credit and cost-sharing subsidies from the federal government to purchase private insurance coverage through an American health benefit exchange without financial penalty to the state; or (2) Remain in the medical assistance program but with increased cost-sharing requirements. The State’s enrollment broker will continue to facilitate enrollment in a health plan either through the auto-assignment process or by assisting beneficiaries as they make their selection. All other health plan enrollment processes set forth in the State’s approved §1915(b) waiver will be used. Individuals who choose health care coverage via the Marketplace will proceed through enrollment consistent with the procedures established by both the Marketplace and the applicable health plan.

Overview of Michigan Medicaid Quality Improvement Program Structure
The Michigan Medicaid Quality Improvement Program (QIP) is part of the Medicaid Services Administration (MSA), which is administered by the Michigan Department of Health and Human Services (MDHHS). The Medicaid Director reports to the MDHHS Director and oversees the Bureau of Medicaid Care Management and Quality Assurance, which is comprised of four divisions: Managed Care Plan Division, Customer Service Division, Pharmacy Management Division, and Program Review Division. Each division has an administrative director and associated staff. The Managed Care Plan Division is responsible for quality improvement and program development and plan management (including contract management and compliance).

MDHHS also conducts a monthly Quality Improvement (QI) meeting with the MHP Quality Directors. The purpose of this meeting is to address internal and external QI program updates. It provides a forum to discuss other QI issues that will impact how the contracted health plans provide services to their Medicaid beneficiaries.

MDHHS has established the Medicaid Health Plan—Clinical Advisory Committee (MHP-CAC), which meets on a quarterly basis is chaired by the Chief Medical Director of the MDHHS Medical Services Administration. The MHP-CAC is comprised of medical or quality improvement directors from each of the contracted health plans and senior leadership from both MDHHS and the plan.

The MHP-CAC oversees the development and implementation of the Medicaid quality improvement program and serves as the primary point of prioritization and integration of quality improvement activities (e.g., HEDIS®, CAHPS®, EQR, performance bonus, performance improvement projects, and monitoring standards). Essential to the MHP-CAC’s success is the long-standing collaborative relationships with contracted Medicaid Health Plans to develop quantifiable, performance-driven objectives and performance goals addressing quality improvement priorities (e.g., maternal and child health, population health, disparities, and access to care). MDHHS and the MHPs also work together to address common areas of clinical and service delivery through statewide committees (i.e., health plan quality improvement directors, medical directors, and government affairs liaisons). MDHHS representatives attend these meetings to ensure ongoing communication and interaction around Medicaid quality improvement priorities. Health plans are also required to maintain a Quality Improvement Committee (QIC) responsible for reviewing, monitoring, making recommendations, and approving the plan’s quality improvement program.
The Michigan Medicaid Quality Improvement Program is integrated with other state operational units and programs that serve the Medicaid population, including Medicaid Policy, MDHHS Maternal and Child Health, the Michigan Care Improvement Registry (MCIR), mental health, and Part C/Early On. The Maternal Infant Health Program (MIHP) is Michigan’s largest home visiting program serving Medicaid pregnant women and infants.

**Michigan Medicaid Managed Care Program Goals**

Michigan Medicaid managed care program goals are to:
- Improve the health status of enrollees through prevention and chronic care management
- Improve quality and safety of care and services delivered to enrollees, including special populations
- Improve access to care for all enrollees
- Reduce disparities and increase equity in care delivered to enrollees
- Improve enrollee engagement and satisfaction
- Cost containment

Program goals and priorities are based on ongoing analysis of the population served by Medicaid managed care (demographics, key population health indicators, geographic analyses, regulatory and legislative priorities, public health programs, program funding, and other factors). To achieve program goals, Michigan Medicaid has formed strategic partnerships with contracted health plans, other state agencies (e.g., state and local public health, Department of Education/Title V), Michigan’s Early Childhood Investment Corporation, the Michigan Association of Health Plans, the Michigan State Medical Society, the Michigan Primary Care Association (MPCA), the Michigan Hospital Association, and professional associations.

Michigan Medicaid has also developed strategic relationships with other entities to achieve program goals. These include university partners, national organizations such as the Center for Health Care Strategies, Robert Wood Johnson Foundation, Pew Charitable Trusts, and the March of Dimes.

**Michigan Medicaid Managed Care Program Objectives**

Michigan’s Medicaid QI Program objectives are developed and continually revised using the quality improvement (PDSA) process as described by HRSA and the Institute for Healthcare Improvement. Quantifiable measures relate to program goals and are established based on available data (e.g., Medicaid HEDIS state weighted averages and national percentiles, performance trends, other national or statewide data, published performance data and research). Priorities are based on clinical and service importance identified by MDHHS, health plans, CMS, legislative, and executive mandates and laws. As discussed in the introductory section of this document, Michigan is analyzing existing goals and objectives to identify gaps relative to NQS aims and priorities.

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To develop specific program priorities, MDHHS analyzes the Medicaid population (demographic characteristics, geographic location, preventive care needs, and prevalence of conditions/diseases), program cost and utilization, and state/national areas of interest.

Once priorities are established or reaffirmed, Michigan assesses performance against validated measures compared with Michigan Medicaid weighted averages, national benchmarks, and trends. These analyses are used to establish objectives for the following year(s), identify opportunities for improvement, and select topics for performance improvement projects.

This process is a component of the annual Quality Strategy Effectiveness Review. Attachment A summarizes the 2015-2017 key measures and standards, trends, and quantifiable objectives in the areas of chronic disease, preventive care, beneficiary satisfaction, and access. The goals cover a three year time period beginning 10/1/2015 through 9/30/2017; and are based on National benchmarks and Michigan weighted averages. Data can be reported by race/ethnicity and language for health equity initiatives, by geographic location to target specific at-risk populations, and matched with state vital records (e.g., birth, death) to analyze outcomes such as low birth weight and infant mortality.

**Healthy Michigan Plan (HMP) Program Goals and Evaluation Objectives**

The goal of the HMP program is to improve the health and well-being of low-income Michigan citizens. The HMP benefit has been designed to significantly assist uninsured or underinsured individuals manage their health care and adopt healthy behaviors.

The overall goals for Michigan’s HMP program are:

- Improve access to healthcare for uninsured or underinsured low-income Michigan citizens;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Help uninsured or underinsured individuals manage their health care issues;
- Encourage quality, continuity, and appropriate medical care; and
- Study the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
  - The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
  - The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
  - Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes; and
  - The extent to which beneficiaries feel that the Healthy Michigan Program has a positive impact on personal health outcomes and financial well-being.
Michigan’s HMP Section 1115 Waiver application noted opportunities for both the state and for CMS to evaluate this unique and market-driven model of public health care delivery. Specific evaluation objectives are to assess:

- The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
- The extent to which the availability of affordable health insurance results in a reduction in the number of uninsured or underinsured Michigan citizens;
- Whether the availability of affordable health insurance, which provides coverage for health and wellness activities, will increase healthy behaviors and improve health outcomes; and
- The extent to which participants feel the HMP has a positive impact on personal health outcomes and financial well-being.
- How increased cost-sharing impacts utilization and coverage choice for a subset of beneficiaries affected by the 2015 waiver revision. (Implementation 2017)

The HMP evaluation process, which was developed in 2014 is reviewed and analyzed on an ongoing basis. The Medicaid Managed Care Performance Monitoring Specifications (Attachment B) include a set of standardized metrics specific to the HMP population including timely completion of the initial health risk assessment and outreach/engagement to facilitate entry into primary care. HMP’s performance is included in the Michigan Medicaid Quality Strategy Annual Review. A separate CAHPS® survey will be conducted for the HMP population beginning in 2016. In addition, the HMP population is included in Michigan Medicaid HEDIS reporting as well as the CMS Medicaid child and adult core measures. An analysis of the demographics by gender, age, and income level is outlined in the Healthy Michigan Plan Progress Report, which reflects updated enrollment data and is available on the MDHHS web site.

**Development and Review of Michigan's Medicaid Quality Strategy**

**Development and Public Comment**
The Michigan Medicaid QS is developed collaboratively with input from health care providers, stakeholders, advocates and multiple state agencies with an interest in improving access, clinical quality, and service quality received by Medicaid enrollees. After stakeholder’s input is obtained, the QS is presented to the Medical Care Advisory Committee (MCAC) for review and comment and then submitted to CMS for final approval.

**Quality Strategy Effectiveness Review**
Medicaid quality improvement staff reviews progress toward QS goals and objectives at least quarterly. These reviews are based on interim data from the Medicaid data warehouse and/or health plans. MDHHS conducts a comprehensive assessment of performance against QS performance objectives on an annual basis. Findings are summarized in the Michigan Medicaid Quality Strategy Annual Effectiveness Review, which drives program activities and priorities for the upcoming year and identifies modifications to the QS. The QS Annual Effectiveness Review is submitted to the MHP-CAC for formal review and approval.
Quality Strategy Modification and Update
Michigan reviews the QS at least annually to determine if modifications or updates are needed. If significant changes are required (which Michigan defines as changes to program priorities, goals, or objectives), the QS is updated, reapproved at the state level, and resubmitted to CMS.

Section II: ASSESSMENT

Quality and Appropriateness of Care
Michigan Medicaid employs a broad range of mechanisms to assess the quality of care and services delivered to beneficiaries. MDHHS has established the Medicaid Health Plan Clinical Advisory Committee (MHP-CAC), which meets oversees the development and implementation of the Medicaid quality improvement program, prioritizes activities (e.g., HEDIS®, CAHPS®, External Quality Review, performance bonus, performance improvement projects, and performance monitoring standards), reviews analyses and data trends, and serves as the point of integration for quality improvement activities. The MHP-CAC also reviews summary findings from annual Performance Improvement Projects (PIPs) conducted by contracted health plans.

The Michigan Medicaid Quality Improvement program is integrated with other state programs that serve the Medicaid population, including the Maternal Infant Health Program (MIHP), the Michigan Care Improvement Registry (MCIR), foster care program, mental health, and Part C/Early On. Medicaid works closely with lead agencies to assess these programs on an ongoing basis, using assessment results to develop targeted initiatives for populations receiving these program services.

Mandatory Populations, Special Health Care Needs, and Medicaid Expansion (Healthy Michigan Plan)
Since 2008, the following populations, formerly voluntary or excluded are now mandatorily enrolled in managed care: pregnant women (effective October 1, 2008), most categories of foster children (effective November 1, 2010), and Children’s Special Health Care Services (CSHCS) (effective October 1, 2012).

Michigan Medicaid defines persons with special health care needs as individuals who are no longer eligible for CSHCS services due to age. To assess the quality of care and services for special populations, MDHHS conducts periodic stratified analyses based on program-specific enrollment. Data sources may include Medicaid claims and encounters (including pharmacy and behavioral health, validated health plan HEDIS submissions, enrollment files, and vital records). Stratified analyses of relevant quality measures are also conducted for the HMP population.

Race, Ethnicity and Primary Language
MDHHS has established policies and procedures to identify beneficiary race, ethnicity, and primary language. These data are self-reported and collected at the time of Medicaid enrollment and are included in the monthly enrollment files data provided to the Medicaid Health Plans. Medicaid reviews the methodology for enrollment and enrollee rights to assure that disclosure of this information is not used in potentially adverse ways and provides guidance to the plans on the appropriate use of race, ethnicity,
and language data. Since 2004, MDHHS has provided these data to contracted health plans with the expectation that plans utilize these data to identify disparities in care among plan enrollees. Health Plans may also have supplementary systems in place to acquire and store this information (i.e. retrieval from EMR systems from contracted network providers). Beginning in January 1, 2016, contractors are required to implement the U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

Efforts or Initiatives to Reduce Disparities in Health Care
The requirement to reduce disparities is codified in federal and state law. Michigan Medicaid is required to monitor the quality and appropriateness of the healthcare services delivered by participating Medicaid Health Plans (MHPs). Federal regulations require that MHPs provide services “in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.” Disparities assessment, identification, and reduction have been priorities for Michigan Medicaid for several years.

In 2005, Michigan Medicaid participated in the Center for Health Care Strategies’ Practice Size Exploratory Project (PSEP) where participating health plans identified racial/ethnic disparities in a number of measures and at the provider level. Results were disseminated to health plans and to providers for their information. In 2008, Michigan Medicaid was awarded a grant by the Center for Health Care Strategies (funded by the Robert Wood Johnson Foundation) to participate in the three-year initiative, Reducing Disparities at the Practice Site Project. This project focused on six high-volume Medicaid practices in Detroit/Wayne County and facilitated the introduction of the Patient Centered Medical Home (PCMH) into the practice. Diabetes-related HEDIS® measures were tracked by race/ethnicity across time at the participating practices. Between 2008 and 2010, MHPs were required to conduct an annual Performance Improvement Project (PIP) specifically aimed at reducing a disparity in a population using a quality measure.

As a continuation of previous efforts to ensure compliance with federal and state laws and to provide high-quality healthcare for all Medicaid Health Plan enrollees, the Quality Improvement and Program Development Section of the Medicaid Managed Care Plan Division developed the Medicaid Health Equity Project. In early 2010, Michigan Medicaid solicited MHPs for input and advice in the development of the methodology, an initial set of measures was agreed upon and specifications were developed.

The purpose of the Medicaid Health Equity Project is to promote health equity by establishing a system to monitor racial and ethnic disparities within the managed care population. The Project also allows MDHHS to identify priority areas for quality improvement initiatives related to health disparities. All contracted health plans submitted data in reporting year 1 (2011), which were analyzed and reported in both plan-specific and statewide reports. Six additional measures were added in year 2 (2012) for a total of 14 measures. These measures with the addition of a fifteenth measure, “Race/Ethnicity by Diversity of

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5 Patient Protection and Affordable Care Act, PUBLIC LAW 111–148, Sec. 1557
6 Patient Protection and Affordable Care Act, PUBLIC LAW 111–148, Sec. 4302
Membership” were reported in 2013 and 2014 using the same submission process. As a means of measuring quality consistently across plans and to facilitate comparison across states, the plans submit audited Health Effectiveness Data and Information Set (HEDIS) data to MDHHS for each measure that pertains to Medicaid covered benefits. Data for Healthy Michigan Plan beneficiaries are included in the health plan HEDIS data and associated activities to reduce health care disparities.

Pairwise disparities are measured between the non-white populations and the reference (White) population. For each indicator, population disparity was estimated with an Index of Disparity (ID), which describes average subpopulation variation around the total population rate. The ID is being used to identify measures where quality improvement is needed to ensure health equity for the Medicaid managed care population.

The following subset of HEDIS measures broken down by race/ethnicity are submitted by contracted health plans for the Health Equity Project:

**Women-Adult Care and Pregnancy**
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening (Combined)

**Child and Adolescent Care**
- Childhood Immunizations Combo 3
- Adolescent Immunizations Combo 1
- Blood Lead Screening
- Well Child Visits 3-6 years

**Access to Care**
- Child Access to Care (25 months to 6 years)
- Adult Access to Care (20-44 years)

**Living with Illness**
- Appropriate Asthma Medications (Combined)
- HbA1c Testing
- Diabetic Eye Exam
- Diabetic Nephropathy

**Efforts or Initiatives to Address Determinants of Health**
Michigan’s population health model recognizes that population health management is built upon a detailed understanding of the distribution of social, economic, familial, cultural, and physical environment factors, which impact health outcomes among different geographic locations and groups; the distribution of health conditions; and health-related behaviors and outcomes including but not limited to physical, dental, behavioral, and social needs. As a result, beginning in 2016 contracted health plans must develop and submit to MDHHS a multi-year plan to incorporate social determinants of health into their processes for analyzing data to support population health management. The plan is to include the manner in which the social determinant data will be collected and analyzed and how Contractor staff and embedded care managers will be trained on using the social determinants data. Data analysis must utilize available information such as claims, pharmacy, and laboratory results; supplemented by utilization data, health risk assessment (HRA) results and eligibility status (e.g., children in foster care, persons receiving Medicaid for the blind or disabled, CSHCS). The goal is to address health disparities, improve community
collaboration and enhance care coordination, case management, targeted interventions, and complex care management services for enrollees. Target populations may include those experiencing a disparate level of social needs such as transportation, housing, food access, unemployment or education level. Subpopulations may include individuals with poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, geographic location or income level.

Contracted health plans must also participate in initiatives to develop a core set of social determinants of health indicators; identify community-based support services and monitor utilization of these services as well as health outcomes; and report on the effectiveness of its population health management initiatives. Intervention strategies may include in-person support services such as Community Health Workers (CHW), patient navigators, home visiting programs (MIHP), or health promotion or prevention programs delivered by a community-based organizations (adult/family shelters, schools, foster homes).

**National Performance Measures**
Beginning in 2013, Michigan Medicaid has been voluntarily reporting the national Child and Adult Core Set Measures.

**Adult Health Care Quality Measures for Medicaid-Eligible Adults**
Section 1139B of the Patient Protection and Affordable Care Act requires the Secretary of the Department of Health and Human Services to identify and publish a core set of health quality measures for adult Medicaid enrollees. The law requires that measures designated for the core set be currently in use.

On December 21, 2012 CMS launched the Adult Medicaid Quality (AMQ) Grant Program: Measuring and Improving the Quality of Care in Medicaid. This two-year grant program was designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Initial Core of Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Initial Core Set). The three main goals of this grant were to:

- Test and evaluate methods for collection and reporting of the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid in varying delivery care settings.
- Develop staff capacity to report, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid; and
- Conduct at least two Medicaid quality improvement projects related to Initial Core Set Measures.

Michigan was one of twenty-six states selected by CMS to participate in the AMQ grant program. Michigan Medicaid has been recognized for its business intelligence system, which includes advanced analytics, data mining, data warehousing, and decision support capabilities. Michigan utilized Year 1 and 2 grant funds to support the development, collection, analysis, and reporting of the Adult Core Set measures. Michigan’s Medicaid data warehouse vendor, Optum developed queries and scripts to create a reporting solution that enabled Medicaid staff to extract real-time data from the warehouse to drive performance improvement. Optum trained Medicaid staff to utilize queries related to these measures, as well as to develop ad hoc queries using the Data
Warehouse to monitor quality on an ongoing basis. Grant activities continued into Year 3 (2015) as a result of a CMS No-Cost Extension (NCE).

Michigan has successfully extracted, stratified, and reported administrative data for the following fifteen (15) Adult Core Set Measures:

**Preventive Care**
- Cervical Cancer Screening (NQF 0032)
- Chlamydia Screening in Women (NQF 0033)
- Breast Cancer Screening (NQF 0031)
- Adult Body Mass Index Assessment

**Maternal and Perinatal Health**
- Elective Delivery (PC-01)
- Prenatal and Postpartum Care: Postpartum Care Rate (NQF 1391)

**Behavioral Health and Substance Use**
- Antidepressant Medication Management (NQF 0105)

**Care of Acute and Chronic Conditions**
- Comprehensive Diabetes Care: Hemoglobin A1c Testing (NQF 0057)
- Asthma in Younger Adults Admission Rate (NQF 0283)
- Diabetes Short-Term Complications Admission Rate (NQF 0272)
- Heart Failure Admission Rate (NQF 0277)
- Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (NQF 0275)
- Plan All-Cause Readmissions (NQF 1768)

**Care Coordination**
- Annual Monitoring for Patients on Persistent Medications (NQF 0021)

**Experience of Care**
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid)

Participating states were also required to stratify three measures by at least two of the following demographic categories: race/ethnicity, gender, language, disability, urban/rural. Michigan stratified the following Adult Core Set Measures by race/ethnicity, gender, urban/rural demographic categories to evaluate disparities:

- Chlamydia Screening in Women
Michigan coordinated this component of the grant reporting with the Medicaid Health Equity Project described earlier this section. Data was also stratified by Medicaid managed care, Fee-for-Service, Healthy Michigan Plan, and by health plan.

MDHHS continues to strengthen capacity to generate and report the Adult Core Set Measures and is actively participating in AMQ activities in measurement development and revision.

Michigan will continue to report the Adult Core Set Measures and establish performance goals following baseline analyses.

**Children’s Health Care Quality Measures**

Child core set measures are outlined in Section 401 of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009. This legislation called for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish an initial core set of children’s health care quality measures for voluntary use by state programs administered under Titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP. Measures are required to be applicable to the duration of enrollment and health care coverage, preventive and health promotion services, and the treatment and management of acute and chronic conditions in children. The legislation also called for measures that could be used to assess families’ experiences with health care, the availability of services, and care in the most integrated health settings. Ultimately, the goals of the core measure set are to provide a national estimate of the quality of health care for children; facilitate comparative analyses across various dimensions of pediatric health care quality; and help identify racial, ethnic, and socioeconomic disparities.

In addition to the Adult Core Set Measures, Michigan reports on the following Child Measures for the Medicaid population:

**Access to Care**
- Child and Adolescent Access to Primary Care Practitioners (CAP)

**Preventive Care**
- Childhood Immunization Status (CIS)
– Immunizations for Adolescents (IMA)
– Chlamydia Screening in Women (CHL)
– Well-Child Visits in the First 15 Months of Life (W15)
– Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)
– Adolescent Well-Care Visit (AWC)
– Developmental Screening in the first Three Years of Life (DEV)
– Human Papillomavirus Vaccine for Female Adolescents (HPV)

*Maternal and Perinatal Health*
– Cesarean Section (PC02)
– Live Births Weighing Less Than 2,500 Grams (LBW)
– Frequency of Ongoing Prenatal Care (FPC)
– Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)

*Behavioral Health*
– Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (ADD)

*Care of Acute and Chronic Conditions*
– Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents (WCC)
– Ambulatory Care: Emergency Department (ED) Visits (AMB)

*Experience of Care*
– Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC)

Performance goals have been established for the following Child Core Set Measures:
– Child and Adolescent Access to Primary Care Practitioners (CAP)
– Childhood Immunization Status (CIS) (Combo 3)
– Immunizations for Adolescents (IMA)
– Chlamydia Screening in Women (CHL) (Total)
– Well-Child Visits in the First 15 Months of Life (W15)
– Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)
– Adolescent Well-Care Visit (AWC)
– Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)
– Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents (WCC)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC)

**Monitoring and Compliance**

Michigan Medicaid has a strong, well-established program to monitor and evaluate health plan compliance with established standards for:

- Access, availability, and capacity of services
- Quality measurement and improvement
- Health equity and disparities
- Continuity and coordination of care
- Structure and operations
- Health information technology

Health plans must also address identification of persons with special health care needs and activities to ensure the quality of care and access for individuals in targeted groups including the Healthy Michigan Plan (HMP) population.

Mechanisms to assess compliance include member and provider surveys, HEDIS, mandatory performance monitoring standards, health plan profiling (annual performance bonus), performance improvement projects, and the External Quality Review (EQR).

The following is a discussion of procedures used by MDHHS to monitor and evaluate health plan compliance with access, structure and operations, and measurement and improvement standards.

**Member and provider surveys**

*Consumer Assessment of Healthcare Providers and Systems (CAHPS®)*

Section 1.022(Z)(6) of the Medicaid Health Plan contract requires plans to conduct an annual consumer satisfaction survey of adult enrollees using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) instrument. The plans provide the survey summary and member-level data to MDHHS on an annual basis. This information is analyzed and findings are included in the External Quality Review technical report. In addition, MDHHS contracts with a certified CAHPS® vendor to conduct surveys of the Medicaid managed care child population annually. Topics covered by the CAHPS® survey include: Personal Doctor, Medical Specialist, Health Care, Health Plan, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, Health Promotion and Education, Coordination of Care, and Customer Service.

Survey results are used to identify quality improvement activities related to member satisfaction with the plan and contracted physicians. CAHPS® data also comprise a portion of the annual health plan Performance Bonus and are used to promote informed consumer choice through publication in Michigan’s annual Medicaid consumer guide.
Results of selected CAHPS® measurements and comparisons are discussed in the Improvement and Interventions section of this document.

Michigan will conduct a separate CAHPS® survey for the HMP population beginning in 2016.

**Medicaid Health Plan Performance Reports**

*Healthcare Effectiveness Data and Information Set (HEDIS®)*

Section 1.042(A)(5) of the Medicaid Health Plan contract requires health plans to submit annual audited Medicaid HEDIS® data. MDHHS requires health plans to have electronic health systems sufficient to report health care claims, membership and provider files, and hardware/software management tools to facilitate accurate and reliable HEDIS® reporting.

MDHHS reviews, analyzes, trends, and reports HEDIS® rates internally, publicly, and to the health plans. MDHHS has established a process to analyze annual HEDIS® data; these analyses drive the identification and prioritization of multiple quality improvement activities. MDHHS uses HEDIS® data for annual performance assessment to establish quality improvement program priorities and objectives, to develop the annual Medicaid consumer guide, and to assess quality of care and service delivered to targeted populations (e.g., CSHCS, children in foster care).

MDHHS currently contracts with Health Services Advisory Group, Inc. (HSAG) to objectively analyze health plan HEDIS® results and evaluate each plan’s current performance level relative to national Medicaid performance. Performance levels have been set at specific, attainable rates and are based on national percentiles or the Michigan Medicaid weighted average. (Refer to **Attachment A**.) This standardization allows for comparison to the performance levels. Health plans meeting the high performance level (national Medicaid HEDIS® 90th percentile) exhibit rates among the top in the nation. The low performance level (national Medicaid HEDIS® 25th percentile) has been set to identify health plans in the greatest need of improvement. HSAG examined key measures along four different dimensions of care: (1) Women’s Health, (2) Children’s Health, (3) Living with Illness, and (4) Access to Care.

Michigan Medicaid HEDIS® results are analyzed utilizing:
- Comparison of current year Michigan Medicaid weighted averages relative to prior year Michigan Medicaid weighted averages and national HEDIS® Medicaid benchmark percentiles
- Performance profile analysis discussing the overall Michigan Medicaid results and presenting a summary of health plan performance relative to the Michigan Medicaid established goals
- A health plan ranking analysis providing a more detailed comparison, showing results relative to the Michigan Medicaid performance levels
- A data collection analysis evaluating the potential impact of data collection methodology on reported rates.

Results of HEDIS® measurements are discussed in the Improvement Section of this document.
Report cards or profiles

Guide to Michigan Medicaid Health Plans
MDHHS annually produces a Medicaid consumer guide entitled “A Guide to Michigan Medicaid Health Plans.” (Refer to Attachment C.) The Guide is developed by HSAG using HEDIS and CAHPS measures and includes ratings in the following five categories of health plan performance: (1) Doctors Communication and Service; (2) Getting Care; (3) Keeping Kids Healthy; (4) Living with Illness; and (5) Taking Care of Women. Health plan performance is compared to the average of all Michigan Medicaid Health Plans using an “apple” symbol for comparison for Above Average (four apples); Average (three apples); or Below Average (two apples). The Guide also outlines covered medically-necessary services, includes the Michigan Enrolls phone number (the contracted enrollment broker), and indicates whether the health plan is accredited by National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC).

Health Plan Performance Bonus Model
During each contract year, MDHHS withholds a specified amount of the approved capitation for each contracted Medicaid Health Plan in a Performance Bonus Pool used to award health plan performance. The 2015 bonus withhold pool (total of 1%) will be distributed among plans that achieve performance standards established by MDHHS. The 2015 bonus increased the withhold amount from 0.19% to 0.75% applied to the entire Medicaid population and will be distributed based on plan achievement for the entire Medicaid population (including the Healthy Michigan Plan expansion population). An additional performance bonus pool (0.25%) was established in 2015 with the specific goal of increasing Healthy Michigan Plan beneficiary compliance with cost sharing requirements.

Bonus awards are based on each plan’s clinical and access scores as reported in the current HEDIS® report, and member satisfaction survey scores utilizing the most recent CAHPS scores. Under this incentive system, all plans have the opportunity to receive award funds in direct proportion to their performance on each of the measures.

Clinical and Access to Care scores are based on the health plans most recently submitted HEDIS® data and compared to the most recent national Medicaid HEDIS® data as published by NCQA. The 50th, 75th, and 90th percentiles are used for scoring purposes. Member satisfaction scores are based on the plan’s most recent Adult and Child CAHPS® results. Scoring is based on the plan score (statistically significant difference) compared with the all plan average.

The remainder of the 2015 bonus award is based on a focus study to be conducted by the plan. The 2015 focus study includes a review of Medicaid Health Plan processes, procedures, and systems related to the Healthy Michigan Plan. Public Act 107 of 2013 calls for MDHHS and the Medicaid Health Plans to implement and report new metrics for the HMP population. Metrics specifically outlined in the legislation will be included in the 2016 Performance Bonus. To ensure consistency among plans in tracking and reporting the 2016 metrics, the 2015 focus study will be utilized to generate the 2016 metrics. In addition, MDHHS is tracking the following measures using encounter data for information purposes during 2015: cost-sharing, 150 day access to care, HRA completion, plan all-cause readmission (30 days), emergency department (ED) utilization, and generic drug utilization.
Public Act 107 of 2013 also calls for innovative and concerted efforts to improve quality and reduce costs by focusing on ED utilization; and authorizes use of the performance bonus incentive to include such endeavors. To align with the ED Utilization Symposium Report submitted to the legislature in 2014, MDHHS is including ED utilization as the focus bonus in 2016 and 2017.

The **FY 2016 Performance Incentive Pool** will include a 1.0% capitation withhold. Revisions to the 2016 Performance Incentive Pool are significant and include the following components:

- **Bonus Template Measures**: 20%
- **Cost-Sharing Performance Pool (PA 107)**: 25%
- **Focus Bonus - ED Utilization**: 20%
- **Shared Metrics with Pre-paid Inpatient Health Plans (PIHPs)**: 7%
- **Pay 4 Performance on Population Health and Health Equity**: 28%

The **Bonus Template** includes the Healthy Michigan Plan measures as well as CAHPS measures for both the HMP and CSHCS populations. In addition, points will only be awarded for plans meeting the 75th and 90th national Medicaid percentiles. The **Cost-Sharing Performance Pool** criteria requires health plans to report on ongoing monitoring of the MI Health Account including incentives, strategies and interventions to improve cost-sharing collection, and a description of how plans encourage the use of high-value services. The **Focus Bonus** will be ED Utilization per Public Act 107 of 2013. The Managed Care Plan Division (MCPD) is working collaboratively with the health plans and Medicaid Behavioral Health and Developmental Disabilities Administration (BHDDA) to develop a **Shared Metrics with Pre-paid Inpatient Health Plans** (PIHPs). The goal is to identify measures that will be valid, meaningful, and actionable.

The final component of the 2016 Performance Incentive Pool includes **Pay 4 Performance Projects (P4P)** on Population Health and Health Equity. This component of the Incentive Pool includes four elements: (1) Medicaid Health Equity; (2) Chlamydia Screening; (3) Community Health Worker (CHW) Program; (4) Non-Emergency Medical Transportation (NEMT); and (5) Tobacco Cessation Programs for Medicaid beneficiaries.

**Required MCO reporting of performance measures**

**Performance Monitoring Standards**

In addition to submitting HEDIS® and CAHPS® data, Section 1.022(Z)(4) of the Medicaid Health Plan contract requires plans to incorporate the statewide performance monitoring standards into their required written quality improvement plans. Michigan Medicaid monitors individual plan performance against minimum thresholds to ensure that all Medicaid enrollees receive necessary levels of care and service. The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer service, and reporting. The process is dynamic and reflects state and national issues that may change on a yearly basis. Performance measurement is
shared with health plans during the fiscal year and compares performance of each plan over time to other health plans and to industry standards where available.

The Performance Monitoring Standards address the following:

- Quality of care
- Access to care
- Customer service
- Claims reporting and processing
- Encounter data submission
- Provider file reporting
- Performance for specific populations (e.g., Healthy Michigan Plan)

For each performance area, the following categories are identified:

- Measure
- Goal
- Minimum standard for each measure
- Data source
- Monitoring intervals (annual, quarterly, monthly)

In 2015, the MCPD updated the Performance Monitoring Report (PMR) with a goal of creating a more useful tool for the Medicaid Health Plans to use in administering and monitoring the care provided to members. As a result, Medicaid developed a standardized set of Managed Care Performance Monitoring Specifications. (Refer to Attachment B for the FY 2014-2015 the PMR standards.) PMR data is generated quarterly from the MDHHS Data Warehouse using administrative data only and shared with the MHPs for ongoing analysis and trending. The PMR report includes quality measures based on encounter data extracted from the data warehouse and aligns with quality initiatives for the Medicaid managed care and Healthy Michigan Plan populations. The use of administrative data only for the purpose of monitoring plan performance represents a significant change in the monitoring and evaluation process. Previously, the PMR measures were derived from annual HEDIS measures using both administrative and medical record data submitted to MDHHS by the contracted health plans. HEDIS measures continue to be monitored, are included in the health plan Performance Bonus, and remain a component of the health plan auto-assignment algorithm.

The PMR measure specifications align with CMS Medicaid and CHIP, the Adult and Child Core Measures, and also s claims processing, encounter and pharmacy data reporting, and provider file reporting. In FY 2015, PMR performance goal targets were established at or above the national Medicaid 75th percentile performance level.

Dental care utilization measures will be established to access dental services and preventive care for Medicaid beneficiaries and sub-populations.
All encounter data are measured and analyzed at the state and health plan level. Contracted health plans are required to measure the performance of providers and at least annually provide performance feedback including a detailed discussion of clinical standards and expectations.

Failure to meet minimum performance thresholds may result in remedial actions and/or improvement plans as outlined in Section 1.022(EE) of the Medicaid Health Plan contract.

**Required MCO reporting on performance improvement projects**
Section 1.022(2)(3) of the Michigan Medicaid Health Plan contract requires health plans to conduct annual performance improvement projects that focus on clinical and non-clinical areas. MDHHS identifies priority areas for statewide PIPs through analysis of HEDIS® and CAHPS® data, population needs, legislative priorities and mandates, and topics based on the state and national health care agenda. These priority areas may vary from year to year, and MDHHS may require specific PIPs for a subset of plans based on individual plan performance, plan demographics (race, ethnicity, and other population characteristics), or prevalent conditions. PIPs are included in the plan’s Quality Assurance and Performance Improvement (QAPI) program and must include use of objective indicators, system interventions, evaluation of interventions for effectiveness, and continuation of activities to sustain improvement. Recent examples of topics covered in PIPs include blood lead testing, access to care for children/adults, childhood obesity, children with special health care needs, and racial/ethnic disparities in screening for breast/cervical cancer.

**Grievances/Appeals**
Section 1.022(I) of the Medicaid Health Plan contract requires plans to establish a detailed process for the management of grievances and appeals. The health plan is required to have staff to coordinate, manage, and adjudicate member and provider grievances. The process must provide for prompt resolution of issues and must assure participation of appropriate health plan leadership. MDHHS specifies timeframes for grievance and appeal resolution, including timeframes for non-expedited and expedited appeals. Grievances and appeals may be submitted telephonically to the health plan or the MDHHS Medicaid Helpline. Complaint calls received by the Medicaid Helpline are transferred to appropriate MDHHS personnel, who then contact the health plan or provider to resolve the complaint.

MDHHS has an established process to assist beneficiaries; beneficiaries may call Michigan Enrolls (the contracted enrollment broker) or the Beneficiary Help Line for assistance in completing forms, filing complaints, or addressing issues during complaint or grievance resolution. An additional protection afforded to Medicaid enrollees is the right to request a MDHHS administrative hearing at any time during the complaint and grievance process. This hearing may occur simultaneously with the health plan’s internal complaint and grievance process.

Enrollee complaints are included in the Medicaid Health Plan performance monitoring standards. Data are extracted quarterly, and plans are expected to meet a minimum standard of less than or equal to 0.15 complaints per 1000 member months.
External Quality Review (EQR)

Medicaid Health Plan EQR
The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes how data from activities conducted by Medicaid Health Plans were aggregated and analyzed, how conclusions were drawn about the quality, timeliness, and access provided by contracted health plans, and assessment of health plan strengths and weaknesses. To meet the External Quality Review (EQR) requirement, MDHHS contracts with the Health Status Advisory Group (HSAG) to conduct an annual, external independent review of the quality and outcomes, timeliness of and access to covered services provided by the health plans.

Section 1.022(Z)(5) of the Michigan Medicaid Health Plan contract requires plans to develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of their QAPI program. MDHHS may also require separate submission of an improvement plan specifically related to the EQR findings. Michigan’s Medicaid Health Plan EQR includes three mandatory activities: validation of performance measures, validation of the performance improvement projects (PIP), and compliance monitoring. The EQR also includes a validation of plan CAHPS results.

In the area of compliance monitoring, Michigan evaluates health plan compliance with federal Medicaid managed care regulations. To validate performance measures, HSAG performs an independent audit of health plans’ most current audited HEDIS® data to determine the validity of each performance measure. To validate Performance Improvement Projects, HSAG reviews one PIP for each health plan to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, driving actual improvements in care and providing confidence in reported improvements. For 2011-13, the mandatory health plan PIP topic was childhood obesity, focusing on the HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity measure. In 2014, health plans were asked to select a PIP topic that addressed a special population to be implemented over a three-year timeframe (2014-2016). PIP topics selected by the MHPs consisted of obesity, well child care, chronic conditions (e.g., asthma, diabetes, cardiovascular disease), blood lead, breast and cervical cancer screening, and prenatal and postpartum care.

Section III: STATE STANDARDS

Access Standards
MDHHS has established standards to ensure that enrollees’ access to care is not restricted and services are readily available. These standards pertain to all Medicaid managed care enrollees, including persons with special health care needs. The contracted health plans must also consider anticipated enrollment and expected utilization of services with respect to all Medicaid populations (e.g., disabled, dually eligible). Health plans are contractually required to make sure that primary care physicians provide or arrange for coverage of services 24 hours a day, 7 days a week. The health plan contract also states that primary care and hospital services must be available to enrollees within 30 minutes of travel time or 30 miles, unless the enrollee chooses otherwise. Hospitals and pharmacies are also required to be within 30 minutes travel time or 30 miles.
Exceptions to this standard may be granted if the health plan documents that no other network or non-network provider is accessible within the 30-minute or 30-mile travel time.

Services may be authorized out of the plan’s service area or out of the plan’s network of providers. Unless otherwise noted in the contract, the contracted health plan is responsible for coverage and payment of all emergency and authorized care provided outside of the established network. Out-of-network claims must be paid at established Medicaid fees according to current Medicaid policy. MDHHS assesses compliance with claims payment standards and requirements through monthly claims reports and as a component of on-site visits.

To ensure adequate appointment access, contracted health plans are required to develop and comply with established standards for appointment availability and appointment wait time. Providers are also required to provide or arrange for coverage of services 24 hours per day, 7 days per week, and be present a minimum of 20 hours at each practice location. MDHHS assesses plan adherence to established policies and standards and monitors compliance with these requirements during annual on-site visits.

MDHHS requires that health plans provide access to appropriate providers, including qualified specialists, for all medically necessary covered services. The health plans are required to establish and maintain coordination of care agreements with the local behavioral health and developmental disability agencies (CMHSPs) for behavioral health and developmental disability services. In addition, Section 1.022(R)(1-2), (S)(3) of the Medicaid Health Plan contract requires plans to provide access to specialists based on the availability and distribution within specialty. MDHHS allows a physician specialist to function as a Primary Care Provider (PCP) in cases where the enrollee’s medical condition warrants this arrangement. Examples of medical conditions warranting a specialist acting as a PCP include, but are not limited to uncontrolled or complicated diabetes, end stage renal disease, or other chronic disease or disability. Physician specialist management is determined on a case-by-case basis.

MDHHS encourages contracted health plans to seek contracts with providers with established relationships with CSHCS enrollees; if the primary and specialty care provider does not wish to join the Contractor’s network, the plan is required to work with the non-contracted provider on care coordination, prior authorization and medical management. Plans must allow a CSHCS enrollee to choose a non-network PCP if the enrollee has an established relationship at the time of enrollment or if the PCP is the most appropriate for the CSHCS member. CSHCS enrollees may be brought into network through transition to an appropriate network provider upon consultation and arrangement with the family and the care team. If a non-contracted provider declines the plan’s offer to participate in the plans network and refuses to coordinate with the health plan’s case management team on prior authorization and medical management, the plan may move the CSHCS enrollee to a network provider. In the event that the plan does not have a contract with the provider, all claims must be paid at the Medicaid FFS rate.

Health plans must also ensure that enrollees have full freedom of choice to family planning providers (in-network and out-of-network); and allow enrollees to seek family planning services, drugs, supplies and devices without prior authorization. Plans
must also allow women who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of her choice.

Sections of the Michigan Medicaid Health Plan contract pertaining to access and availability are cited below:

**Availability of Services**

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>Description</th>
<th>Michigan Medicaid Health Plan Contract Page Number or Comment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.206</td>
<td><strong>Availability of Services</strong></td>
<td></td>
</tr>
<tr>
<td>§438.206(b)(1)</td>
<td>Maintains and monitors a network of appropriate providers</td>
<td>1.022(R)(1)</td>
</tr>
<tr>
<td>§438.206(b)(2)</td>
<td>Female enrollees have direct access to a women’s health specialist</td>
<td></td>
</tr>
<tr>
<td>§438.206(b)(3)</td>
<td>Provides for a second opinion from a qualified health care professional</td>
<td>1.022(R)(2)(e)</td>
</tr>
<tr>
<td>§438.206(b)(4)</td>
<td>Adequate and timely coverage of services not available in network</td>
<td>1.022(R)(2)(e)</td>
</tr>
<tr>
<td>§438.206(b)(5)</td>
<td>Out-of-network providers coordinate with the MCO or PIHP with respect to payment</td>
<td>1.022(F)(2)</td>
</tr>
<tr>
<td>§438.206(b)(6)</td>
<td>Credential all providers as required by §438.214</td>
<td>1.022(V)(1)</td>
</tr>
<tr>
<td>§438.206(c)(1)(i)</td>
<td>Providers meet state standards for timely access to care and services</td>
<td>1.022(2)(b)(x)</td>
</tr>
<tr>
<td>§438.206(c)(1)(ii)</td>
<td>Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicare fee-for-service</td>
<td></td>
</tr>
<tr>
<td>§438.206(c)(1)(iii)</td>
<td>Services included in the contract are available 24 hours a day, 7 days a week</td>
<td>1.022(R)(1); 1.022(R)(2)(l); 1.022(S)(2)</td>
</tr>
<tr>
<td>§438.206(c)(1)</td>
<td>Mechanisms/monitoring to ensure compliance</td>
<td>1.022(2)(1)(b)(x); 1.032(14)</td>
</tr>
<tr>
<td>§438.206(c)(2)</td>
<td>Culturally competent services to all enrollees</td>
<td>1.022(R)(2)(i); 1.022(H)(1); 1.022(G)(a)(b); 1.032(18)</td>
</tr>
</tbody>
</table>

* In May 2015, MDHHS had a request for proposal for the Comprehensive Health Plan for Michigan’s Medicaid Health Plans (MHPs). A new contract is being prepared for a January 1, 2016 effective date.

**Adequacy of Capacity and Services**

*Initial review and approval*

The State’s Department of Insurance and Financial Services (DIFS) is responsible for the initial review and approval of health plan service area and capacity. DIFS review and approval requires the health plan to attest that adequate capacity is available through both contracted and out-of-network arrangements. MDHHS accepts the DIFS determination, conducts a Medicaid program network adequacy review, and issues all final approvals for the adequacy of the health plan physician, hospital and
ancillary network. Effective January 1, 2016, MDHHS requires that health plan service areas comply with the state designated Prosperity Regions.

**Ongoing monitoring of capacity and services**

After initial approval, MDHHS monitors the network adequacy throughout the year to assure that any changes in the network arrangements do not affect the ability of an enrollee to obtain needed care. MDHHS has established provider capacity requirements for contracted health plans to maintain a network of qualified providers in sufficient numbers, mix, and geographic locations. At a minimum, health plans must provide one full-time PCP per 750 members. MDHHS assesses health plans against this ratio to determine maximum enrollment capacity for the health plan in an approved service area. Contracted health plans are required to submit provider files to the State’s Enrollment Services Contractor (MI Enrolls) that provide a description of the plan’s service network, including the specialty and hospital network and other arrangements for provision of medically necessary non-contracted specialty care. Providers included in the initial DIFS service area approval process comprise each plan’s provider file maintained by MI Enrolls. The provider file is updated by MI Enrolls on a monthly basis. MDHHS receives a capacity report every two weeks from MI Enrolls. The capacity report illustrates overall network capacity for the State as well as network capacity by county, region, and health plan. The Plan Management Section utilizes the capacity report to identify “critical” counties in which network changes may create access issues. The network capacity reported on the capacity report is also a component of the quarterly algorithm scoring for member auto-assignment.

MDHHS also requires health plans to ensure adequate capacity of specialty services, ancillary services (such as durable medical equipment services), home health services, and maternal and infant health services.

MDHHS determines access, availability, and capacity during the annual on-site visit. Access and availability of services are components of the mandatory health plan accreditation process; plans must meet or exceed established standards to maintain accreditation status.

Sections of the Michigan Medicaid Health Plan contract pertaining to capacity are cited below:

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>Description</th>
<th>Michigan Medicaid Health Plan Contract Page Number or Comment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.207</td>
<td><strong>Assurance of Adequate Capacity and Services</strong></td>
<td></td>
</tr>
<tr>
<td>§438.207(a)</td>
<td>Assurances and documentation of capacity to serve expected enrollment</td>
<td>1.022(R)(2)(c)</td>
</tr>
<tr>
<td>§438.207(b)(1)</td>
<td>Offer an appropriate range of preventive, primary care, and specialty services</td>
<td>1.022(R)(1)-(2)</td>
</tr>
<tr>
<td>§438.207(b)(2)</td>
<td>Maintain network sufficient in number, mix, and geographic distribution</td>
<td>1.022(R)(1)</td>
</tr>
</tbody>
</table>

* In May 2015, MDHHS had a request for proposal for the Comprehensive Health Plan for Michigan’s Medicaid Health Plans (MHPs). A new contract is being prepared for a January 1, 2016 effective date.
Coordination and Continuity of Care

Michigan provides comprehensive, continuous and coordinated care to Medicaid beneficiaries. Medicaid Health Plans are contractually responsible for coordinating and collaborating with local health departments and Children’s Multidisciplinary Specialty (CMDS) Clinics to make a wider range of essential health care and support services available to enrollees. Plans are also contractually responsible for the coordination and continuity of care provided to enrollees who require integration of medical, behavioral health and/or substance abuse services. Section 1.022(F)(18) of the Medicaid Health Plan contract specifies that plans must demonstrate a commitment to case managing the complex needs of enrollees and support the physician–patient relationship in the development of plans of care, which must take into account all of an enrollee’s needs (e.g., home health services, therapies, durable medical equipment and transportation). Plans must submit evidence of care coordination to MDHHS upon request. During the annual on-site visit, MDHHS assesses the continuity of the coordination of care and case management processes. In addition, continuity and coordination of care are components of the mandatory health plan accreditation process; plans must meet or exceed established standards to maintain accreditation status.

Primary Care

The primary care provider (PCP) is responsible for supervising, coordinating, and providing all primary care to each assigned enrollee. In addition, the PCP is responsible for initiating referrals for specialty care, maintaining continuity of each enrollee’s health care, and maintaining the enrollee’s medical record, which includes documentation of all services provided by the PCP as well as any specialty or referral services. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, or pediatric physician; or when appropriate (based on the enrollee’s health condition) a physician specialist, nurse practitioner or physician assistant. The health plan is responsible for the continuity of treatment if a provider’s participation in the plan is terminated during the course of a member’s treatment by that provider (e.g., authorizing out of network referrals).

CSHCS enrollees must be assigned to PCP’s that have attested to being willing care for the potentially complex health conditions of the population and provide family-centered care. Prior to mandatory enrollment of CSHCS in managed care, health plans were required to submit policies and procedures to demonstrate effective care coordination for this population. In 2013 and 2014, MDHHS reviewed a select sample of beneficiary clinical files to verify coordination of care between primary care, specialty care, and community-based care provided by local public health departments. In addition, MDHHS conducts bi-annual meetings with health plans, CSHCS, and local public health to identify program issues and discuss opportunities for process improvement. MDHHS also assessed health plan capacity to meet CSHCS contractual requirements as a part of the 2015 re-bid process.

Behavioral Health and Disability Services

Section 1.022(X) of the Medicaid Health Plan contract requires plans to coordinate care for enrollees eligible for behavioral health services and services for persons with disabilities. While contracted health plans are not responsible for the direct delivery of specified behavioral health and developmental disability services (as delineated in Medicaid policy), the plans must establish and maintain agreements with MDHHS-contracted local behavioral health and developmental disability agencies or organizations. In Michigan, mental health and developmental disability services are delivered through county-based Community
Mental Health Services Programs (CMHSPs). Agreements between health plans and the local Behavioral Health and Development Disability managed care providers must address the following: emergency services, pharmacy and laboratory service coordination, medical coordination, data and reporting requirements, quality assurance coordination, grievance and appeal resolution, and dispute resolution. These agreements must be available for review upon request.

MDHHS determines health plan compliance with coordination of care agreement requirements and continuity and coordination of medical and behavioral health services during the annual on-site survey. In addition, continuity and coordination of care is examined as a significant component of the mandatory health plan accreditation process.

Integration of behavioral health services
MDHHS recognizes the importance of integrating both physical health and behavioral health services to effectively address enrollee needs and improve health status. To meet this goal, health plans are required to work with MDHHS to develop initiatives to better integrate services covered by the Contractor and the Prepaid Inpatient Health Plans (PIHP) serving Contractor’s enrollees and to provide incentives to support behavioral health integration.

Health plans are also required to collaborate with MDHHS and the PIHPs to develop shared metrics to measure the quality of care provided to enrollees jointly served by the Contractor and PIHPs. As a result, MDHHS, the MHPs, and the Behavioral Health and Developmental Disabilities Administration (BHDDA) selected the Follow-up after Hospitalization for Mental Illness HEDIS measure as the first shared metric to be reported in 2016. This measure is valid, meaningful, and actionable for both the MHPs and PIHPs who are jointly responsible for making sure the follow-up visit occurs. The shared metrics with PIHPs is included in the FY 2016 Performance Incentive Pool, which is funded through a capitation withhold.

Another new component in 2015 is the requirement that health plans provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to enrollees who have significant behavioral health issues and complex physical co-morbidities. CHWs will serve as a key resource for services and information needed for enrollees to have healthier, more stable lives. Examples of CHW services include, but are not limited to: conducting home visits; participating in office visits; arranging for social services; and helping enrollees with self-management skills.

To facilitate care coordination, health plans must designate key personnel to oversee the appropriate use of CareConnect360 (CC360). CC360 is a MDHHS-supported statewide web-based care management system that allows for the bi-directional exchange of health care information. CC360 allows for the identification and coordination of services to enrollees with significant behavioral health issues and complex physical co-morbidities to facilitate sharing of critical cross-system information between plans and PIHPs. CC360 makes it possible to effectively assess and analyze healthcare program data, manage and measure programs and improve enrollee health outcomes. All MHPs have access to CC360 for coordination of care.

The Contractor must also work with the PIHPs to jointly develop care management standards including development of person-centered care plans; and create and implement performance improvement projects using shared metrics and incentives for
performance. Health plans must also facilitate placement of primary care clinicians in community mental health centers (CMHC) as well as the placement of behavioral health clinicians in primary care settings.

In 2012-2014, Michigan Medicaid participated in Screening Kids in Primary Care Plus (SKIPP), an initiative grant funded by the Flinn Foundation. SKIPP was a collaborative including Medicaid, the MDHHS Public Health Administration, BHDDA, primary care practices, and Wayne County Community Mental Health. The project provided for the standardized developmental, social-emotional and mental health screening, assessment, referral and follow-up for Medicaid children ages 3 months to 18 years in Wayne County who are newly placed in foster care homes. SKIPP provided mental health assessment and linkages to mental health services through the use of Mental Health Consultants at four selected pediatric practices in Wayne County.

A majority of contracted health plans have implemented quality improvement initiatives addressing continuity and coordination of medical and behavioral health care.

**Pregnancy and Postpartum Care**

Since October 1, 2008, pregnant Medicaid enrollees are required to enroll in a managed care health plan. Health plans must ensure that a maternity care provider is designated for all enrolled pregnant women for the duration of the pregnancy and postpartum care. An appropriately credentialed individual provider must be named as the maternity care provider and is responsible for continuity of care. An OB/GYN clinic or practice may be designated as a PCP or maternity care provider if chosen by the enrollee. Designation of a clinic or practice is appropriate as long as an individual provider, within the clinic or practice, agrees to accept responsibility for the enrollee’s care for the duration of the pregnancy and post-partum care (Section 1.022(S)(4)).

MHPs must allow women who are pregnant at the time of enrollment to select or remain with the Medicaid maternity care provider of her choice; and allow pregnant women to receive all medically necessary obstetrical and prenatal care without prior authorization. Contracted health plans must also allow enrollees to seek family planning services, drugs and supplies and devices without prior authorization; and may not limit the type, duration or frequency of drugs, supplies and devices for the purpose of family planning.

Care coordination is also mandated in the Maternal Infant Health Program (MIHP), Michigan’s largest home visiting program targeting pregnant Medicaid enrollees and infants to age one. MIHP promotes healthy pregnancies, positive birth outcomes and healthy infant growth and development. MIHP provider organizations must be certified by MDHHS and adhere to program policies, procedures, and expectations outlined in Medicaid policy, the MIHP Program Operations Manual and Public Act 291 of 1012. Healthy Michigan Plan beneficiaries are eligible for MIHP services. Health plans are required to have written Care Coordination Agreements with MIHP providers in their service areas. Compliance with this requirement is monitored during health plan on-site surveys and MIHP provider on-site surveys.

Currently, MIHP benefits are carved-out of the MHPs. Beginning October 2016, MIHP will be carved-into managed care benefits. Health plans need to ensure the following components are implemented for the MIHP population: medical coordination,
including pharmacy and laboratory coordination; data and reporting requirements; quality assurance coordination; grievance and appeal resolution; dispute resolution; transportation; enrollee assignment to an MIHP provider organization within 30 days of MIHP eligibility determination (if the enrollee is not already enrolled in another evidenced based home-visiting program); sufficient number of MIHP providers to meet enrollee service and visitation needs within the required response time according to MDHHS MIHP protocols; and service delivery response times. In addition, the health plan must assign all MIHP-eligible enrollees to an MIHP provider organization for outreach, screening and care coordination if an enrollee is not already enrolled in another evidence-based home visiting program.

**Persons with Special Health Care Needs**

As of October 1, 2012, people who have both Children's Special Health Care Services (CSHCS) and Medicaid coverage are enrolled into a contracted health plan. The MHPs are responsible for all of the medical care and treatment of their CSHCS members. Community based services beyond medical care and treatment continue to be available through the local health department CSHCS offices.

To ensure continuity, MDHHS identifies CSHCS enrollees and provides contact information to the local health departments (LHD). The LHD conducts outreach and education with the CSHCS family to explain Medicaid Health Plan choices, assists the family in evaluating the health plan provider network and access to PCPs, and helps the enrollee make an informed decision regarding the selection of a plan. The plan then receives notification of member enrollment for the Medicaid beneficiary. The health plan is required to contact the enrollee/family and establish care management procedures and referrals to specialists. MDHHS assesses plan compliance with CSHCS enrollment procedures during the plan’s annual on-site compliance review visit. MDHHS also receives monthly reports from MI Enrolls regarding plan enrollment activity.

For persons with special health care needs, contracted health plans are required to **conduct an assessment** to identify any special conditions of the enrollee that require ongoing case management services and develop a **family-centered care plan**. These assessments must be conducted by appropriate health care professionals. Plans are also required to allow direct access to specialists, as appropriate; and provide case management and/or care coordination services based on the enrollee’s condition and identified needs. For individuals requiring case management services, plans are required to maintain documentation that demonstrates the outcome of the assessment and services provided based on the special conditions of the enrollee (Section 1.022 (F)(17)).

MDHHS encourages health plans to seeks contracts with providers with established relationships with CSHCS enrollees; if the primary and specialty care provider does not wish to join the Contractor’s network, the plan is required to work with the non-contracted provider on care coordination, prior authorization and medical management. Health plans must allow CSHCS enrollees to remain with primary and specialty care providers with whom they have an established relationship at the time of enrollment in the health plan. Plans are required to work with the family and established primary and specialty care providers to assure access to the most appropriate provider for the enrollee. CSHCS enrollees may be brought into network through transition to an appropriate network provider upon consultation and arrangement with the family and the care team. If a non-contracted provider declines the plan’s offer to participate in the plans network and refuses to coordinate with the health plan’s
case management team on prior authorization and medical management, the plan may move the CSHCS enrollee to a network provider. In the event that the plan does not have a contract with the provider, all claims should be paid at the Medicaid FFS rate.

Section 1.022(F)(13) requires contracted health plans to facilitate support services that are not the direct responsibility of the plan, but are services to which enrollees may be entitled. This care coordination should be provided consistent with individual or person-centered planning necessary for enrollees with special health care needs.

In order to preserve continuity of care for ancillary services, such as therapies and medical supplies, contracted plans must accept prior authorizations in place at the time of enrollment. If the prior authorization is with a non-network ancillary provider, plans must reimburse the ancillary provider at the Medicaid rate through the duration of the prior authorization until the beneficiary can be safely brought into the network. Upon expiration of the prior authorization, plans may use existing prior authorization procedures and network ancillary services.

**Case Management, Care Coordination, and Disease Management**

Case management is a coordination of care and services, (e.g., home health services, therapies, durable medical equipment) provided to members needing extended use of resources and help navigating the system of care. Disease management is a proactive multidisciplinary process and approach to identify populations with, or at risk for chronic medical conditions. Contracted health plans are required to provide case management, care coordination, and disease management to meet the complex health care needs of enrollees, including but not limited to those with special health care needs, disabled populations, high-risk pregnancy, and children with elevated blood lead. These services must be operationally integrated into the Contractor's utilization management and enrollee services. Plans must also refer enrollees to and coordinate services with appropriate resources to reduce socioeconomic barriers and address social determinant of health (e.g., access to safe and affordable housing, employment, food, fuel assistance and transportation to health care appointments).

Both complex case management and disease management are required for mandatory health plan accreditation. Health plans are required to conduct population analyses on an ongoing basis and apply specified criteria for beneficiary inclusion in case management and/or disease management programs. This process includes stratification of the plan population or sub-populations based on the beneficiary’s health status, condition, severity, current or anticipated health care needs, and utilization. Plans are required to appropriately tailor interventions and develop individualized plans of care. To administer these programs, plans must maintain sufficient IT systems, including population registries, risk stratification and intervention tracking, care management functions, tracking, and outcomes assessment.
Sections of the Michigan Medicaid Health Plan contract pertaining to coordination and continuity of care are cited below:

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>Description</th>
<th>Michigan Medicaid Health Plan Contract Page Number or Comment*</th>
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<tbody>
<tr>
<td>§438.208</td>
<td><strong>Coordinating and Continuity of Care</strong></td>
<td></td>
</tr>
<tr>
<td>§438.208(b)(1)</td>
<td>Each enrollee has an ongoing source of primary care appropriate to his or her needs</td>
<td>1.022(S)(1)</td>
</tr>
<tr>
<td>§438.208(b)(2)</td>
<td>All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP</td>
<td>1.022(W)(X)</td>
</tr>
<tr>
<td>§438.208(b)(3)</td>
<td>Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services</td>
<td>1.022(W)(X); 1.022(F)(22)</td>
</tr>
<tr>
<td>§438.208(b)(4)</td>
<td>Protect enrollee privacy when coordinating care</td>
<td>1.022(W)(5)</td>
</tr>
<tr>
<td>§438.208(c)(1)</td>
<td>State mechanisms to identify persons with special health care needs</td>
<td>1.032(17)</td>
</tr>
<tr>
<td>§438.208(c)(2)</td>
<td>Mechanisms to assess enrollees with special health care needs by appropriate health care professionals</td>
<td>1.022(F)(17)(a)</td>
</tr>
<tr>
<td>§438.208(c)(3)</td>
<td>If applicable, treatment plans developed by the enrollee’s primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee, approved in a timely manner, and in accord with applicable state standards</td>
<td>1.022(F)(18)</td>
</tr>
<tr>
<td>§438.208(c)(4)</td>
<td>Direct access to specialists for enrollees with special health care needs</td>
<td>1.022(F)(17)(b)</td>
</tr>
</tbody>
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* In May 2015, MDHHS had a request for proposal for the Comprehensive Health Plan for Michigan’s Medicaid Health Plans (MHPs). A new contract is being prepared for a January 1, 2016 effective date.

**Coverage and Authorization of Services**

The Michigan Medicaid Health Plan contract requires plans to have a utilization management (UM) program that encompasses, at a minimum, written policies with review decision criteria and procedures that conform to managed care industry standards; a formal utilization review committee directed by the plan medical director to oversee the UM process; sufficient resources to regularly review the UM process and make changes, as needed; an annual review and reporting of UM activities, outcomes, and interventions; and UM program integration with the plan’s quality assessment and improvement program (QAPI).

Section 1.022(E)(1) of the Medicaid Health Plan contract describes covered services. In general, covered services are related to the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity. Health plans are required to use all applicable Medicaid provider manuals and publications for coverage and limitations. If new services are added or if services are expanded, eliminated, or otherwise changed, the plan must implement changes consistent with State direction in accordance with the provisions of Medicaid contract Section 2.024. Plans are required to provide a full range of covered services listed in Section 1.022(E)(1), including inpatient and outpatient hospital; Federally Qualified Health Center (FQHC); laboratory and x-ray; short-
term and long-term restorative; Early and Periodic Screening, Diagnosis and Treatment (EPSDT); family planning; maternal and infant health services; outpatient mental health visits; physician services; home health services; vision; hearing aids; and emergency services. Plans may also choose to provide services over and above those specified.

In conjunction with covered services, section 1.022(E)(2) specifies enhanced services to be covered, including health promotion, education, early intervention and management strategies for various illnesses, and collaborative projects with other plans focusing on improvements in the overall delivery of health services.

Carve-out services for Medicaid include, but are not limited to mental health (inpatient and outpatient) and substance abuse; dental, and custodial in long term care (LTC) beyond 45 days. Dental and vision services are covered services for HMP enrollees (e.g., are not carved-out).

All health plan policies, procedures, and clinical guidelines supporting coverage, medical necessity, and authorization determinations must be in writing and available to MDHHS and/or CMS upon request. The plan’s medical director or physician designee must be actively involved in all health plan medical necessity determinations. These policies and procedures are reviewed extensively during the health plan accreditation process, where cases are reviewed to ensure adherence to policies, procedures, and timelines. MDHHS assesses plan compliance with requirements for coverage and authorization during the annual on-site visit.

As part of the UM program, contracted health plans must establish and use prior approval policies and procedures. These procedures must prohibit plans from avoiding the provision of medically necessary services. Policies must ensure that review criteria for Authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review and is not incentivized to deny, limit, or discontinue medically necessary services. For prior authorization decisions related to CSHCS enrollees, plans are encouraged to consult with the Office of Medical Affairs Medical Consultants to determine pediatric sub specialists, hospitals and ancillary providers available and appropriate to render services to CSHCS enrollees.

The plan’s authorization policy must establish timeframes for standard and expedited authorization decisions. These timeframes may not exceed 14 calendar days from date of receipt for standard authorization decisions and 3 working days from date of receipt for expedited authorization decisions. These timeframes may be extended up to 14 additional calendar days if requested by the provider or enrollee or if the plan justifies the need for additional information and explains how the extension is in the enrollee’s interest. The enrollee must be notified in writing of the plan’s intent to extend the timeframe. Plans must ensure that individuals conducting UM activities are not compensated or incentivized to deny, limit, or discontinue medically necessary services. If an authorization decision is not made within the specific timeframes, the plan must issue an adverse action notice as described in Section 1.022(I). Prior authorization processes and timeframes, denials, and appeals are also extensively reviewed during the health plan accreditation process.
Sections of the Michigan Medicaid Health Plan contract pertaining to coverage and authorization of services are cited below:

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<tr>
<td>§438.210</td>
<td>Coverage and Authorization of Services</td>
<td></td>
</tr>
<tr>
<td>§438.210(a)(1)</td>
<td>Identify, define, and specify the amount, duration, and scope of each service</td>
<td>1.022(E)(1-2);(F)(1)(c);(F)(2)</td>
</tr>
<tr>
<td>§438.210(a)(2)</td>
<td>Services are furnished in an amount, duration, and scope that is no less than those furnished to beneficiaries under fee-for-service Medicaid</td>
<td>1.022 (E)</td>
</tr>
<tr>
<td>§438.210(a)(3)(i)</td>
<td>Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished</td>
<td>1.022 (E)(1)</td>
</tr>
<tr>
<td>§438.210(a)(3)(ii)</td>
<td>No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition</td>
<td>1.022 (E)(1)</td>
</tr>
<tr>
<td>§438.210(a)(3)(iii)</td>
<td>Each MCO/PIHP may place appropriate limits on a service, such as medical necessity</td>
<td>1.022 (E)(1)</td>
</tr>
<tr>
<td>§438.210(a)(4)</td>
<td>Specify what constitutes “medically necessary service”</td>
<td>1.022 (A)(10)</td>
</tr>
<tr>
<td>§438.210(b)(1)</td>
<td>Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services</td>
<td>§1.022(AA)(2)</td>
</tr>
<tr>
<td>§438.210(b)(2)</td>
<td>Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions</td>
<td>§1.022(AA)(2)</td>
</tr>
<tr>
<td>§438.210(b)(3)</td>
<td>Any decision to deny or reduce services is made by an appropriate healthcare professional</td>
<td>§1.022(AA)(2)</td>
</tr>
<tr>
<td>§438.210(c)</td>
<td>Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested</td>
<td>§1.022(AA)(2)</td>
</tr>
<tr>
<td>§438.210(d)</td>
<td>Provide for the authorization decisions and notices as set forth in §438.210(d)</td>
<td>§1.022(AA)(2)</td>
</tr>
<tr>
<td>§438.210(e)</td>
<td>Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services</td>
<td>§1.022(AA)(2)</td>
</tr>
</tbody>
</table>

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**Structure and Operations Standards**

In order to achieve Michigan Medicaid managed care objectives, contracted health plans are required to adhere to structure and operations standards delineated in the Medicaid contract. These standards ensure that plans have network of appropriately credentialed providers; enrollee information adheres to Federal regulations; confidentiality is maintained; and
Sections 1.022(K), 1.030, and 1.040 of the health plan contract require health plans to be in compliance with the following operational requirements, which MDHHS assesses prior to contracting and during annual on-site reviews:

- Certificate of Authority to operate as a health maintenance organization in Michigan
- Organizational structure with key specified personnel
- Management information systems capable of collecting, processing, reporting and maintaining information as required
- Governing body that meets contract specifications
- Administrative requirements (i.e., quality improvement/QAPI, utilization management, provider network, reporting, member services, provider services and staffing)

**Provider Selection**

Contracted health plan provider selection processes must include a requirement that the plans may not discriminate against any provider with respect to participation, reimbursement, or indemnification if the provider is acting within the scope of his or her license or certification under applicable state law, solely on the basis of such license or certification. Plans are also required to adhere to federal regulations and state law precluding reimbursement for any services ordered, prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program.

Section 1.022(V) of the health plan contract requires health plans to have policies and procedures in place to credential and recredential all providers prior to contracting, review, and authorize all network provider contracts, and comply with all federal and state business requirements. Health plans must also ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state. Health plans must also have written policies and procedures for monitoring contracted providers and for sanctioning providers who are out of compliance with the health plan’s quality and utilization management requirements. Section 1.022(V) of the Medicaid Health Plan contract requires plans to ensure that debarred or suspended providers are excluded from participation in their networks and identify and act upon potential fraud and abuse by members, providers, or plan employees. MDHHS assesses compliance with credentialing, recredentialing, contracting, and fraud and abuse monitoring during the annual on-site visit. Provider credentialing, recredentialing, and contracting are also components of the mandatory health plan accreditation process; plans must meet or exceed established standards to maintain accreditation status.

**Enrollee Information**

Section 1.022(H)(3)(a-b) of the contract requires health plan member handbooks to be current, clear, and understandable. Health plans are required to maintain documentation verifying that the information in the member handbook is reviewed for accuracy at least annually. The readability level of the member handbook must be written at no higher than a 6.9 grade reading level and must be available in languages other than English when more than five percent of the health plan’s enrollees speak another language. All written and oral materials directed to enrollees relating to benefits, coverage, enrollment, grievances,
appeals, or other administrative and service functions (e.g., handbooks, newsletters, member enrollment materials) must be approved by MDHHS prior to distribution to enrollees. In addition, member handbooks and marketing/educational materials are assessed by MDHHS contract managers during the annual on-site visit. Information required in member handbooks is also delineated in Section 1.022(H)(3)(b).

The provider directory is published separate from the member handbook. Section 1.022(H)(3)(c) specifies that the provider directory must list providers by county including provider name, address, telephone numbers and any hospital affiliation; day and hours of operation; languages spoken at the primary care sites; and whether the provider is accepting new patients. A list of all hospitals, pharmacies, medical suppliers, and other ancillary health providers must also be included. Health plans are required to review and update the provider directory (including web version) at least monthly and must submit a copy of their Medicaid provider directory to MDHHS as a component of their Annual Report, and MDHHS must approve the both the member handbook and the provider directory prior to distribution. MDHHS also assesses provider directories during the annual on-site visit.

Section 1.022(H)(2) requires health plans to establish and maintain web-based education and outreach specifically directed to CSHCS enrollees. The website must also provide a mechanism for CSHCS enrollees/families to contact specially trained staff to assist with access to services and enrollee-specific questions. Monitoring is a component of the compliance review process.

In addition, health plans must address the need for culturally appropriate interventions and make reasonable accommodations for enrollees with hearing and/or vision impairments including those with limited proficiency in English. Oral interpretation services must be available free of charge to all enrollees (Section 1.022 (H)(1)).

Confidentiality
Section 1.022(J) of the health plan contract requires plans to protect all enrollee information, medical records, data and data elements collected, maintained, or used in the administration of the contract from unauthorized disclosure. The health plan must provide safeguards that restrict the use or disclosure of information concerning enrollees in accordance with HIPAA privacy regulations. The health plan must have written policies and procedures for maintaining the confidentiality of data. MDHHS monitors plan adherence during the annual on-site visit.

Enrollment and Disenrollment
Section 1.022(A-C) of the contract specifies enrollment and lock-in processes. With exceptions noted in contractual provisions, health plan enrollment is for a period of 12 months. Enrollees may also disenroll for cause, including but not limited to poor quality of care or lack of access to necessary specialty covered services. A beneficiary may request a medical exception to enrollment in a health plan within 30 days of Medicaid enrollment if s/he has a serious medical condition and is undergoing active treatment for that condition with a physician that does not participate with the health plan at the time of enrollment. The beneficiary must submit a medical exception request to MDHHS. MDHHS tracks disenrollments and transfers between health plans through a monthly report produced by MI Enrolls. MDHHS uses this report to monitor and assess for fluctuations, trends, and reasons for disenrollment or transfer and takes action, as appropriate.
Grievance Systems
Contracted health plans must have MDHHS approved, written policies and procedures for the resolution of grievances and appeals. The enrollees must be informed about the plan’s internal grievance procedures at the time of initial enrollment and any other time an enrollee expressed dissatisfaction by filing a grievance with the plan. MDHHS assesses compliance with complaint and grievance requirements during the annual on-site visit, which includes review of grievance and appeal logs. Grievance and appeals processes and compliance with timeframes is also a required component of the health plan accreditation process, which includes a review of complaint and grievance files. Plans must inform enrollees about internal grievance and appeal procedures at the time of initial enrollment and any time an enrollee files a grievance. When a plan makes a decision subject to appeal, a written adverse action notice must be provided to the enrollee and the requesting provider. Grievance and appeal requirements are outlined in Section 1.022(1)(1-7).

Intermediate Sanctions
Section 1.022(EE) of the Medicaid Health Plan contract outlines the process for the use of intermediate sanctions that may include:

- Civil monetary penalties
- Appointment of temporary management
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll
- Suspension of all new enrollment (including auto-assignment)
- Suspension of payment for recipients
- Additional sanctions allowed under state statute or regulation that address areas of noncompliance.

The State may terminate the plan contract if intermediate sanctions or general remedies are not successful (or if MDHHS determines that immediate termination of the Contract is appropriate (per section 2.152 of the Medicaid Health Plan contract).

Subcontractor Relationships and Delegation
Sections 2.070, 2.071, 2.072, 2.073 of the contract specify that plans are responsible for subcontractor adherence to all provisions of the health plan contract. The health plan is required to furnish information to the State regarding cost of the subcontract, procedures for oversight and monitoring of subcontractor performance, and any other data that may be required by the State. Section 2.070 of the contract indicates that the health plan shall not delegate any duties or obligations to a Health Benefits Manager not named in the bid unless MDHHS is notified 30 days prior to the effective date of the contract. Delegation is a component of the mandatory health plan accreditation process and is also monitored by the Department of Insurance and Financial Services (DIFS) as part of the annual review of licensed Michigan health maintenance organizations.
Sections of the Michigan Medicaid Health Plan contract pertaining to structure and operations are cited below:

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>Description</th>
<th>Michigan Medicaid Health Plan Contract Page Number or Comment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.214</td>
<td><strong>Provider Selection</strong></td>
<td></td>
</tr>
<tr>
<td>§438.214(a)</td>
<td>Written policies and procedures for selection and retention of providers</td>
<td>1.022 (S)(1)</td>
</tr>
<tr>
<td>§438.214(b)(1)</td>
<td>Uniform credentialing and recredentialing policy that each MCO/PIHP must follow</td>
<td>1.022 (S)(1)</td>
</tr>
<tr>
<td>§438.214(b)(2)</td>
<td>Documented process for credentialing and recredentialing that each MCO/PIHP must follow</td>
<td>1.022 (V)(1-2) 1.022 (N)</td>
</tr>
<tr>
<td>§438.214(c)</td>
<td>Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment</td>
<td>1.022 (U)(2)</td>
</tr>
<tr>
<td>§438.214(d)</td>
<td>MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs</td>
<td>1.022 (O)(4)</td>
</tr>
<tr>
<td>§438.218</td>
<td><strong>Enrollee Information</strong></td>
<td></td>
</tr>
<tr>
<td>§438.218</td>
<td>Incorporate the requirements of §438.210</td>
<td>1.022 (N)(3);(H)(2-3);(J);(A-C)</td>
</tr>
<tr>
<td>§438.224</td>
<td><strong>Confidentiality</strong></td>
<td></td>
</tr>
<tr>
<td>§438.224</td>
<td>Individually identifiable health information is disclosed in accordance with Federal privacy requirements</td>
<td>1.022 (FF)(2)</td>
</tr>
<tr>
<td>§438.226</td>
<td><strong>Enrollment and Disenrollment</strong></td>
<td></td>
</tr>
<tr>
<td>§438.226</td>
<td>Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in §438.56</td>
<td>1.022(A)(1);(B)(C)</td>
</tr>
<tr>
<td>§438.228</td>
<td><strong>Grievance Systems</strong></td>
<td></td>
</tr>
<tr>
<td>§438.228(a)</td>
<td>Grievance system meets the requirements of Part 438, subpart F</td>
<td>1.022(l)(a)</td>
</tr>
<tr>
<td>§438.228(b)</td>
<td>If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner</td>
<td>1.022 (l)(3)</td>
</tr>
<tr>
<td>§438.230</td>
<td><strong>Subcontractual Relationships and Delegation</strong></td>
<td></td>
</tr>
<tr>
<td>§438.230(a)</td>
<td>Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities</td>
<td>2.070; 2.071; 2.072; 2.073</td>
</tr>
<tr>
<td>§438.230(b)(1)</td>
<td>Before any delegation, each MCO/PIHP must evaluate prospective subcontractor’s ability to perform</td>
<td>2.091</td>
</tr>
</tbody>
</table>
Measurement and Improvement Standards
Michigan has established stringent measurement and improvement standards to assure contracted health plans meet or exceed program goals and objectives.

Practice Guidelines
Section 1.022(Z)(1)(b) of the contract requires Medicaid Health Plans to develop and/or adopt clinically appropriate practice parameters and protocols/guidelines and give their providers enough information about the protocols to enable them to meet the established standards. MDHHS and all contracted Medicaid Health Plans endorse the Michigan Quality Improvement Consortium (MQIC) guidelines. MQIC is a statewide collaborative body comprised of health plans, physicians, researchers, and others that develops, implements, and disseminates preventive and chronic disease clinical practices guidelines to Michigan physicians. In clinical areas where no MQIC guideline has been developed, MDHHS and Medicaid Health Plans adopt nationally recognized, evidence-based guidelines for care. Guidelines are disseminated to providers and are made available to enrollees upon request.

Health plans are required to demonstrate processes to adopt, implement, use, and measure clinical practice guidelines as a component of the mandatory accreditation process. MDHHS uses evidence-based guidelines to develop performance standards and measures for prevention and prevalent chronic conditions, which are incorporated into the QI program. Guidelines also serve as a basis for disease management, case management, and care management program development and intervention, and utilization management programming (e.g., medical necessity determination).

Quality Assurance and Performance Improvement (QAPI) Program
As previously discussed, Section 1.022(Z)(1-6) of the health plan contract requires contracted plans to maintain Quality Assessment and Improvement Programs (QAPs). Required QAPI elements are: written quality improvement plan with goals and objectives, lines of authority and accountability, data responsibilities, performance improvement activities, and evaluation tools. The plan must also describe how the plan will analyze processes and outcomes of care, determine reasons for variation in care, establish clinical and non-clinical priority areas and indicators for assessment and performance improvement, use measures to analyze the delivery of care and services (including over- and under-utilization) and trends, measure provider performance and establish feedback mechanisms, conduct peer review, establish utilization management standards and monitoring processes, conduct enrollee education, assess enrollee satisfaction, and implement improvement strategies. In
addition, the written QAPI must describe how the plan will ensure equitable distribution of health care services to their entire population, including members of racial/ethnic minorities, members whose primary language is not English, members in rural areas, and members with disabilities. Section 1.022Z(2) also requires health plans to conduct an annual effectiveness review of its QAPI. MDHHS assesses the QAPI program during the annual on-site Compliance Review.

Performance Improvement Projects
Section 1.022(Z)(3) of the Michigan Medicaid Health Plan contract requires health plans to conduct annual performance improvement projects that focus on clinical and non-clinical areas. MDHHS identifies priority areas for statewide PIPs through analysis of HEDIS® and CAHPS® data, population needs, legislative priorities and mandates, and topics based on the state and national health care agenda. These priority areas may vary from year to year, and MDHHS may require specific PIPs for a subset of plans based on individual plan performance, plan demographics (race, ethnicity, and other population characteristics), or prevalent conditions. PIPs are included in the plan’s QAPI program and must include use of objective indicators, system interventions, evaluation of interventions for effectiveness, and continuation of activities to sustain improvement. Recent examples of PIP topics include obesity (2011-13), blood lead testing, access to care for children/adults, and racial/ethnic disparities in screening for breast/cervical cancer. In 2014, health plans selected a PIP topic that was related to a special population identified by the plan to be implemented over a three year timeframe (2014-2016) as outlined in the Medicaid Health Plan EQR section of this document. In addition, Emergency Department (ED) Utilization is a focus bonus initiative in FY 2016 and 2017.

Health Information Systems
Section 1.022(P) of the health plan contract requires plans to maintain management information systems capability to collect, analyze, integrate and report data to achieve the objectives of the Medicaid Program. Plans are required to collect data on enrollee and provider characteristics and services delivered as outlined in the contract and required by MDHHS. This includes but is not limited to collecting and tracking enrollee-specific health risk assessment information, healthy behaviors and goals for HMP enrollees, and key health indicators.

Plans must ensure that data received from providers is accurate and complete by verifying accuracy and timeliness; screening for completeness, logic, and consistency; collecting information in standardized formats; and identifying/tracking fraud and abuse. Plans must meet the HIPAA and MDHHS guidelines and requirements for electronic billing capacity (Section 1.022(Y)(1)) and must have a management information system sufficient to support provider payments and data reporting between the health plan and MDHHS. The health plan must also collect service-specific procedure and diagnosis data and maintain detailed records of remittances to providers. Michigan Medicaid performance monitoring and data oversight processes require health plans to submit quarterly member complaint and grievance data, monthly claims and encounters, and monthly provider file data. Plans are also required to submit annual HEDIS data using the approved IDSS submission format.

Section 1.022(P)(5) of the health plan contract requires contracted health plans to comply with MDHHS performance programs and contract requirements designed to advance provider adoption and meaningful use of certified health information technology (HIT). MDHHS is implementing the Medicaid Electronic Health Record (EHR) incentive program pursuant to the final rule on
meaningful use of EHRs under the Medicare and Medicaid EHR incentive programs. Plans are encouraged to utilize these rules as guidelines when designing and establishing HIT programs and processes.

Contracted health plans must engage in activities that further MDHHS’s goal that Medicaid eligible professionals and hospitals become meaningful users. At a minimum, the Contractor should perform the following activities:
- Assist MDHHS in statewide efforts to target high volume Medicaid providers that may be eligible for the EHR incentive payments
- Align provider incentives with meaningful use measures
- Promote the EHR Incentive program as part of regular provider communications
- Exchange eligibility and claim information electronically to promote the use of electronic health records

Sections of the Michigan Medicaid health plan contract pertaining to measurement and improvement standards are cited below:

<table>
<thead>
<tr>
<th>Regulatory Reference</th>
<th>Description</th>
<th>Michigan Medicaid Health Plan Contract Page Number or Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>§438.236</td>
<td>Practice Guidelines</td>
<td>1.022 (N)(2); 1.022(P)(5); 1.022(Z)(1)</td>
</tr>
<tr>
<td>§438.236(b)</td>
<td>Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate</td>
<td>1.022 (Q)(6); 1.022(Z)(1)</td>
</tr>
<tr>
<td>§438.236(c)</td>
<td>Dissemination of practice guidelines to all providers, and upon request, to enrollees</td>
<td>1.022 (Z)</td>
</tr>
<tr>
<td>§438.240</td>
<td>Quality Assessment and Performance Improvement Program (QAPI)</td>
<td></td>
</tr>
<tr>
<td>§438.240(a)</td>
<td>Each MCO and PIHP must have an ongoing quality assessment and performance improvement program</td>
<td>1.022(Z)(1);(Z)(3)</td>
</tr>
<tr>
<td>§438.240(b)(1)&amp;(d)</td>
<td>Each MCO and PIHP must conduct PIPs and measure and report to the state its performance; list out PIPs in the Quality Strategy</td>
<td>1.022 (Z)</td>
</tr>
<tr>
<td>§438.240(b)(2)&amp;(c)</td>
<td>Each MCO and PIHP must measure and report performance measurement data as specified by the state; list out performance measures in the Quality Strategy</td>
<td>1.022 (Z)</td>
</tr>
<tr>
<td>§438.240(b)(3)</td>
<td>Each MCO and PIHP must have mechanisms to detect both under- and over-utilization of services</td>
<td>1.022 (Z)(1-2); 1.022 (AA)</td>
</tr>
<tr>
<td>§438.240(b)(4)</td>
<td>Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs</td>
<td>1.022(Z)</td>
</tr>
<tr>
<td>§438.240(e)</td>
<td>Annual review by the state of each quality assessment and performance improvement program; if the state requires that an MCO or PIHP have in effect a process for its own</td>
<td>1.022 (Z)(3)</td>
</tr>
</tbody>
</table>
evaluation of the impact and effectiveness of the QAPI, indicate this in the Quality Strategy.

§438.242 Health Information Systems

§438.242(a) Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility

§438.242(b)(1) Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees

§438.242(b)(2) Each MCO and PIHP must ensure data received is accurate and complete

* In May 2015, MDHHS had a request for proposal for the Comprehensive Health Plan for Michigan’s Medicaid Health Plans (MHPs). A new contract is being prepared for a January 1, 2016 effective date.

Section IV: IMPROVEMENT AND INTERVENTIONS

MDHHS designs and implements quality improvement interventions based on assessment findings (i.e., HEDIS, CAHPS, performance improvement projects, EQR, performance monitoring standards, on-site reviews, health equity projects, and adult and child quality measures). To date, Michigan has identified and is focusing on the following topics:

- Maternal and child health (well child care, developmental screening, prenatal and postpartum care, early elective deliveries reduction)
- Special populations (pregnant women, CSHCS, foster care, dual enrollees)
- Emergency Department utilization/reduction
- Primary care delivery (prevention, access, care coordination, Patient-Centered Medical Home, patient engagement, integration of mental health services)
- Chronic care (diabetes, adult asthma, cardiovascular disease)
- Patient safety (pharmacy, EHR/meaningful use)

The following discussion summarizes Michigan’s interventions in these areas and how the state is attempting to align QI initiatives with the National Quality Strategy.

Maternal and Child Health

Examples of prior interventions to improve maternal and child health have included: modifying payment policies for preventive services (e.g., unbundling childhood immunizations from EPSDT services) to improve data quality; clarifying standardized screening payment codes to allow for increased numbers of screenings per day; reinforcing evidence-based guidelines by aligning Medicaid policy with American Academy of Pediatrics guidelines for preventive services; and collaborative health plan activities to improve lead screening rates.
In addition, current maternal and child health interventions include: improving standardized developmental screening rates through cross-agency collaboration with MDHHS Maternal and Child Health, the Michigan Department of Education (Part C Early Intervention Program), health systems, and local public health. MDHHS has been reporting developmental screening rates to the MHPs since 2013, and developmental screening is a component of the MHP Performance Monitoring Standards.

Medicaid is also collaborating with the health plans, the Bureau of Maternal and Child Health, local public health, and community providers to increase Maternal Infant Health Program (MIHP) services. MIHP is a well-established population-based home visiting program available to all Medicaid-eligible pregnant women and infants up to age one. It is Michigan’s largest home visiting program targeting pregnant Medicaid enrollees and infants in the first year of life with a goal of improving maternal and child health outcomes, particularly in the areas of prenatal/postpartum care and well child exams.

On August 1, 2012 Michigan’s Governor signed into law Act No. 291, Public Acts of 2012 ensuring the state's investment in home visiting goes to proven, effective programs. The Act mandates that home visiting programs track and measure outcomes such as preterm births, reduction in child abuse, improved family self-sufficiency, and increased school readiness. The law requires that all of Michigan’s funding for home visiting go to support evidence-based or promising programs, ensuring the state will receive solid returns on investment for taxpayers and strong results for participating families. Michigan Medicaid supports and is an active participant in efforts across state agencies/departments to achieve the requirements outlined in the Act. As a result, MDHHS successfully produced the first Home Visiting Initiative Report in December 2014.

The Maternal Infant Health Program (MIHP) meets the PA 291 evidence-based model requirement as a result of independent evaluation of the MIHP conducted by Michigan State University. Using a quasi-experimental study design, research indicates that MIHP participation has favorable effects on:

- Prenatal Care: MIHP participation increased the likelihood of receiving prenatal care and improved the prenatal care adequacy.
- Birth Outcomes: Participation in MIHP reduced risks of prematurity, extreme prematurity, low birth weight, and very low birth weight.
- Maternal Postnatal Care: MIHP participation increased the likelihood of mothers receiving an appropriate postnatal checkup.
- Infant health care: Participation in MIHP increased the likelihood for infants to present for any well-child visits and of receiving the appropriate number of well-child visits during the first year of life.

MIHP participation demonstrated favorable effects on infant mortality among Black infants and among infants of other races and were robust in reducing neonatal mortality.⁸

MIHP has also demonstrated cost savings due to the reduction in the preterm birth rates.⁹

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Michigan also receives grant funding from the *Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP)*, a provision of the Affordable Care Act of 2010. The current MIECHVP funding, which runs through September 2017, provides an opportunity to deliver evidence-based, early childhood home visiting services to improve outcomes for families who reside in at-risk communities. The funds are being used to continue to expand and improve home visiting services in several counties; build infrastructure to support the quality and success of home visiting services; and expand local stakeholder involvement and coordination. Past awards have similarly been used to help strengthen Michigan’s home visiting system and support integration of early childhood home visiting within Michigan’s Great Start Early Childhood system. The Michigan Home Visiting Initiative is a multi-agency effort of the MDHHS in support of Michigan families to implement evidence-based home visiting programs that are proven to be an effective way to improve health, safety, and child development. Medicaid actively supports this grant, which seeks to improve home visiting for at-risk populations, including Medicaid women and children.

In 2012, Michigan was awarded a *CMS Adult Medicaid Quality (AMQ) grant* and selected early elective deliveries (PC-01) from the Adult Core Set as one of the two required quality improvement project topics. Interventions include collaboration with the Michigan Health and Hospital Association, the Bureau of Maternal and Child Health, the Medicaid health plans, the March of Dimes, and advocacy groups such as the Michigan Council for Maternal and Child Health. As a result of the AMQ grant, in 2014 a web-based educational course was developed for the Maternal Infant Health Program (MIHP) providers, and the MIHP maternal plans of care were revised to ensure all women received educational information on early elective deliveries. The educational materials were developed using current literature and evidence-based guidelines.

In September 2014, MDHHS conducted an in-depth analysis of the Cesarean Rate for Nulliparous Singleton Vertex (NSV) (PC-02) and Low Birth Weight (LBW) Child Core Set measures. Preliminary analyses indicate that among the Medicaid births in 2013, Michigan’s live birth rate for infants weighing less than 2500 grams was 8.5%; and the very low birth rate (less than 1500 grams) was 1.5%. The 2013 cesarean deliveries rate for nulliparous singleton vertex births was 19.5% for low-risk women. MDHHS will continue to report and monitor these data on an ongoing basis and compare Michigan rates to established benchmarks moving forward.

MDHHS participated in the *Center for Medicaid and CHIP Services’ (CMCS) Maternal and Infant Health Initiative – A Focus on Women’s Health* in 2015. The aim of the initiative is to increase the rate of postpartum visits by 10%, and improve the content of postpartum care over a three-year period. MDHHS facilitated the collaborative efforts with technical support from the Bureau of Maternal and Child Health and in partnership with four of the contracted health plans and their identified pilot practices. The goals of the collaborative were to increase by 10% both the rate of postpartum care visits and the use of Medicaid transportation services for postpartum care visits by clarifying and streamlining the transportation process and

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facilitating referrals between participants. The collaborative, which used a PDSA approach, was initiated in January 2015 and concluded in September 2015. The qualitative component of the initiative was completed during October-November, 2015.

The Center for Medicaid and CHIP Services (CMCS) also awarded Michigan an "Adult Medicaid Quality: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP" grant in September 2015. This is a four-year project to collect and report data on a new developmental quality measure, Use of Contraceptive Methods in Women. The goal is to increase the use of effective methods of contraception among all women in Medicaid and CHIP as part of efforts to improve pregnancy planning and birth spacing. The initiative builds on the work of an Expert Panel that identified strategies CMS and states could undertake to improve maternal and infant outcomes in Medicaid and CHIP. Grant funding will increase Michigan’s capacity for standardized family planning data collection and reporting and identify opportunities for reproductive health care quality improvement. This new measure complements Michigan Medicaid’s (MM) strategy to implement all administrative measures in the 2014 CMS Maternity Core Set for Medicaid and CHIP. It also aligns with Michigan’s Infant Mortality Reduction Plan and assists MM managed care to improve access to effective contraception. The grant period is September 16, 2015 through September 15, 2019.

Health plans are required to annually collect and report HEDIS maternal and child health measures annually and Adult CAHPS and Child CAHPS surveys. These measures are included in the Performance Bonus (pay-for-performance) program, health plan performance monitoring standards, and consumer engagement materials such as the annual Medicaid consumer guide.

Health plans are also required to submit HEDIS data for the Medicaid Health Equity Project. Data is reported by race/ethnicity for multiple maternal and child health measures (breast, cervical and chlamydia screening; childhood immunizations; blood lead screening, access to care, well child visits, and postpartum care). Results are being used to identify targeted quality improvement projects.

Special Populations

Foster Children
Michigan Medicaid is participating in a cross-agency collaborative project with MDHHS to improve care and service delivery for children enrolled in foster care. Foster children are a high priority population and initiatives are in place to improve the delivery of well child services to these children (e.g., medical, dental, and developmental). To facilitate outreach, care coordination and case management activities, MHP enrollment files include a flag to identify children enrolled in foster care.

Duals
Michigan Medicaid has also received CMS funding and technical assistance to develop person-centered approaches to coordinate care across primary, acute, behavioral health, and long-term supports and services for dual-eligible enrollees. MI Health Link is a new Michigan health care program, which blends Medicare & Medicaid programs to eliminate gaps or overlaps
in care with care coordination as a primary benefit. The goal of MI Health Link is to provide seamless, high quality care through coordination of services currently covered separately by Medicare and Medicaid.

MI Health Link offers a broad range of medical and behavioral health services, nursing home care, pharmacy and home and community based services through new managed care entities called Integrated Care Organizations (ICO) and Medicaid’s existing Pre-paid Inpatient Health Plans (PIHP). ICOs, PIHPs and providers are connected through the Care Bridge, a web-based platform for information exchange that is used to coordinate supports and services. Enrollees currently eligible for the program include individuals who: reside in the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne, or any county in the Upper Peninsula; are age 21 or older; have full Medicare and full Medicaid; and are not enrolled in hospice. Currently, four of the contracted Michigan Medicaid Health Plans participate in the MI Health Link program.

Children’s Special Health Care Services (CSHCS)
Prior to mandatory enrollment of the Children’s Special Health Care Services (CSHCS) population in Medicaid managed care, Medicaid convened a collaborative team comprised of Medicaid Policy, CHSCS staff, physician advisors, health plans, parents, and advocacy groups to guide the process. Activities included policy improvement, transitioning guidelines for benefit determination, assuring continuity of care, developing health plan core competencies and contractual requirements. Specific requirements for collaboration between contracted health plans and local public health departments were outlined in the 2015 Medicaid managed care re-bid including formal agreements for data sharing, communication, quality coordination, care coordination and care planning.

CSHCS integration was an element of the 2013 Performance Bonus (pay-for-performance) program, and the FY2013 and FY2014 compliance review focus study. MDHHS also implemented a CSHCS focus study as a component of the 2015 annual health plan compliance review. As a part of the 2015 focus study, “Secret Shopper” calls were made to each MHP using a call script developed by MDHHS. Questions asked during the calls related to CSHCS care and services including transportation, physical and speech therapy, durable medical equipment, referrals to community agencies, and the availability of health plan support and resources. The qualitative data was analyzed and areas of opportunity were addressed during MDHHS on-site compliance reviews.

A CSHCS-specific CAHPS survey will be conducted in 2016. The 2016 MHP Performance Bonus will also include CAHPS scores for special populations including CSHCS.

In 2014, Michigan was selected to participate in the Association of Maternal and Child Health Programs (AMCHP) Action Learning Collaborative (ALC), Taking a Leadership Role in Transitioning to Medicaid Managed Care. Teams are comprised of CYSHCN directors and key partners including Medicaid/CHIP, providers, health plans, and families/consumers. The purpose of the ALC is to provide targeted technical assistance for states transitioning Children & Youth with Special Health Care Needs (CYSHCN) into Medicaid managed care and to identify opportunities to improve the quality of care delivered to enrollees.
in Medicaid managed care. Michigan’s team attended a kickoff meeting of the ALC in April 2014 and identified improvement in care coordination and case management as focus for the State’s participation strategy. Michigan’s efforts focus on developing strategies to strengthen and integrate care coordination and case management for Medicaid families receiving CYSHCN services. Participants include Medicaid Health Plans, local public health departments, Children’s Multidisciplinary Specialty Clinics, health systems, providers, and families.

**Emergency Department Reduction**
Michigan has consistently identified inappropriate Emergency Department (ED) use as a safety, coordination of care, and cost issue for the Medicaid population. Reducing inappropriate ED use is a departmental priority and a legislative mandate. Public Act (PA) 107 of 2013 calls for innovative and concerted efforts to improve quality and reduce costs by focusing on emergency department (ED) utilization; and authorizes use of the performance bonus incentive to include such endeavors. PA 107 called for a symposium to examine the issues of ED utilization and provide best practice recommendations for its reduction to the legislature by December 31, 2014. In response to the request, statewide work groups met to identify and refine best-practice recommendations to address patterns of high ED utilization and define “improper emergency service usage.” The Symposium report outlines 11 recommendations to address the complex healthcare needs of individuals visiting the ED.\(^\text{10}\)

PA 107 also requires that ED utilization be included in the MHP Performance Bonus. The Medicaid Health Plans will be required to conduct a focus study on ED utilization during 2016-2017. The purpose of the FY 2016-2017 ED Utilization Focus Bonus is to formulate a process to: a) develop an in-depth understanding of ED Utilization relative to the plan’s population of interest; and b) design interventions that move towards a more systematic approach to addressing complex issues that impact beneficiary utilization. MHPs will explore and create a range of innovations and initiatives and focus interventions on high-risk or problem-prone areas to improve the effectiveness and performance of ED utilization. The MHPs are conducting pre-work for these ED utilization initiatives during FY 2015.

**Primary Care Delivery**

**Patient-Centered Medical Home**
MDHHS recognizes the need to support a robust primary care delivery system based on a patient centered medical home (PCMH) model to ensure patient care is managed across a continuum of care and specialty services will be accessed as appropriate. Contracted health plans are expected to develop initiatives to promote and support PCMH adoption among primary care providers and commit to increasing the percentage of enrollees receiving services from PCMH-designated practices (e.g., National Committee for Quality Assurance or Blue Cross Blue Shield of Michigan’s Provider Group Incentive Program). PCMH expansion supports population health management concepts including person-centered care, and care coordination/case

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management. Plans must coordinate with practice-based care management and Michigan Primary Care Transformation (MiPCT) care managers for enrollees and report semi-annually on the percentage of primary care practices with embedded or shared care managers.

MDHHS is leading the Michigan Primary Care Transformation Project (MiPCT). This CMS Multi-Payer Advanced Primary Care Demonstration Project is the largest in the county and seeks to expand primary care and improve care coordination in patient centered medical homes. The three year demonstration began in January of 2012 and Michigan was granted a two-year extension in December 2014. The Demonstration is expected to conclude in December 2016.

Michigan Medicaid is actively participating in MiPCT and partnered with Medicare, Blue Cross Blue Shield of Michigan, Blue Care Network, and Priority Health to create a multi-payer bonus to incentivize physicians to fully implement the PCMH model. The MiPCT demonstration supports population health management as well as evidence and value-based care delivery models (supported by health information technology/health information exchange), to build a Medicaid managed care delivery system that maximizes the health status of beneficiaries, improves beneficiary experience and lowers cost. Key components of MiPCT include, pay for value, integration of care and structural transformation (e.g., registries, dashboards, support for health information technology and analytics). Focus areas include care management, self-management support, care coordination, and linkages to community services.

The demonstration is evaluating whether PCMH practices with additional financial support will:

- Reduce unjustified variation in utilization and expenditures;
- Improve the safety, effectiveness, timeliness, and efficiency of health care;
- Increase the ability of beneficiaries to participate in decisions concerning their care;
- Increase the availability and delivery of care that is consistent with evidence-based guidelines in historically underserved areas; and
- Reduce unjustified variation in utilization and expenditures under the Medicare program.

The MiPCT links with and creates synergy with the State Innovation Model (SIM) and Blueprint for Health. MiPCT is a building block for advanced primary care delivery in Michigan, integrates with the ability of organized systems of care to improve the delivery of care, and is a proof of concept for multi-payer participation. Contracted health plans are expected to participate in these community-based initiatives as they are developed and implemented in the plan’s service areas.

Health plan accreditation also requires plans to comply with standards to improve elements of the PCMH (e.g., access, care coordination, population management, health information technology).

Chronic Care
Section 1.022(F)(18) of the Medicaid Health Plan contract requires plans to provide disease management and case management programs for beneficiaries with, or at risk for, chronic medical conditions. Case management must be provided for beneficiaries with complex needs or requiring extended use of resources. Contractually mandated health plan
**accreditation** requires plans to meet stringent disease management standards required by the accrediting bodies. Examples of current disease management programs conducted by the health plans include diabetes, asthma, hypertension, cardiovascular disease, congestive health failure, chronic obstructive pulmonary disease, chronic kidney disease, depression, and substance abuse. Chronic care topics included in the Medicaid performance bonus (*pay-for-performance*) are diabetes, cardiovascular disease, and asthma).

Michigan was awarded a **CMS Adult Medicaid Quality (AMQ) grant** to improve Medicaid’s capacity to collect, analyze, and report on the quality of care adult beneficiaries receive. The AMQ grant focused on the CMS Adult Core Set measures and also required two quality improvement projects. Michigan selected adult asthma and early elective deliveries (EED) as areas of focus.

Chronic conditions in the Adult Core Set measures include:
- Comprehensive Diabetes care: Hemoglobin A1c Testing (NQF 0057)
- Asthma in Younger Adults Admission Rate (NQF 0283)
- Diabetes Short-Term Complications Admission Rate (NQF 0272)
- Heart Failure Admission Rate (NQF 0277)
- Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (NQF 0275)

The identification and management of chronic conditions are also components of PCMH and MiPCT.

Section 2703 of the Affordable Care Act provides a State option for health homes for enrollees with chronic conditions. **Michigan’s Primary Care Health Homes Program** provides an important opportunity for MDHHS to address and receive support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness. The health homes service delivery model creates a person-centered system of care that achieves improved outcomes for beneficiaries and better services and better value. The Health Homes Program facilitates access to an inter-disciplinary medical care, behavioral health care, and community-based social services and supports for children and adults with chronic conditions. MDHHS anticipates that the Program will lower rates of emergency room use, reduce hospital admissions/re-admissions, reduce health care costs, decrease reliance on long-term care facilities, and improve experience of care and quality of care outcomes.  

Beneficiaries eligible for the Health Homes Program include enrollees with: two or more chronic conditions; one chronic condition and at risk of having a second chronic condition; or one serious and persistent mental health condition. Chronic conditions include:

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11 Department of Health & Human Services, Centers for Medicare & Medicaid Services, State Medicaid Director Letter, SMDL# 10-024, ACA# 12  
- Mental health condition;
- Substance use disorder;
- Asthma;
- Diabetes;
- Heart disease;
- Body Mass Index"(BMI)over 25; or
- Other chronic condition.

Health Homes provide comprehensive care management services; care coordination and health promotion, comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services; and uses health information technology to link services.

In the past year, the MDHHS has taken action to improve the coordination of physical and behavioral health care by expanding the exchange of electronic health records to providers. **Care Connect 360**, an online, claims-based electronic health record (care management system), was developed and is currently available to Michigan’s contracted Medicaid Health Plans, Prepaid Inpatient Health plans (PIHP), and Community Mental Health Service Providers (CMHSP) for the purposes of sharing critical cross-system information. The CareConnect 360 database has information about paid claims that summarizes patients' medical and behavioral services to facilitate care coordination efforts across health care systems. The database makes it possible to more effectively assess and analyze populations and healthcare program data; enhance the decision-making process at the point of care; and improve outcomes. The MHPs are required to designate key personnel to oversee the appropriate use of the web-based care management system and maintain bidirectional exchange of information with PIHPs.

The Affordable Care Act required all Medicaid programs to cover all **tobacco cessation** medications beginning January 1, 2014. Limitations to coverage, including duration, prior authorization, using certain medications before others, and counseling to receive medications, however, varied by MHP. In an effort to support beneficiary smoking cessation efforts, in January 2016 MHPs must not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco treatments. The 2016 Pay for Performance Bonus also includes a component related to support for tobacco cessation services for beneficiaries.

**Patient Safety**
During fiscal year 2010, MDHHS implemented a **pay-for-performance** incentive for contracted health plans to promote e-prescribing. Following implementation, Medicaid has monitored e-prescribing usage for managed care and FFS enrollees. As a result, Medicaid Health Plans have implemented e-prescribing initiatives, and Michigan has one of the highest rates of e-prescribing in the country. E-prescribing was a scored component of the Medicaid Comprehensive Health Care Program 2015 re-bid process.
\textit{E-prescribing} improves patient safety and quality of care; and is an important tool that allows health care practitioners to safely and efficiently manage patients' medications. With the increasing volume of medications and the growing complexity of patients' medical needs, there is an increased risk of errors and adverse drug events. Compared to paper or fax prescriptions, e-prescribing improves medication safety, prescribing accuracy and efficiency; and increases practice efficiency. It provides the practitioner with access to a patient’s complete medication history, eliminates illegible prescriptions, reduces oral miscommunications, and includes warning and alert systems at the point of prescribing to reduce adverse drug events. E-prescribing also facilitates patient convenience thereby increasing patient compliance and decreasing the number of unfilled prescriptions. Finally, it can produce direct cost savings through the identification of formulary medications and encourages an increased use of generic medications or lower cost therapeutically equivalent medications.\textsuperscript{12}

In addition, MDHHS is implementing a \textbf{Managed Care Common Formulary}. The development of the common formulary is required under Section 1806 of Public Act 84 of 2015. The purpose of the common formulary is to:

- Promote continuity of care
- Reduce interruptions in a beneficiary’s drug therapy due to a change in health plan
- Streamline drug coverage policies and reduce administrative burden for providers
- Facilitate collaboration among health plans

The common formulary will promote safe medication transitions and minimize the burden on patients and prescribers. It will also reduce interruptions in a beneficiary’s drug therapy due to a change in health plan. All contracted health plans will be required to follow one set of policies and procedures for the transition of care and grandfathering of drug therapy. Health plans may be less restrictive, but not more restrictive, than the coverage parameters of the common formulary.

Managed care members will be transitioned to the Common Formulary within a 6-month period beginning in April 2016. Plans will code and test common formulary in claims systems from January through March 2016; and members will begin to be transitioned to the common formulary in April 2016. It is expected that all members' drug therapies will be transitioned to the common formulary by September 30, 2016. \textsuperscript{13}

\textit{Medication reconciliation} is a key component of the Primary Care Health Homes Program (e.g., transitions of care) supported by the Care Connect 360 web-based care management system. Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking including drug name, dosage, frequency, and route — and

\textsuperscript{12} Department of Health & Human Services, What Are Some Benefits of E-Prescribing http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/ElectronicPrescribing/benefitspres.html
\textsuperscript{13} MDHHS, Medicaid Policy 1540-Pharmacy, Medicaid Health Plan Common Formulary. https://www.michigan.gov/documents/mdch/1540-Pharmacy-P_496051_7.pdf
comparing that list against the admission, transfer, and/or discharge orders. The goal of medication reconciliation is to ensure that the medications patients are taking are correct and to prevent unintended changes or omissions of medications at all transition points. Medication reconciliation supports patient safety by preventing adverse drug events and patient harm.\textsuperscript{14}

**Changes in benefits for enrollees**
As previously discussed, Michigan’s 2014 Medicaid Expansion (Healthy Michigan Plan) has expanded benefits to cover vision, dental, hearing aids, and habilitative services. Benefit changes for 2016 include the requirement for plans to allow enrollees access to family planning services, drugs and supplies, and devices without prior authorization; or limitation of type, duration or frequency of drugs, supplies and devices. Similarly, MHPs may not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco cessation treatments. The 2015 Comprehensive Health Care Program re-bid also requires MHPs to provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to enrollees with significant behavioral health issues and complex physical co-morbidities. These MHP staff will conduct outreach and engagement activities, educate, and coordinate services for enrollees with a focus on social determinants of health. A significant change in 2016 benefit structure includes the implementation of a Common Formulary, which will provide consistency in the pharmacy benefit across MHPs.

**Health Information Technology**
Michigan’s Medicaid data warehouse plays a key role in the state’s ability to measure, evaluate, and report QI program outcomes. The warehouse also includes human services agency data (e.g., justice, treasury, and education), which provides for interdepartmental sharing of data by allowing individual department data to be linked to combine data. The investment in the State of Michigan has been recognized for its acquisition of a business intelligence system, which includes advanced analytics, data mining, data warehousing, and decision support capabilities.

It is estimated that the Michigan business intelligence (BI) system generates an estimated annual savings of between $75 and $100 million through health care analysis and a 25% reduction in Medicaid administrative costs associated with rapid response to queries, combined resources, and streamlining operations. The BI system has also doubled MDHHS’s identification of fraudulent Medicaid activity. Michigan’s data warehouse enables the department to conduct broader, more complex studies and initiatives involving multiple agencies. WIC data are housed in the warehouse and can be linked with Medicaid data for various uses, including program evaluation and outcome studies.

**Enhancements to the data warehouse** as a result of the CMS AMQ grant have allowed MDHHS staff to query the system at the desk level enhancing data analysis and the identification of opportunities for improvement. In addition, the AMQ grant allowed MDHHS to create the infrastructure to move forward with the development of a data mart for the purpose of

\textsuperscript{14} Institute for Healthcare Improvement, Reconcile Medications at All Transition Points.  
http://www.ihi.org/resources/Pages/Changes/ReconcileMedicationsatAllTransitionPoints.aspx
implementing a **Dashboard**. The data mart, which will include a defined subset of data pulled from the Medicaid data warehouse, will allow users to access data to track progress toward meeting established performance goals, and support quality improvement initiatives. The vision is to create an online manipulative database similar to the quarterly Medicaid Health Plan Performance Monitoring Standards Report that can be accessed real-time.

A key component of data analysis is the ability to link Medicaid data to Michigan vital records data. These linkages are essential to MDHHS’s ability to report the CMS Adult and Child Core measures Elective Delivery (PC-01), Cesarean Section (PC-02) and Live Births Weighing Less Than 2,500 Grams (LBW).

Michigan has also developed the **Michigan Care Improvement Registry (MCIR)**, formerly Michigan Childhood Immunization Registry. MCIR was initially created in 1998 to collect reliable immunization information for children; however, as a result of a 2006 revision to the Michigan Public Health Code, MCIR was able to transition from a childhood immunization registry to a lifespan registry including Michigan citizens of all ages. MCIR is an approved data source for HEDIS immunization and lead testing data; and has the potential to serve as a fully-functional birth to death registry for preventive and chronic health care indicators. Recent MCIR enhancements include the addition of a “flag” for children who are not up-to-date on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child visits according to the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule. All Medicaid Health Plans have access to MCIR for their respective members.

In the past year, MDHHS has taken action to improve the coordination of physical and behavioral health care by expanding the exchange of electronic health records to providers in two ways. The first is to develop an electronic data product called **Care Connect 360**. The online, claims-based electronic health record is currently available to Michigan’s contracted Medicaid Health Plans and Prepaid Inpatient Health plans (PIHP), and Community Mental Health Service Providers (CMHSP) for the purposes of sharing critical cross-system information. The CC360 database contains information about paid claims that summarizes patients' medical and behavioral services to facilitate care coordination efforts across health care systems. The database makes it possible to more effectively assess and analyze populations and healthcare program data; enhance the decision-making process at the point of care; and improve outcomes.

The second way is through real-time clinical information that also is becoming available through the **Michigan Health Information Network (MiHIN)**. Contractors are required to join the MiHIN Shared Services and engage and incentivize their provider network to increase the number and percentage of providers that are members of the Health Information Exchange Qualified Organization (HIE QO).

**Section V: Delivery System Reforms**

As previously discussed in the “Mandatory Populations and Special Health Care Needs” section of this document, the following populations were previously voluntary or excluded but are now mandatorily enrolled in managed care: pregnant women, most
categories of foster children, and CSHCS. The decision to mandate these populations was made after careful review of health plan performance in the areas of clinical care, access, network adequacy, member satisfaction, and administrative capacity.

Prior to mandatory enrollment for each group, MDHHS conducted extensive internal study and discussion, policy development and review, and developed an implementation plan. Proposals were presented at the Medical Care Advisory Council (MCAC) (comprised of members representing consumers, consumer advocates, health care providers, and the community).

**Pregnant Women**

Prior to mandatory enrollment, women newly eligible for Medicaid due to pregnancy had a choice to enroll in managed care or remain in Medicaid FFS. After studying quality, satisfaction, and cost data, MDHHS determined that mandatory enrollment of pregnant women would enhance outcomes for this population. MDHHS uses multiple data sources to track, trend, and monitor care and service delivery for pregnant women. Contracted plans are required to report audited HEDIS annually, which includes performance on prenatal and postpartum care indicators. Plans are also required to report monthly claims and encounters, which are cross-referenced with enrollment files and Vital Records matched birth and death records. These data are further analyzed against indicators for infant mortality, Maternal Infant Health Program participation, pregnancy services, and pregnancy risk. Under the scope of Michigan’s CMS Adult Quality Measures Grant, Michigan increased Medicaid analyst capacity to query and analyze Medicaid data for quality improvement purposes.

**Children’s Special Health Care Services (CSHCS)**

The decision to mandatorily enroll Children’s Special Health Care Services (CSHCS) beneficiaries was made to improve quality and cost outcomes. MDHHS strongly believed the opportunity to use a population management approach (including Medicaid managed care’s proven data reporting and analysis capabilities) would benefit quality and cost outcomes for this complex population. MDHHS developed a collaborative planning group comprised of Medicaid staff, CSHCS program staff and physicians, health plans, community partners, advocacy groups, and parents to ensure the smooth transition of the population to managed care. A component of the planning process was the development of performance-driven criteria to assess individual health plan capacity in the areas of network development, access, registry capability and data reporting, dedicated customer service support, coverage (e.g., durable medical equipment, pharmacy), and grievances/appeals. Health plans are required to document processes demonstrating capability to meet the needs of CSHCS families.

Prior to contracting for CSHCS, health plans were required to demonstrate the ability to analyze CSHCS-specific data for all relevant HEDIS measures and provide data on customer service inquiries, complaints, grievances, and access to care. Onsite compliance reviews were conducted in 2013 and 2014 to validate performance. In 2015, health plans bidding on the Comprehensive Health Care Program who were not previously approved to serve the CSHCS population in Michigan were required to meet submit documentation in support of the eight established core competencies. Bidders previously approved to serve the CSHCS population were required to attest that they have been approved and will continue to serve the CSHCS population in accordance with MDHHS core competencies.
**Foster Care**

Effective November 1, 2010, most categories of foster children were mandatorily enrolled in Medicaid managed care. Rationale for enrollment included demonstrated Medicaid Health Plan performance on well child care. Foster children comprise a complex population with high need for care coordination and integration between the medical and behavioral health care systems (also emphasized by contracted health plans). Foster children are all children committed to the Department of Human Services (DHS) or placed with the department by a court, or who are in out-of-home care.

Medicaid analyzes claims data in the data warehouse to identify rates of preventive and dental services received by children in foster care, timeliness of care, and provider type.

**MIChild**

MDHHS is converting the MIChild program to a Medicaid expansion program. Currently, Michigan administers its Title XXI CHIP as a stand-alone program titled MIChild. Effective January 1, 2016, MIChild will be administered through the Medicaid Health Plans (MHPs). Children currently enrolled in MIChild will be automatically transitioned into the MIChild Medicaid expansion program. MIChild enrollees will receive Medicaid benefit in accordance with current Medicaid policy, but will continue to pay a ten dollar ($10.00) premium. The MIChild Medicaid program will provide Medicaid health care coverage for children who are age zero to eighteen; have income at or below 212% of the Federal Poverty Level under the Modified Adjusted Gross Income methodology (MAGI); do not have other comprehensive medical insurance; do not qualify for other MAGI related Medicaid programs; and are residents of Michigan.

Administering MIChild through the MHPs gives this population access to Medicaid covered services not offered through the stand-alone MIChild program, including school based services, home help, Maternal Infant Health Program (MIHP), podiatry and non-emergency medical transportation (NEMT), expanded autism services, and a comprehensive array of preventive, diagnostic, and treatment services provided through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit as defined in the Medicaid Provider Manual. The transition to Medicaid also provides administrative efficiencies for both MDHHS and the MHPs.

Currently, Michigan Medicaid analyzes claims data to identify quality and timeliness of care received by children in the MIChild program. After January 2016, the MIChild population will be included in all Medicaid data analyses.

**Healthy Michigan Plan**

Medicaid began accepting applications for the Healthy Michigan Plan (HMP) in April 2015. As previously discussed, the intent of the HMP is to extend health care coverage to low-income Michigan citizens who are uninsured or underinsured and to implement systemic innovations to improve quality and stabilize health care costs through a continued emphasis on value-based services. Key features include incentives for healthy behaviors to encourage personal responsibility; encouraging use of high-value services; and promoting overall health and well-being. All HMP beneficiaries, with the exception of some beneficiaries (e.g., those who are voluntary or excluded), are required to enroll into a Medicaid Health Plan. Beneficiaries in the Adult Benefits Waiver were automatically transitioned into the Healthy Michigan Plan effective April 1, 2014.
Unique aspects of the HMP include the expectation that HMP enrollees contact their primary care physician within 60 days of enrollment to schedule an initial appointment. When contacted, providers are expected to make reasonable efforts to promptly schedule an appointment. Pursuant to PA 107 of 2013, sections 105d(1)e and 105d(12), a MDHHS developed a Health Risk Assessment (HRA) for the Healthy Michigan Plan. The HRA assesses a broad range of health issues and behaviors including, but not limited to, the following: obesity; physical activity; nutrition; alcohol, tobacco, and substance use; mental health; and immunizations. It also includes a readiness to change assessment, an annual physical exam and a discussion about behavior change with their primary care provider. While completion of an HRA is voluntary, HMP members enrolled in a health plan are encouraged to complete a HRA annually. HMP health plan enrollees have the opportunity to reduce and/or eliminate cost-sharing responsibilities if they complete the HRA and agree to address and/or maintain behaviors necessary for improving health as attested by their primary care provider (PCP).

Medicaid began analyzing enrollment and HRA data, and established performance monitoring metrics for the HMP in 2014. Among enrollees who completed the HRA with their PCP, 98.9% agreed to address health risk behaviors or maintain current healthy behaviors. The most frequently selected health risk behaviors enrollees chose to address (alone or in combination) are: weight loss, tobacco cessation, immunization status, follow-up of chronic conditions, and addressing alcohol or substance use.

**Payment Reform**

Paying for value is an integral component of Michigan’s strategy to improve the health and well-being of Medicaid beneficiaries. Key strategies include aligning payment around improving population health outcomes, member experience, and controlling cost. MDHHS is committed to moving away from fee-for-service (FFS) models and embracing accountable and transparent payment structures that reward and penalize based on defined performance metrics. Value-based payment models are defined as those that reward providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries.

Value-based payment models may include, but are not limited to:
- Total capitation models
- Limited capitation models
- Bundled payments
- Supplemental payments to build practice-based infrastructure and enrollee management capabilities
- Payment for new services that promote more coordinated and appropriate care, such as care management and community health work services, that are traditionally not reimbursable

Consistent with MDHHS’s policy to move reimbursement from FFS to value-based models, beginning in 2016 MHPs are contractually required to increase the total percentage of health care services reimbursed under value-based contracts.

Medicaid Health Plans must fully participate with MDHHS-directed initiatives to integrate systems of care and ensure all Medicaid beneficiaries, particularly those with complex physical, behavioral, and social service needs, are served by person-
centered models across all health care domains. MDHHS encourages the plans to propose and pilot innovative payment reform projects. Key concepts include performance bonuses linked to outcomes (e.g., reducing inappropriate ED use); common performance metrics (e.g., physical and behavioral health); value-based strategies (e.g., Patient Centered Medical Homes, leveraging health plan provider contracts to promote reform, shared savings); accountable systems of care/accountable care organizations; value purchasing; and payment and delivery system reform at the provider level.

Payment reform is also a central feature of the Healthy Michigan Plan. The HMP rewards providers for outcomes, including improving the quality of services provided, promotes provision of appropriate services, and aims to reduce the total cost of services provided to Medicaid beneficiaries. Key HMP concepts include: the advancement of health information technology; structural incentives for healthy behaviors and personal responsibility; and promoting the overall health and well-being of Michigan citizens.

The Managed Care Common Formulary also supports payment transformation and reduces drug costs through standardized drug coverage policies and reducing administrative burden for beneficiaries and providers.

Section VI: CONCLUSIONS AND OPPORTUNITIES

Health Plan Performance

Successes and Promising Practices
Michigan Medicaid’s managed care program structure continues to demonstrate success, with contracted plans meeting and exceeding established requirements in the areas of infrastructure, administrative practices, access and availability, coverage and benefits, quality assessment and improvement, and utilization. All plans meet the contractual requirement for accreditation by NCQA or URAC, providing an additional impetus for continuous improvement in programs and services delivered to beneficiaries.

HEDIS® performance levels for Michigan Medicaid Health Plans have been established based on national percentiles. Plans continue to demonstrate increases in the vast majority of measures, and plans meeting the high performance level are among the top in the nation. The Michigan Medicaid HEDIS 2014 Results showed statistically significant improvement in sixteen of thirty-one measures. Eight of these measures where in the child and adolescent care dimension (i.e., Appropriate Treatment for Children with Upper Respiratory Infection and Childhood Immunization Status—Combinations 4 through 10). In addition, the HEDIS 2014 statewide performance improved for the Obesity dimension of care when compared to 2013 HEDIS rates with three measures showing statistically significant improvement (i.e., Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total and Counseling for Physical Activity—Total, and Adult BMI Assessment).
The Michigan Medicaid HEDIS 2015 Results also demonstrated improvements. The HEDIS 2015 Michigan weighted average for the Immunizations for Adolescents – Combination 1 measure performed above the national HEDIS 2014 90th percentile; Appropriate Testing for Children with Pharyngitis improved significantly from 2014 (increase of 8.06 percentage points); and the Child and Adult BMI measures increased significantly from HEDIS 2014.

Similarly, Medicaid beneficiaries report high levels of satisfaction based on CAHPS results. The most recent (2014) Adult CAHPS indicated all four global ratings scored at or between the 50th and 89th national percentiles. The Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate composite measures scored at or between the 75th and 89th national percentiles. The Customer Service composite measure scored at or above the 50th to 74th percentile while trend analyses showed that Michigan Medicaid Health Plans demonstrated significant increases from 2013 to 2014 in Shared Decision Making measures. The 2014 Child CAHPS indicated the Rating of all Health Care and Rating of Personal Doctor composite measures scored at or between the 50th and 74th national percentiles. The Composite measures for Getting Care Quickly, and How Well Doctors Communicate scored at or above the 75th and 89th national percentiles. Results from the trend analysis showed that the Medicaid Health Plans scored significantly higher in 2014 than in 2012 on two measures: Getting Care Quickly and Customer Service.

Michigan Medicaid has a **strong collaborative model** with contracted health plans, which fosters goal alignment between state and plan-specific quality improvement programs. Plans actively participate in the development of statewide HEDIS and CAHPS goals and the Performance Monitoring Standards. Plans have also demonstrated collaborative success in projects such as:

- **Reducing Disparities at the Practice Site**, a three-year project funded by the Center for Health Care Strategies, where Detroit-area plans developed a shared bonus pool to incentivize physician practices to implement PCMH principles.

- **Medicaid Health Equity Project**, an ongoing initiative in which all Medicaid contracted health plans participated in developing methodology and are reporting a defined set of HEDIS® measures stratified by race/ethnicity.

- **Adult Medicaid Quality Grant**, a three-year project funded by the Centers for Medicare and Medicaid Services (CMS) designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Initial Core of Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Initial Core Set). The three main goals of this grant were to: (1) test and evaluate methods for collection and reporting of the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid; (2) develop staff capacity to report the data, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid; and (3) conduct at least two Medicaid quality improvement projects related to Initial Core Set Measures.

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16 MDHHS September 2014 Child CAHPS report, page 1-5.
• Maternal and Infant Health Initiative – A Focus on Women’s Health, an initiative supported by the Center for Medicaid and CHIP Services’ (CMCS) to increase the rate of postpartum visits and improve the content of postpartum care.

• Adult Medicaid Quality: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP grant, which utilizes the new CMCS developmental measure, Use of Contraceptive Methods by Women, to: (1) increase Michigan’s capacity for standardized family planning data collection and reporting; (2) track the removal of barriers to contraception access; and (3) identify opportunities for reproductive health care quality improvement.

• Million Hearts® is a national initiative intended to prevent 1 million heart attacks and strokes by 2017. Million Hearts® brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke.

• CMS State Demonstration to Integrate Care for Dual Eligible Individuals, which was initiated in January 2014, integrates care for persons dually eligible for Medicare and Medicaid. Four of Michigan’s contracted Medicaid Health Plans are participating in the demonstration as Integrated Care Organizations (ICOs).

• Alliance for Innovation on Maternal Health (AIM) Program is a national partnership of organizations poised to reduce severe maternal morbidity by 100,000 events and maternal mortality by 1,000 deaths by 2018. Over the next 4 years, Michigan’s AIM Program will implement safety bundles for Obstetric Hemorrhage and Severe Hypertension and data-driven quality improvement initiatives to improve maternal safety and decrease maternal morbidity and mortality. The AIM initiative will build upon the work already being done by the Michigan Health and Hospital Association (MHA) Keystone Center, which has supported and guided Michigan hospitals in the identification of best practices for the improving maternal health outcomes. The AIM proposal also aligns with Michigan's Infant Mortality Reduction Plan to promote healthier infants and mothers through an enhanced network of support systems to ensure that all Michigan infants survive to celebrate their first birthday and continue to thrive.

• MDHHS and the MHPs also participate in regularly scheduled meetings to collaboratively discuss and address issues dealing with the Medicaid population including: MHP-CAC; Medical Directors; Quality Improvement Directors; Pharmacy Directors; Maternal Child Health Workgroup; and Operations and Bi-Monthly meetings. Topics of discussion may include but are not limited to the MHP contract, Medicaid policy and procedure, and performance and monitoring (e.g., HEDIS, CAHPS, PIPs, etc.).

Ongoing Challenges and Opportunities
A critical opportunity for Michigan Medicaid is to conduct analyses for subpopulations and establish population performance thresholds and goals. This is particularly important given the implementation of the Healthy Michigan Plan Medicaid program and requirements to track, trend, and improve performance in care and service delivery for this population.
To meet these requirements, MDHHS has developed the infrastructure and capacity to generate data reports specific to the HMP and include these data in the quarterly Performance and Monitoring Report. (Attachment B)

Ongoing data collection and reporting for the Medicaid Health Equity Project continues to be a critical information source for analysis of subpopulations. The 2015 Medicaid Health Equity Project 3-Year report indicated that all fourteen of the Year 3 measures exhibited racial/ethnic differences to varying degrees. Rates for African American Medicaid beneficiaries fell below that of White beneficiaries for ten measures, and for eight of these measures the African American population had the lowest rate of all the populations considered. To address these disparities, beginning in 2016, all contracted health plans are required to develop a process for incorporating social determinants of health into processes for analyzing data in support of population health management. The new health plan requirement to provide or arrange for community health worker or peer-support specialist services for beneficiaries with significant behavioral health issues and complex physical co-morbidities, is also intended to positively impact these identified disparities. MDHHS acknowledges that while HEDIS measures applicable to subpopulations provide a starting point for data collection and reporting, population analyses may identify conditions of interest where there are no corresponding HEDIS measures. This will require additional benchmarking, providing an excellent opportunity to use available expertise (e.g., public health, epidemiology, and state and national experts in population health).

Opportunities to improve Medicaid statewide HEDIS performance in the dimensions of Women’s Care and Access to Care have been identified. Although the Women’s Care measures were above the national HEDIS Medicaid 50th percentile, the HEDIS 2014 statewide performance saw a general decline compared to HEDIS 2013. Similarly, the HEDIS 2014 statewide performance declined in the Access to Care measures compared to HEDIS 2013. MDHHS will work collaboratively with the contracted health plans to identify best practices and interventions to address these dimensions of care.

The Medical Services Administration will also partner with the Population Health and Community Services Administration of MDHHS to address Michigan’s Winnable Battles. To keep pace with emerging public health challenges and address the leading causes of death and disability, the Centers for Disease Control and Prevention (CDC) initiated this effort to achieve measurable impact quickly. 17 MDHHS has identified the population health priorities with the largest-scale impact and known effective strategies for the five following areas: Nutrition, Physical Activity, and Obesity; Healthy Babies; Heart Disease and Stroke; Immunizations, and Tobacco. By identifying priority strategies, defining clear targets and working closely with public health partners, MDHHS intends to make significant progress in reducing health disparities and the overall health burden from these diseases and conditions. These population health priorities correspond well with the Medicaid Health Plan quality improvement activities.

17 Center for Disease Control and Prevention Winnable Battles. http://www.cdc.gov/winnablebattles/
IT Integration and Data Warehouse Capability

Successes and Promising Practices
MDHHS continues to expand data warehouse capacity to analyze and report Medicaid program outcomes. Examples include analyses for special populations (e.g., foster care, CSHCS, and pregnant women), chronic care, and targeted conditions. In CY 2015, MDHHS increased the capacity to collect, report, and analyze data on the Core of Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Initial Core Set). These activities were undertaken as a result of the Adult Medicaid Quality (AMQ) Grant. Through grant supported activities, Medicaid data analysts were trained at a desk-level to readily access data for analysis, conduct real-time program analyses, and drive rapid-cycle improvement. Optum, Medicaid’s data warehouse vendor, provided the training and support necessary for the MDHHS staff to understand the complex structure of the data warehouse and query model required for accurate data extraction. The ability to effectively track, trend, and identify population-specific issues and conditions has enabled MDHHS to proactively target interventions and resources.

Medicaid has been able to utilize knowledge gained during the AMQ Grant to create measure specifications to generate health plan Performance Monitoring Standards using encounter data extracted from the Medicaid data warehouse. The Performance Monitoring Standards include a subset of the CMS Core Adult Quality Measures, a number of HEDIS measures as well as key measures for the Healthy Michigan Plan. The AMQ grant also increased MDHHS capacity to conduct data analyses stratified by race, ethnicity, gender and region (e.g., Medicaid Health Equity Project). Plan specific data are reported quarterly in the Medicaid Managed Care Performance Monitoring Reports and will continue to be generating on an ongoing basis moving forward. MDHHS has the capability of reporting and analyzing these data at the member level.

Ongoing Challenges and Opportunities
The MDHHS Medicaid Data Analysts will receive continual support and training from Optum to navigate the data warehouse and query model to generate data reports. MDHHS intends to continue to submit the Adult and Child Core Set measures to CMS on an ongoing basis; and additional measures will be added, as indicated.

During the process of implementing the reporting process, MDHHS found that the technical specifications for certain measures are more clearly defined than others making it difficult to effectively generate and report these data. The Early Elective Delivery (PC-01) measure is one example. MDHHS chose to report this measure using administrative data only. The fact that PC-01 is a hybrid measure, introduces some amount of error. MDHHS has ongoing communication with the CMS Project Officer and participating states to interpret measure specifications and data discrepancies.

The transition to using administration encounter data extracted from the Medicaid data warehouse for the Performance Monitoring Standards has also been challenging. Health plans typically augment HEDIS rates using NCQA approved supplemental data sources. Generating the Monitoring Standards using measure specifications pulled from the Medicaid data warehouse does not allow for inclusion of these additional data sources. As a result, the administrative only rates are
anticipated to be lower than health plan reported HEDIS rates. During 2015 and 2016, MDHHS will assess health plan performance, identify baseline rates and establish performance goals using the administrative data.

**QI Program Integration and Leadership**

**Successes and Promising Practices**
MDHHS has a long-established Medicaid quality improvement program infrastructure to support implementation of the Affordable Care Act and Healthy Michigan Plan Medicaid expansion program. Medicaid developed the capacity and infrastructure to successfully implement the Healthy Michigan Plan in April 2014. Medicaid policy was promulgated; program requirements were established; and quality processes, standards, reporting requirements and measurement specifications were defined and implemented (e.g., Healthy Michigan Plan Performance Monitoring Standards). In addition, Healthy Michigan Plan Progress Reports were implemented and are being monitored on an ongoing basis.¹⁸

The HMP progress reports, which outline characteristics of the enrolled population, demonstrate higher than anticipated enrollment numbers during FY 2015.

Michigan Medicaid also obtained prominent national grants and demonstrations (e.g., CMS Multi-payer Demonstration of Advanced Primary Care Practices, CMS State Demonstration to Integrate Care for Dual Eligible Individuals, CMS Adult Medicaid Quality Measures Grant), and Michigan is using these initiatives to develop successful programs to inform national health care delivery for Medicaid enrollees.

A significant structural change occurred in February 2015, when Michigan’s Governor signed an executive order to align family and health related services by creating the Michigan Department of Health and Human Services (MDHHS). The vision, termed, “The River of Opportunity,” aims to better serve residents by promoting improved health outcomes, reducing health risks, and supporting stable and safe families while encouraging self-sufficiency.

The merging of the Michigan Department of Community Health and Department of Human Services better aligns programs across Michigan governmental departments/agencies. As a result, Medicaid is working even more closely with its public health partners to improve the health and well-being of Michigan residents through health promotion and disease prevention. Collaborative efforts are demonstrated in the work being done to support pregnant women and infants, CSHCS enrollees, and children in foster care. A key collaborative effort is Medicaid’s active participation in and support of Michigan’s Infant Mortality Reduction Plan which outlines nine goals and strategies to reduce infant mortality across the state. Medicaid programs and services play an integral role in the reduction of infant mortality in Michigan. The requirement for contracted health plans to stratify populations by race/ethnicity/region and address social determinants of health will positively impact and drive improvements in care and services provided to Medicaid enrollees.

¹⁸ Healthy Michigan Plan Progress Reports, Available at: [http://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797---,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797---,00.html)
Ongoing Challenges and Opportunities

Michigan Medicaid’s quality improvement program, while robust, can be further enhanced by conducting analyses for special populations (e.g., geographic analyses by region and community, consistent with analyses currently being developed to address infant mortality). Other opportunities include integration of physical and behavioral health; implementing planned activities to address inappropriate ED use, inpatient readmissions, ambulatory care/PCMH, and generic drug use; developing targeted interventions for high-risk, high-cost populations; and collaborating with communities and health plans to address community-specific prevalent conditions and health issues. Significant opportunities are also present for the Healthy Michigan Plan Medicaid expansion population. It is crucial to identify and understand prevalent conditions for the HMP population and conduct population-specific clinical, access, satisfaction, and cost measurement on an ongoing basis.

Requirements in the FY 2016 Medicaid Health Plan contract are intended to provide opportunities to meet these challenges through the following activities:

- Incorporation of social determinants of health into data analyses for populations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment or education level.

- Health plan participation in community-led initiatives to improve population health through collaborating in community health needs assessments and community health improvement plans conducted by hospitals and local public health agencies or other regional coalitions.

- Integration of behavioral health services into primary care and community health centers; and the provision of community health workers or peer support specialists for persons with significant issues and complex physical co-morbid conditions. Integration efforts focus on robust care management, evidence-based behavioral health service models for primary care providers, and data sharing capabilities. A prominent feature intended to enhance care coordination of behavioral health services is the web-based care management system, CareConnect 360 (CC360). MDHHS and the plans are also in the process of collaboratively identifying and defining measurement specifications for reporting care management and quality metrics for shared populations. In addition, contracted health plans will work collaboratively with PIHPs, primary care providers and MDHHS to develop and implement performance improvement projects involving shared metrics and incentives for performance.

- Supporting the expansion and transformation of primary care practices into patient-centered medical homes (PCMH) and committing to increasing the percentage of enrollees receiving services from PCMH-designated practices. Plans must also support the Michigan Primary Care Transformation (MiPCT) Demonstration, and report the percent of primary care practices with embedded or shared care managers. And, as community-based initiatives are funded by the Michigan Blueprint for Health Innovation, including Accountable Systems of Care (ASCs) and Community Health Innovation Regions, contracted health plans are expected to participate in these initiatives.
• Implementation of focused quality improvement initiatives intended to reduce inappropriate emergency room use utilization.

Integration with the National Quality Strategy
In addition to compliance with Federal rules, Michigan is striving to align the state’s Quality Strategy with National Quality Strategy (NQS). The NQS, mandated by the Affordable Care Act of 2010, is a national plan to improve the delivery of health care services, patient health outcomes, and population health. The NQS is organized around three aims (better care, healthy people and communities, and affordable care) and six priorities (making care safer/reducing harm, ensuring that people and families are engaged as partners in care, promoting effective communication/coordination, promoting the most effective treatment practices, working with communities to use best practices to enable healthy living, and making care more affordable by spreading new care delivery models).

Aligning with the NQS will enable Michigan to approach the QS from a strategic perspective, focusing on population health and engaging in continuous improvement consistent with national efforts under ACA. It also enables Michigan to mindfully increase quality improvement efforts for special populations, disparities reduction, integrated care, and value-based delivery models and identify gaps in areas such as community engagement.

Tables 2 and 3 briefly illustrate the relationship between current Michigan Medicaid initiatives and relationships to NQS Priorities.

Table 2: Michigan Medicaid Initiatives and National Quality Strategy Priorities by Initiative

<table>
<thead>
<tr>
<th>Michigan Medicaid Initiatives</th>
<th>NQS Priorities</th>
<th>(1) Making Care Safer</th>
<th>(2) Person- and Family-Centered Care</th>
<th>(3) Communication and Coordination</th>
<th>(4) Effective Prevention and Treatment</th>
<th>(5) Health and Well-Being of Communities</th>
<th>(6) Making Care Affordable</th>
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<tbody>
<tr>
<td>Electronic prescription (eRx)</td>
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<td></td>
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<tr>
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<td>X</td>
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<td>X</td>
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<td>X</td>
<td></td>
<td></td>
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<td>X</td>
</tr>
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<td></td>
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### Table 3: Michigan Medicaid Initiatives and National Quality Strategy Priorities by Priority Area

<table>
<thead>
<tr>
<th>NQF Priorities</th>
<th>(1) Making Care Safer</th>
<th>(2) Person-and Family-Centered Care</th>
<th>(3) Communication and Coordination</th>
<th>(4) Effective Prevention and Treatment</th>
<th>(5) Health and Well-Being of Communities</th>
<th>(6) Making Care Affordable</th>
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<td>PCMH</td>
<td>Electronic prescription (eRx)</td>
<td>EHR/ Meaningful Use</td>
<td>Quality metrics for shared populations and performance incentives</td>
<td>Value-based payment models</td>
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<tr>
<td></td>
<td>Common Formulary</td>
<td>Michigan Blueprint for Health Innovation</td>
<td>Common Formulary</td>
<td>CMS Adult Quality Measures – Warehouse Capability and Reporting</td>
<td>PCMH expansion and coordination with Accountable Systems of Care</td>
<td>Electronic prescription (eRx)</td>
</tr>
<tr>
<td></td>
<td>EHR/ Meaningful Use</td>
<td>Michigan Primary Care Transformation</td>
<td>EHR/ Meaningful Use</td>
<td>CMS Adult Quality Measures Grant – Reduction in Early</td>
<td>Population health framework that includes</td>
<td>EHR/ Meaningful Use</td>
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<td>Project (MiPCT)</td>
<td>Elective Deliveries</td>
<td>analysis/intervention to address social determinants of health</td>
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<td>----------------------------------------------------------</td>
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<tr>
<td>Michigan Primary Care Transformation Project (MiPCT)</td>
<td>Integrated Care/Duals</td>
<td>PCMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CMS Adult Quality Measures - Adult Asthma</td>
<td>MHP participation in community-lead initiatives</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Michigan Blueprint for Health Innovation</td>
<td>Clinical guidelines and associated reduction in variation</td>
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<tr>
<td></td>
<td>Support and implementation of CHW/peer support interventions</td>
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<td>Special populations: CSHCS, foster care</td>
<td>Integrated Care/Duals</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Michigan Primary Care Transformation Project (MiPCT)</td>
<td>Health Equity Project</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Michigan’s Winnable Battles</td>
<td>CMS Adult Quality Measures Grant – Reduction in Early Elective Deliveries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integration of Behavioral Health Workers/peer support specialist</td>
<td>CMS Adult Quality Measures Grant – Reduction in Early Elective Deliveries</td>
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<td></td>
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<tr>
<td></td>
<td>Maternal and Child Health Home Visiting Programs</td>
<td>Integration of Behavioral Health Workers/peer support specialist</td>
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<td></td>
<td>Michigan’s Winnable Battles</td>
<td>Infant Mortality Reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to Evidence-based/best practices educational programs</td>
<td>Infant Mortality Reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maternal and Child Health Home Visiting Programs</td>
<td>Allied for Innovation on Maternal Health (AIM) Program</td>
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<td></td>
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<td></td>
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<tr>
<td></td>
<td>Health Risk Assessments for HMP</td>
<td>Health Equity Project</td>
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<td></td>
<td>Maternal and Child Health Home Visiting Programs</td>
<td>Health Equity Project</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CMS Adult Quality Measures Grant – Reduction in Early Elective Deliveries</td>
<td>Community Health Workers/peer support specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Equity Project</td>
<td>Infant Mortality Reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Special populations: CSHCS, foster care</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Clinical guidelines and associated reduction in variation</th>
<th>Integration of Behavioral Health Workers/peer support specialist</th>
<th>Michigan Primary Care Transformation Project (MiPCT)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Michigan’s Winnable Battles</td>
<td>CMS Adult Quality Measures Grant – Reduction in Early Elective Deliveries</td>
</tr>
<tr>
<td></td>
<td>Integrated Care/Duals</td>
<td>Health Equity Project</td>
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<tr>
<td></td>
<td>Maternal and Child Health Home Visiting Programs</td>
<td>Community Health Workers/peer support specialist</td>
</tr>
<tr>
<td></td>
<td>Michigan’s Winnable Battles</td>
<td>Infant Mortality Reduction</td>
</tr>
<tr>
<td></td>
<td>Access to Evidence-based/best practices educational programs</td>
<td>Community Health Workers/peer support specialist</td>
</tr>
<tr>
<td></td>
<td>Maternal and Child Health Home Visiting Programs</td>
<td>Community Health Workers/peer support specialist</td>
</tr>
<tr>
<td></td>
<td>Reduction in Infant Mortality</td>
<td>Community Health Workers/peer support specialist</td>
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<td>Integrated Care/Duals</td>
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<td></td>
<td>Health Equity Project</td>
<td>Community Health Workers/peer support specialist</td>
</tr>
<tr>
<td></td>
<td>CMS Adult Quality Measures Grant – Reduction in Early Elective Deliveries</td>
<td>Community Health Workers/peer support specialist</td>
</tr>
<tr>
<td></td>
<td>Special populations: CSHCS, foster care</td>
<td>Community Health Workers/peer support specialist</td>
</tr>
</tbody>
</table>
Summary
MDHHS is committed to improving the health and well-being of Michigan residents. Michigan Medicaid has a well-developed and highly successful managed care program to meet this goal. Further development and integration of quality improvement program functions will continue in an effort to impact care and services for all Medicaid populations and programs consistent with the NQS.
### Attachment A

2015-2017 HEDIS and CAHPS
Quality Strategy Measures and Performance Standards

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50  75  90</td>
</tr>
<tr>
<td>Pediatric</td>
<td>Developmental Screening-DW</td>
<td>--</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td></td>
<td>Imms Combo 3</td>
<td>80</td>
<td>72.90</td>
<td>Down^</td>
<td>71.53/76.50/81.25</td>
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<tr>
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<td>Imms Adolescent</td>
<td>90</td>
<td>88.94</td>
<td>NC</td>
<td>73.15/81.51/87.71</td>
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<tr>
<td></td>
<td>BMI Child (Total)</td>
<td>74</td>
<td>78.34</td>
<td>Up^</td>
<td>67.23/77.98/85.61</td>
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<tr>
<td></td>
<td>Lead Screening</td>
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<td>80.37</td>
<td>NC</td>
<td>71.93/79.67/85.93</td>
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<td></td>
<td>Well-Child 15 months (6+)</td>
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<td>64.76</td>
<td>Down^</td>
<td>59.76/66.24/74.47</td>
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<td>Well-Child 3-6 yrs.</td>
<td>82</td>
<td>75.76</td>
<td>NC</td>
<td>72.02/78.46/83.75</td>
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<td>54.02</td>
<td>Down^</td>
<td>49.15/59.98/66.58</td>
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<tr>
<td></td>
<td>Appropriate URI Treatment</td>
<td>90</td>
<td>88.00</td>
<td>Up^</td>
<td>88.09/92.51/95.17</td>
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<td>Appropriate Pharyngitis Testing</td>
<td>63</td>
<td>67.25</td>
<td>Up^</td>
<td>71.48/79.83/85.25</td>
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<td>Women</td>
<td>Breast Cancer Screening</td>
<td>NA</td>
<td>59.65</td>
<td>Down^</td>
<td>58.37/66.02/71.32</td>
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<td></td>
<td>Cervical Cancer Screening</td>
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<td>68.46</td>
<td>NC</td>
<td>60.98/67.88/73.08</td>
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<td>Chlamydia Screening Total</td>
<td>68</td>
<td>62.20</td>
<td>Down^</td>
<td>54.40/61.90/68.60</td>
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<tr>
<td></td>
<td>Prenatal Care Timeliness</td>
<td>92</td>
<td>84.45</td>
<td>Down^</td>
<td>85.19/88.66/91.73</td>
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<td>Postpartum Care</td>
<td>75</td>
<td>66.69</td>
<td>Down^</td>
<td>62.77/68.85/72.43</td>
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<td>Living with Illness</td>
<td>Appropriate Asthma Meds (Total)</td>
<td>90</td>
<td>80.64</td>
<td>NC</td>
<td>84.51/87.47/91.07</td>
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<td></td>
<td>Appropriate Asthma Meds 5-11</td>
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<td>88.54</td>
<td>--</td>
<td>91.23/93.42/95.12</td>
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<tr>
<td></td>
<td>Diabetes HbA1c testing</td>
<td>88</td>
<td>85.99</td>
<td>NC</td>
<td>86.29/89.55/91.94</td>
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<tr>
<td></td>
<td>Diabetes HbA1c good control (&lt;8.0%)</td>
<td>58</td>
<td>53.78</td>
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<td>47.91/54.01/58.58</td>
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<td>Diabetes-Nephropathy</td>
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<td>83.73</td>
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<td>Diabetes eye exam</td>
<td>67</td>
<td>59.48</td>
<td>Down^</td>
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<td>Controlling high B/P</td>
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<td>62.06</td>
<td>NC</td>
<td>57.47/65.29/70.32</td>
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<td>90.31</td>
<td>Up^</td>
<td>83.45/89.62/92.94</td>
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<td>Access to Care</td>
<td>Advising smokers (and Tobacco users) to quit</td>
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<td>79.90</td>
<td>NC</td>
<td>76.74/79.41/81.91</td>
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<td>54.26</td>
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<td>42.50/47.60/51.21</td>
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<td></td>
<td></td>
<td></td>
<td>50 75 90</td>
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<td>Member Satisfaction Adult (CAHPS)</td>
<td>25 months – 6 years 1 PCP visit</td>
<td>92</td>
<td>88.73</td>
<td>NC</td>
<td>88.46/91.22/92.93</td>
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<td>7-11 years 1 PCP visit</td>
<td>94</td>
<td>91.14</td>
<td>Down^</td>
<td>91.42/93.90/95.88</td>
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<td>12-19 years 1 PCP visit</td>
<td>93</td>
<td>90.21</td>
<td>NC</td>
<td>90.06/92.46/94.91</td>
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<td>20-44 years 1 PCP visit</td>
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<td>83.42</td>
<td>Down^</td>
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<td>45-64 years 1 PCP visit</td>
<td>92</td>
<td>90.77</td>
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<td>Adults getting needed care</td>
<td>85</td>
<td>82.80</td>
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<td>Adults getting care quickly</td>
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<td>82.80</td>
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<td>Adults health plan rating</td>
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<td>Adult How well doctors communicate</td>
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<td>Member Satisfaction Child (from 2012 CAHPS)</td>
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<td></td>
<td>Children getting care quickly</td>
<td>91</td>
<td>89.90</td>
<td>NC</td>
<td>89.61/92.30/93.65</td>
</tr>
<tr>
<td></td>
<td>Children health plan rating</td>
<td>82</td>
<td>65.10</td>
<td>NC</td>
<td>68.90/72.38/76.08</td>
</tr>
<tr>
<td></td>
<td>Children personal doctor or nurse rating</td>
<td>84</td>
<td>72.30</td>
<td>NC</td>
<td>74.89/76.74/79.10</td>
</tr>
<tr>
<td></td>
<td>Children medical specialist rating</td>
<td>80</td>
<td>68.60</td>
<td>NC</td>
<td>70.54/73.91/77.62</td>
</tr>
<tr>
<td></td>
<td>Children rating of all health care</td>
<td>80</td>
<td>65.30</td>
<td>NC</td>
<td>66.29/69.20/71.30</td>
</tr>
<tr>
<td></td>
<td>Children how well doctors communicate</td>
<td>92</td>
<td>93.50</td>
<td>NC</td>
<td>93.53/94.64/95.65</td>
</tr>
</tbody>
</table>

^ Statistically significant change
NC No significant change
___ Not established
## ATTACHMENT B

**October 2015**  
**Michigan Medicaid Managed Care**  
**Performance Monitoring Standards**

<table>
<thead>
<tr>
<th>Program Area</th>
<th>Measure</th>
<th>Measure Source¹ (YR)</th>
<th>Measure Steward² (YR)</th>
<th>Data Source</th>
<th>2015-2016 Minimum Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care</td>
<td>Childhood Immunization Status</td>
<td>CMS (2015)</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>N/A Informational Only</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Postpartum Care</td>
<td>CMS (2015)</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse &amp; Vital Records</td>
<td>70%</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Blood Lead Testing for 2 Year Olds</td>
<td>MDHHS (2016)</td>
<td>MDHHS (2016)</td>
<td>MDHHS Data Warehouse</td>
<td>81%</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Blood Lead Extract for 10 Months to 3 Year Olds</td>
<td>MDHHS (2016)</td>
<td>MDHHS (2016)</td>
<td>Lead Statewide Database &amp; CHAMPS</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Managed Care        | Developmental Screening                      | MDHHS (2016)         | MDHHS (2016)          | MDHHS Data Warehouse                             | First year of life: 19%  
Second year of life: 23%  
Third year of life: 17%                        |
<p>| Managed Care        | Well-Child Visits in the First 15 Months of Life | CMS (2015)          | NCQA/HEDIS (2015)     | MDHHS Data Warehouse                             | 71%                                         |
| Managed Care        | Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life | CMS (2015)          | NCQA/HEDIS (2015)     | MDHHS Data Warehouse                             | 79%                                         |
| Managed Care        | Enrollee Complaints                          | MDHHS (2016)         | MDHHS (2016)          | Customer Relations System (CRM)                 | At or below 0.15 complaints/1,00 member months |
| Managed Care        | Claims Reporting and Processing              | MDHHS (2016)         | MDHHS (2016)          | Claims Report Form MSA 2010                     | 95% of non-pharmacy clean claims processed within 30 days |
| Managed Care        | Encounter Data Reporting (Institutional, Professional) | MDHHS (2016)     | MDHHS (2016)          | MDHHS Data Exchange Gateway &amp; MDHHS Data Warehouse | N/A                                         |
| Managed Care        | Encounter Data Reporting (Pharmacy)          | MDHHS (2016)         | MDHHS (2016)          | MDHHS Data Exchange Gateway &amp; MDHHS Data Warehouse | N/A                                         |
| Managed Care        | Provider File Reporting                      | MDHHS (2016)         | MDHHS (2016)          | Michigan ENROLLS                                 | N/A                                         |
| Healthy Michigan Plan | Adults’ Generic Drug Utilization            | CMS (2014)           | CMS (2014)            | MDHHS Data Warehouse                             | 80%                                         |
| Healthy Michigan Plan | Timely Completion of Initial Health          | MDHHS (2016)         | MDHHS (2016)          | MDHHS Data Warehouse                             | 20%                                         |</p>
<table>
<thead>
<tr>
<th>Risk Assessment</th>
<th>Measure</th>
<th>Source(s)</th>
<th>Data Source</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Michigan Plan Outreach and Engagement to Facilitate Entry to Primary Care</td>
<td>MDHHS (2016)</td>
<td>MDHHS Data Warehouse</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Healthy Michigan Plan Plan All-Cause Acute 30-Day Readmissions</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Healthy Michigan Plan Adults’ Access to Ambulatory Health Services</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Adult Body Mass Index Assessment</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Breast Cancer Screening</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Cervical Cancer Screening</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Diabetes Short-Term Complications Admissions Rate</td>
<td>AHRQ (2014 4.5a)</td>
<td>MDHHS Data Warehouse</td>
<td>N/A Informational Only</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures COPD or Asthma in Older Adults Admission Rate</td>
<td>AHRQ (2014 4.5a)</td>
<td>MDHHS Data Warehouse</td>
<td>N/A Informational Only</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Heart Failure Admission Rate</td>
<td>AHRQ (2014 4.5a)</td>
<td>MDHHS Data Warehouse</td>
<td>N/A Informational Only</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Asthma in Younger Adults Admission Rate</td>
<td>AHRQ (2014 4.5a)</td>
<td>MDHHS Data Warehouse</td>
<td>N/A Informational Only</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Chlamydia Screening in Women Ages 21-24</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Comprehensive Diabetes Care: Hemoglobin A1c Testing</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>Adult Quality Measures Antidepressant Medication Management</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>Acute Phase Treatment: 56% Continuous Phase Treatment: 40%</td>
<td>87% (Total Rate)</td>
</tr>
<tr>
<td>Adult Quality Measures Annual Monitoring for Patients on Persistent Medications</td>
<td>NCQA/HEDIS (2015)</td>
<td>MDHHS Data Warehouse</td>
<td>87% (Total Rate)</td>
<td></td>
</tr>
</tbody>
</table>

1 The measure source is the organization responsible for publishing the measure for use. CMS: The Affordable Care Act required the Secretary of Health and Human Services (HHS) to identify and publish core sets of health care quality measures for Medicaid-enrolled children and adults. Implementation of the core sets will help CMS and states move toward a national system for measurement, reporting, and quality improvement. MDHHS: Public Act 107 of 2013 requires the MDHHS to evaluate the impact of Healthy Michigan Plan coverage will have on measures such as access to primary care, utilization of preventive services, utilization of emergency services, and health behaviors. Evaluation of these measures will help MDHHS monitor access, utilization, and health outcomes.
2 The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes. AHRQ: Agency for Healthcare Research & Quality.
All Medicaid health plans cover medically-necessary services such as:
- Ambulance
- Doctor visits
- Emergency care
- Family planning
- Health checkups for children and adults
- Hearing and speech
- Home health care
- Hospice care
- Hospital care
- Immunizations (shots)
- Lab and x-ray
- Medical supplies
- Medicine
- Mental health
- Physical and occupational therapy
- Prenatal care and delivery
- Surgery
- Vision

All Medicaid health plans are required to provide the services listed above. Some services are limited. Your doctor or health plan can tell you what Medicaid covers.

Note: The information in this pamphlet was collected from health plans by independent survey companies. The information reported by the health plans was reviewed for accuracy. Information was also collected from health plan members.

Accreditation: Checking for quality
Accreditation is another way of assessing health plan quality. An outside organization checks to see whether the plan has the right systems and people in place to do a good job providing health care.

NCQA – Accredited by the National Committee for Quality Assurance.

URAC – Accredited by the Utilization Review Accreditation Commission.

For more information, call Michigan ENROLLS at
1-888-ENROLLS
(1-888-367-6557)
OR
1-800-975-7630

A Guide to Michigan Medicaid Health Plans

Quality Checkup
January 2015

You can learn about different programs and services provided by MDCH, and see the latest news releases about important healthcare issues.
## Category Ratings for Michigan Medicaid Health Plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Doctors Communication and Service</th>
<th>Getting Care</th>
<th>Keeping Kids Healthy</th>
<th>Living with Illness</th>
<th>Taking Care of Women</th>
<th>Accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Complete of Michigan</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>CoventryCares</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>HAP Midwest Health Plan, Inc.</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>Harbor Health Plan, Inc.</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>URAC</td>
</tr>
<tr>
<td>HealthPlus Partners</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
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<tr>
<td>McLaren Health Plan</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
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<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
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<tr>
<td>Meridian Health Plan of Michigan</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>Molina Healthcare of Michigan</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>Priority Health Choice, Inc.</td>
<td>🍎🍎🍎🍎</td>
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<td>🍎🍎🍎🍎</td>
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<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>Sparrow PHP</td>
<td>🍎🍎🍎🍎</td>
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<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>Total Health Care, Inc.</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td>🍎🍎🍎🍎</td>
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<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
<tr>
<td>Upper Peninsula Health Plan</td>
<td>🍎🍎🍎🍎</td>
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<td>🍎🍎🍎🍎</td>
<td>🍎🍎🍎🍎</td>
<td>NCQA</td>
</tr>
</tbody>
</table>

Performance compared to the average of all Michigan Medicaid Health Plans:
- 🍎🍎🍎🍎: Above Average
- 🍎🍎🍎: Average
- 🍎🍎: Below Average

The categories:
- **Doctors' Communication and Service:** Members in the plan believe all of their doctors and healthcare providers do a good job explaining things to them and their children, and that they spend enough time with them and their children.
- **Getting Care:** Members in the plan believe they get the care they need for themselves and their children and that they get the care quickly.
- **Keeping Kids Healthy:** Children in the plan get regular checkups and important shots that help protect them against serious illness.
- **Living with Illness:** The plan takes care of members with asthma, diabetes and high blood pressure by giving them tests, checkups and the right medicine.
- **Taking Care of Women:** Women in the plan get tests for breast and cervical cancer, and for an infection called Chlamydia. These tests help to find these diseases early. This gives women more choices for treatment and a better chance of survival. Moms in the plan also get care before and after their baby is born to help keep mom and baby healthy.

**Accreditation:** Explanations on back cover.