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State Fiscal Year 2021 External Quality Review Technical Report

for Integrated Care Organizations

April 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

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

The Medical Services Administration (MSA)[1-1] within MDHHS administers and oversees the Michigan Medicaid managed care program, including the MI Health Link program, which contracts with seven[1-2] MCEs, referred to as integrated care organizations (ICOs), to provide Medicare and Medicaid benefits to dual-eligible members in Michigan. The ICOs contracted with MDHHS during state fiscal year (SFY) 2021 are displayed in Table 1-1.

Table 1-1—ICOs in Michigan

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

[1-1] The Health and Aging Services Administration (HASA) was created under Executive Order 2021-14, combining the Aging and Adult Services Agency and MSA under one umbrella within MDHHS effective December 14, 2021. The Executive Order can be accessed at: https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-573368--,00.html. MDHHS also announced that HASA will become the Behavioral and Physical Health and Aging Services Administration (BPHASA) effective March 21, 2022. The Behavioral Health and Developmental Disabilities Administration (BHDDA) will become part of BPHASA to demonstrate equal prominence of behavioral and physical health.

[1-2] Michigan Complete Health merged with MeridianComplete effective January 1, 2022.

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the CMS EQR Protocols).[1-3] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality of, timeliness of, and access to care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher performing healthcare delivery systems for their dual-eligible Medicare-Medicaid members. For the SFY 2021 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each ICO. Detailed information about each activity's methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS EQR Protocol
Validation of Quality Improvement Projects (QIPs)[1-4]	This activity verifies whether a QIP conducted by an ICO used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects (PIPs)
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by an ICO are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which an ICO is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP [Children's Health Insurance Program Managed Care] Regulations
Network Adequacy Validation (NAV)	This activity assesses the extent to which an ICO has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy*

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 21, 2022.

[1-4] MCEs that participate in Medicare and/or Medicaid are required by regulation to develop and implement quality/performance improvement projects. Medicare plans are required to conduct and report on quality improvement projects (QIPs), and Medicaid plans are required to conduct and report on performance improvement projects (PIPs). Because both Medicare and Medicaid plans are referenced in this report, QIPs and PIPs will be referenced throughout the report.

Activity	Description	CMS EQR Protocol
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-5] Analysis	This activity assesses member experience with an ICO and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

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

MI Health Link Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2021 activities to comprehensively assess the ICOs' performance in providing quality, timely, and accessible healthcare services to dual-eligible members. For each ICO reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the ICO's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all ICOs were also compared and analyzed to develop overarching conclusions and recommendations for MDHHS and the MI Health Link program. Table 1-3 highlights substantive findings and actionable, state-specific recommendations, when applicable, which MDHHS can use to target specific goals and objectives in its quality strategy to further promote improvement in the quality and timeliness of, and access to healthcare services furnished to its Medicaid managed care members, and specifically, its MI Health Link program members. Refer to Section 6 for more details.

Table 1-3—MI Health Link Program Substantive Findings

Program Strengths
• **Quality**, **Timeliness**, and **Access** – Through the PIP activity, the MI Health Link program is focusing its efforts on improving follow-up visits after a hospitalization for mental illness, which should help members manage their mental health and in turn decrease emergency department (ED) utilization for mental illness. All ICOs demonstrated performance strengths through the QIP activity by using appropriate quality improvement (QI) tools to conduct a causal/barrier analysis and prioritizing the identified barriers, meeting the requirements for data analysis and implementation of improvement strategies, designing a methodologically sound improvement project, and/or achieving the goal of statistically significant improvement over the baseline rate for the first and/or second remeasurement periods. – While performance in all measures within the Behavioral Health domain remained low, with indicator rates ranging between approximately 30 to 70 percent, the measurement year (MY) 2020 statewide rates for all measures increased compared to the MY 2018 statewide rates. These findings indicate that the MI Health Link program is making progress in improving performance for the *Antidepressant Medication Management*, *Follow-Up After Hospitalization for Mental Illness*, and/or *Follow-Up After Emergency Department Visit for Mental Illness* measures.

[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Program Strengths
• **Quality** – Through the compliance review activity, five of the seven ICOs demonstrated appropriate oversight of their delegates, including evidence of periodic formal reviews which comprised a review of all delegated functions; development of corrective action plans (CAPs), when necessary; and regular meetings with delegates which included performance metric reviews. Robust oversight and monitoring of delegated entities strengthen program integrity efforts. This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS, and/or identifies poor performance which may require remediation. – As demonstrated through the PMV activity, six of the seven ICOs received a measure designation of *Reportable (R)* for all measures, signifying that these ICOs reported the measures in compliance with CMS and state-specific reporting requirements and that rates could be reported. While the remaining ICO received a *Do Not Report (DNR)* designation, three of its four measure rates were *Reportable (R)*. • **Access** – All ICOs serving Region 7 and Region 9 except one met all Medicaid and long-term services and supports (LTSS) minimum network requirements, indicating an adequate network of providers is available to render care and services to members residing in these regions. An adequate provider network is imperative to ensure MI Health Link members have timely access to a wide range of primary care providers (PCPs), specialists, and behavioral health and LTSS providers.

Program Weaknesses[1-6]
• **Quality** – As indicated through the PIP activity, while five ICOs' study indicator rates increased from the baseline rate, four ICOs' rates declined between Remeasurement 1 and Remeasurement 2. Only two of the seven ICOs experienced statistically significant improvement in the SFY 2021 performance rate over the baseline rate and/or Remeasurement 1 rate for the study indicator. None of the three ICOs that had identified a performance goal met the goal, indicating that the implemented interventions were ineffective in increasing or sustaining QI. Two ICOs noted that the coronavirus disease 2019 (COVID-19) pandemic impacted member access to behavioral health providers, and that restrictions on in-person medical care impacted the ability to carry out many interventions. Three ICOs had a relatively small eligible population; therefore, a greater increase in the number of members who are numerator compliant must occur for the ICOs to achieve the desired goal. – Five of the seven ICOs did not consistently adhere to the Provider Selection individual practitioner credentialing requirements, and four of the seven ICOs did not consistently adhere to the Provider Selection organizational credentialing requirements, under 42 CFR §438.214 and MDHHS-specific requirements as demonstrated through the compliance review activity. Not conducting all required Medicare and Medicaid exclusion checks and/or not obtaining disclosure of ownership and control interest forms were the primary deficiencies across the ICOs. Adherence to federal and MDHHS

[1-6] The COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent and/or nonessential services to slow the spread of COVID-19. Additionally, the pandemic resulted in the closure of medical offices, and due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Program Weaknesses[1-6]
individual and organizational credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. • **Quality**, **Timeliness**, and **Access** – Through the compliance review activity, all seven ICOs demonstrated deficiencies related to Coverage and Authorization of Services, specifically related to the content of the integrated denial notice (IDN). Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a denied service in easily understood language and have access to their appeal and State fair hearing (SFH) rights. Additionally, none of the seven ICOs consistently adhered to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintain access to high-quality care and services. Additionally, the notice to the member about an appeal should be written at the appropriate reading grade level in order for members to understand the action and their rights. – As identified through the secret shopper survey, a moderate to large percentage of sampled providers (16 to 71 percent) were unable to be reached, did not accept the ICO, or did not accept and/or recognize the MI Health Link program, which suggests that inaccuracies in the ICOs' provider data are creating barriers for members in accessing needed care. Additionally, of those providers reached, a limited number offered appointment dates and times to the callers indicating additional barriers to receiving timely care. • **Quality** and **Access** – The statewide average within the Prevention and Screening domain ranged between approximately 56 and 67 percent, indicating many MI Health Link adult members did not receive a breast cancer screening or colorectal cancer screening; and older adults did not receive advance care planning, a medication review, a functional status assessment, or a pain assessment. Further, the statewide average rate for MY 2020 for the *Breast Cancer Screening* measure and for all *Care for Older Adults* measures decreased from the MY 2018 statewide averages. – Within the Diabetes domain, five of the seven MY 2020 statewide averages declined in performance compared to the reported MY 2018 statewide averages. These findings indicate that fewer MI Health Link adult members diagnosed with diabetes had hemoglobin A1C (HbA1c) testing, HbA1c control, retinal eye exams, and medical attention for nephropathy; and more MI Health Link adult members had poor HbA1c control. • **Quality** and **Timeliness** – As demonstrated through the results of the compliance review activity, six of the seven ICOs did not consistently adhere to the Grievance Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is essential to maintain high-quality care and services and to ensure member retention. • **Access** – While the MY 2020 statewide averages remained relatively high, with indicator rates ranging from approximately 82 to 93 percent, all four MY 2020 statewide averages for the *Adults' Access to Preventive/Ambulatory Health Services* within the Access/Availability of Care domain decreased slightly from the MY 2018 statewide averages, indicating fewer MI Health Link members 20 years of age and older had an ambulatory or preventive care visit with their physician.

Program Recommendations
Quality Strategy Goals/Objectives to Target for Improvement[1-7]
• **Goal 1:** Ensure high quality and high levels of access to care. – **Objective 1.2**: Assess and reduce identified racial disparities. • **Goal 3:** Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external). – **Objective 3.1**: Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems. • **Goal 4:** Reduce racial and ethnic disparities in healthcare and health outcomes. – **Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible. – **Objective 4.5**: Expand and share promising practices for reducing racial disparities. • **Goal 5:** Improve quality outcomes and disparity reduction through value-based initiatives and payment reform. – **Objective 5.2**: Align value-based goals and objectives across programs.
To improve program-wide performance in support of the objectives under **Goal 1**, **Goal 3**, **Goal 4**, and **Goal 5**, and to enhance monitoring efforts, improve all members' access to timely care and services, and align value-based goals and objectives across programs, HSAG recommends the following: • **SFY 2022 PIP**—For SFY 2022, the ICOs will be initiating a QIP topic on racial and ethnic disparities with a focus on reducing existing disparities in access to healthcare or health outcomes. The ICOs should evaluate their performance measure outcomes and target efforts in areas with more prevalent opportunities for improvement (e.g., Diabetes, Prevention and Screening). As part of the PIP process, specifically when the ICOs are in the process of developing PIP interventions, MDHHS should consider the following: – To ensure interventions are actionable and will support performance improvement, MDHHS should review the ICOs' planned interventions prior to ICO implementation and provide feedback and/or approval on any planned interventions. MDHHS could also consider whether a state-required intervention would be appropriate for the ICOs to implement. MDHHS could consult with HSAG through these processes. – Once interventions have been developed and implemented, MDHHS could consider assessing the ICOs' processes to continuously measure and analyze intervention effectiveness through required quarterly status updates. These updates could include a summary of the ICOs' intervention effectiveness, including any noted barriers, steps to mitigate those barriers, and any revisions that have been made to the interventions to support improvement. This is especially important through the COVID-19 pandemic as ICOs have reported the pandemic as a barrier to successfully improving performance. MDHHS could leverage the HSAG-developed Intervention Progress Form to obtain

[1-7] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy: 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Feb 24, 2022.

Program Recommendations
feedback; however, this recommendation is specifically for MDHHS as MDHHS could provide valuable feedback to the ICOs through its knowledge of the environment in Michigan. – MDHHS could also consider having the ICOs share promising practices (e.g., effective interventions) through a dedicated workgroup session to reduce racial disparities and improve performance specifically through the PIP activity. This session could also be used to discuss how COVID-19 was considered when developing interventions that could be successful even through a pandemic. • **Provider Directory Validation**—Ensuring that members have access to current, accurate provider data is important to streamline access to care and maintain member satisfaction. However, as demonstrated through the secret shopper surveys, inaccuracies were identified in the ICOs' provider data. MDHHS could consider implementing a statewide initiative to improve the accuracy of provider information available to members through the provider directories. As part of this initiative, MDHHS could require ICOs to conduct the following: – To supplement the NAV activities conducted by HSAG, the ICOs could conduct quarterly secret shopper surveys of rotating provider types to identify provider data inaccuracies. The results of the survey, including the assessed provider types, number of providers surveyed, response rates, and outcomes, should be provided to MDHHS in a report format and include the ICOs' remediation plans for improving provider data. – The ICOs could provide MDHHS with an annual provider directory improvement plan that dictates its process to obtain complete and accurate provider data. As part of the improvement plan, MDHHS could require periodic outreach to providers to validate provider directory information. The improvement plan should include the schedule for outreach and describe the mode of communication to providers, the data elements being confirmed, and the process for providers to confirm/update provider data. • **MDHHS Collaborative—**MDHHS is responsible for several separate Medicaid managed care programs. These programs are managed separately by multiple teams within MDHHS with minimal program alignment. To support the sharing of best practices and potentially reduce duplicative efforts, HSAG recommends the following for all Medicaid managed care programs in Michigan: – MDHHS should establish a collaborative workgroup whose membership consists of representation from all Medicaid managed care programs. As part of this workgroup, MDHHS should implement a communication channel and protocol for ongoing collaboration between the managed care programs. Through the workgroup, MDHHS could: o Determine processes within the programs that could be streamlined to reduce efforts. o Designate team members from each program area to report regularly on program-level activities, including successes and challenges, and solicit feedback from other program team members, when necessary, to identify potential opportunities for improvement and program enhancements.

2. Overview of the Integrated Care Organizations

Managed Care in Michigan

In Michigan, management of the Medicaid program prior to an October 2021 executive reorganization under Executive Order No. 2021-14[2-1] was spread across two different administrations and four separate divisions within MDHHS. Physical health, children's and adult dental services, and mild-to-moderate behavioral health services were managed by the Managed Care Plan Division in the MSA. Three different MDHHS program areas implemented LTSS including the Long-Term Care Services Division (MI Choice Program), the Integrated Care Division (MI Health Link Medicaid/Medicare Dual Eligible Demonstration and the Program of All-Inclusive Care for the Elderly), and the Behavioral Health and the Developmental Disabilities Administration (BHDDA). BHDDA also administers Medicaid waivers for people with intellectual/developmental disabilities, mental illness, and serious emotional disturbance, and it administers prevention and treatment services for substance use disorders (SUDs). Table 2-1 displays the Michigan Medicaid managed care programs, the MCE(s) responsible for providing services to members, and the MDHHS division accountable for the administration of the benefits included under each applicable program in SFY 2021.

Table 2-1—Medicaid Managed Care Programs in Michigan

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

[2-1] HASA was created under Executive Order 2021-14, combining the Aging and Adult Services Agency and MSA under one umbrella within MDHHS effective December 14, 2021. The Executive Order can be accessed at: https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-573368--,00.html. MDHHS also announced that HASA will become BPHASA effective March 21, 2022. BHDDA will become part of BPHASA to demonstrate equal prominence of behavioral and physical health.

MI Health Link Program

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

Overview of Integrated Care Organizations

During the SFY 2021 review period, MDHHS contracted with seven ICOs. These ICOs were responsible for the provision of services to MI Health Link members. Table 2-2 provides a profile for each ICO. Figure 2-1 shows a visual representation of the counties included in each region served.

Table 2-2—ICO Profiles and Enrollment Data

ICO	Covered Services[2-2]	Service Area/Regions Served[2-3]	Member Enrollment[2-4]
AET	MI Health Link benefits include: • No co-pays for in-network services, including medications • No deductibles for in-network services • Medications • Care coordination • Behavioral healthcare • Dental care • Hearing care • Medicare care • Vision care • Home and community-based services • Transportation for covered medical services • Medical equipment and supplies • Nursing facility care	Regions 4, 7, and 9	8,017
AMI		Regions 7 and 9	3,215
HAP		Regions 7 and 9	4,552
MER*		Region 4	5,168
MCH*		Regions 7 and 9	3,760
MOL		Regions 7 and 9	12,654
UPP		Region 1	4,567

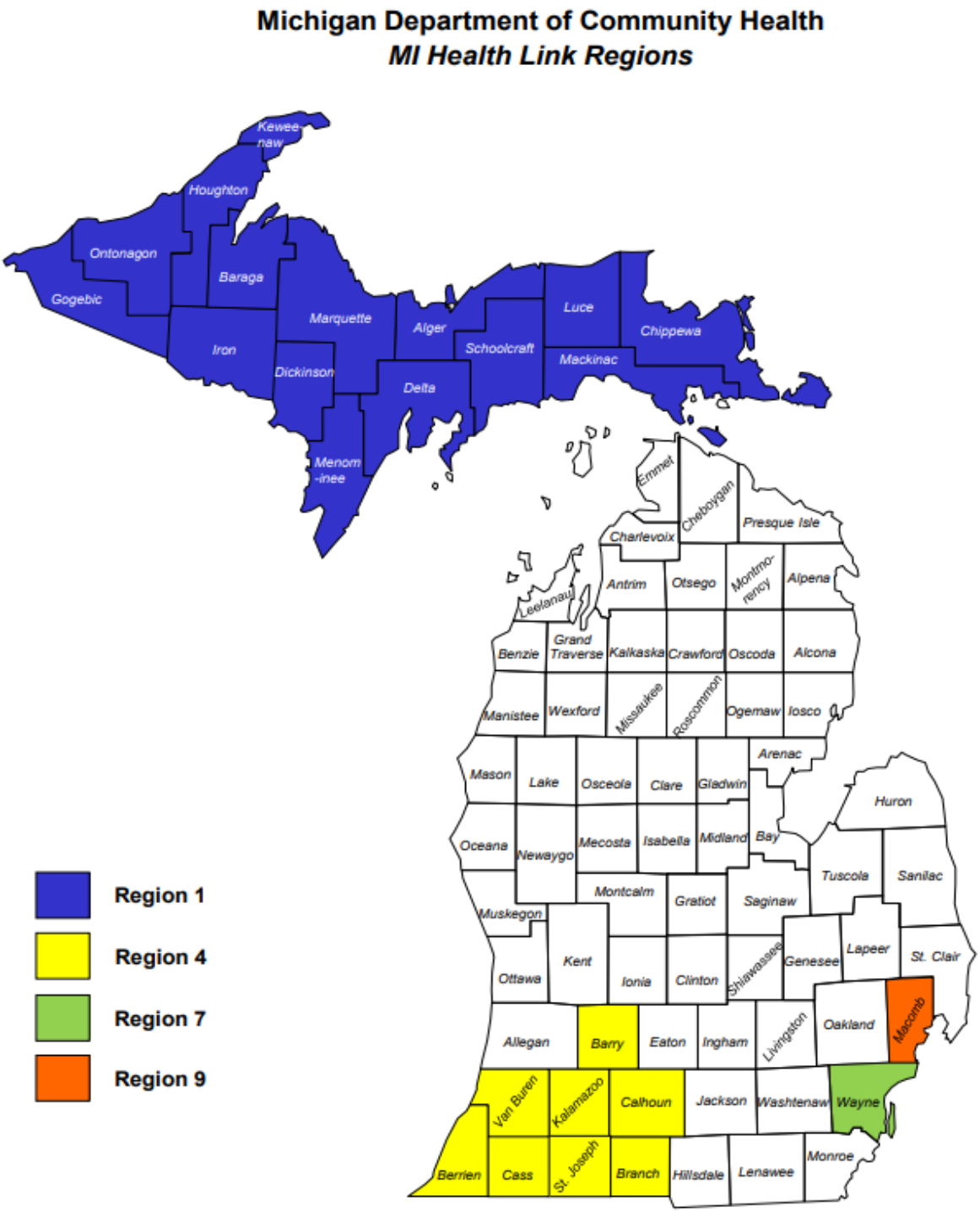
* During the review period for this annual EQR, MCH served Regions 7 and 9 and MER served Region 4. MCH merged with MER effective January 1, 2022, and MER now serves Regions 4, 7, and 9.

2-2 Michigan Department of Health and Human Services. *MI Health Link.* Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html. Accessed on: Jan 21, 2022.

2-3 Michigan Department of Health and Human Services. Integrated Care Division. *Integrated Care Organization (ICOs) Health Plan Telephone Numbers, Websites, and County Service Areas* Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077-354084--,00.html. Accessed on: Jan 21, 2021.

2-4 September 2021 enrollment data were provided by MDHHS.

Figure 2-1—ICO Regions[2-5]



[2-5] Michigan Department of Community Health. *MI Health Link Regions*. Available at: https://www.michigan.gov/documents/mdch/MI_Health_Link_Counties_468767_7.pdf. Accessed on: Jan 21, 2022.

Quality Strategy

The 2020–2023 MDHHS Comprehensive Quality Strategy (CQS)[2-6] provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including the MI Health Link program. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 CQS, MDHHS strives to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The CQS also aligns with CMS' Quality Strategy and the United States (U.S.) Department of Health and Human Services' (HHS') National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. The MDHHS CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3 and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and specifically were designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

Table 2-3—MDHHS CQS Goals and Objectives

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

[2-6] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Mar 8, 2022.

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

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

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

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

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

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

Quality Initiatives and Interventions

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

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

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

3. Assessment of Integrated Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2021 review period to evaluate the performance of ICOs on providing quality, timely, and accessible healthcare services to MI Health Link members. Quality, as it pertains to EQR, means the degree to which the ICO increased the likelihood of desired outcomes of its members through its structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the ICOs were at successfully demonstrating and reporting on outcome information for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data from all EQR activities and draw conclusions about the quality and timeliness of, and access to care furnished by each ICO.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for each ICO to identify strengths and weaknesses that may pertain to the domains of quality, timeliness, and access to services furnished by the ICO for the EQR activity.
- **Step 2**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about overall quality and timeliness of, and access to care and services furnished by the ICO.
- **Step 3**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities as they relate to strengths and weakness in one or more of the domains of quality, timeliness, and accessibility of care and services furnished by the ICO.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2021 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Quality Improvement Projects

For the SFY 2021 validation, the ICOs concluded their MDHHS-mandated QIP topic, reporting Remeasurement 2 study indicator outcomes. The QIP topic *Follow-Up After Hospitalization for Mental Illness* addresses follow-up visits with a mental health practitioner within 30 days of discharge for a hospitalization for mental illness. This topic has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care. Since the QIPs were initiated in SFY 2019, the methodology HSAG used to validate the QIPs was based on CMS

guidelines as outlined in CMS' *Protocol 3. Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (2012 CMS EQR Protocol 3). Table 3-1 outlines the selected study indicator for the QIP for all ICOs.

Table 3-1—Follow-Up After Hospitalization for Mental Illness QIP Study Indicators

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

Performance Measure Validation

The purpose of PMV was to assess the accuracy of performance measures reported by ICOs and to determine the extent to which performance measures reported by the ICOs followed *Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements* (MMP Core Reporting Requirements)[3-1] and *Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements* (Michigan-Specific Reporting Requirements).[3-2] For the SFY 2021 PMV, the ICOs were required to submit a completed Information Systems Capabilities Assessment Tool (ISCAT) that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure reporting. HSAG subsequently validated

[3-1] The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements*. Available at: https://www.cms.gov/files/document/corereportingreqscy2021.pdf. Accessed on: Feb 24, 2022.

[3-2] The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements*. Available at: https://www.cms.gov/files/document/mireportingrequirements02262021.pdf. Accessed on: Feb 24, 2022.

the ICOs' data collection and reporting processes used to calculate and report performance measure results for performance measures MDHHS selected for validation.

Table 3-2 lists the performance measures calculated and reported by the ICOs for calendar year (CY) 2020 (i.e., January 1, 2020, through December 31, 2020), along with the performance measure number. The performance measures are numbered as they appear in the *MMP Reporting Requirements* and the *Michigan-Specific Reporting Requirements* technical specification manuals.

Table 3-2—Performance Measures for Validation

Performance Measure	Description
Core Measure 9.1	*Emergency Department (ED) Behavioral Health Services Utilization*
Core Measure 9.3	*Minimizing Institutional Length of Stay*
MI2.6	*Timely Transmission of Care Transition Record to Health Care Professional*
MI5.6	*Care for Adults—Medication Review*

Performance Measure Rates

MDHHS and CMS also required each ICO to contract with an NCQA-certified Healthcare Effectiveness Data and Information Set (HEDIS®)[3-3] vendor and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS MY 2020 performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and risk-adjusted utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR. The HEDIS measures and performance areas reviewed by HSAG are included in Table 3-3.

Table 3-3—HEDIS Measures

HEDIS Measure
Prevention and Screening
BCS—Breast Cancer Screening
COL—Colorectal Cancer Screening
COA—Care for Older Adults—Advance Care Planning
COA—Care for Older Adults—Medication Review
COA—Care for Older Adults—Functional Status Assessment
COA—Care for Older Adults—Pain Assessment

[3-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS Measure
Respiratory Conditions
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
Cardiovascular Conditions
CBP—Controlling High Blood Pressure
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%
Diabetes
CDC—Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)
CDC—Comprehensive Diabetes Care—Eye Exam
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%
Musculoskeletal Conditions
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
OMW—Osteoporosis Management in Women Who Had a Fracture
Behavioral Health
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days
Medication Management and Care Coordination
TRC—Transitions of Care—Notification of Inpatient Admission
TRC—Transitions of Care—Receipt of Discharge Information
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge
TRC—Transitions of Care—Medication Reconciliation Post-Discharge
Overuse/Appropriateness
*Prostate-Specific Antigen (PSA)—Non-Recommended PSA-Based Screening of Older Men**
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**

HEDIS Measure
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**
*DAE—Use of High-Risk Medications in Older Adults—Total**
Access/Availability of Care
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total
IET—Initiation of Alcohol and Other Drug Dependence Treatment
IET—Engagement of Alcohol and Other Drug Dependence Treatment
Risk-Adjusted Utilization
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**

* Measures for which lower rates indicate better performance

Compliance Review

SFY 2021 marked the third year of the current three-year compliance review cycle. The compliance reviews for the MDHHS-contracted ICOs ending in SFY 2021 comprised 11 program areas, referred to as standards, that correlated to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also included applicable state-specific contract requirements and areas of focus identified by MDHHS, and each standard included an information system review and ICO demonstration, as applicable. Table 3-4 below displays the scope of the reviews for each year of the current three-year cycle. Refer to Section 5 for a summary of findings for all three years.

Table 3-4—Current Three-Year Compliance Review Cycle (SFY 2019–SFY 2021)

Year One (SFY 2019)		Year Two (SFY 2020)	Year Three (SFY 2021)
Full Compliance Review	**Associated Federal Citation**	**CAP Review**	**Focused Compliance Review**
Standard I—Availability of Services	§438.206	Review of standards/elements that received a *Not Met* score during the SFY 2019 review. The standards/elements reviewed varied between each ICO.	Review of focus areas identified during the SFY 2019 and SFY 2020 reviews.
Standard II—Assurance of Adequate Capacity and Services	§438.207		
Standard III—Coordination and Continuity of Care	§438.208		
Standard IV—Coverage and Authorization of Services	§438.210		
Standard V—Provider Selection	§438.214		

Year One (SFY 2019)		Year Two (SFY 2020)	Year Three (SFY 2021)
Standard VI—Confidentiality	§438.224		
Standard VII—Grievance and Appeal Systems	§438.228 and Subpart F		
Standard VIII—Subcontractual Relationships and Delegation	§438.230		
Standard IX—Practice Guidelines	§438.236		
Standard X—Health Information Systems[1]	§438.242		
Standard XI—Quality Assessment and Performance Improvement	§438.330		

[1] This standard includes a comprehensive assessment of each ICO's information systems capabilities.

For SFY 2021, MDHHS requested that HSAG conduct a focused compliance review targeting specific areas of opportunity identified during the SFY 2019 and SFY 2020 reviews. The review consisted exclusively of comprehensive case file reviews for six program areas. Table 3-5 outlines the program areas for the case file reviews and their associated standard. For any program area that was determined to be out of compliance, the ICOs were required to submit a CAP.

Table 3-5—SFY 2021 Focused Compliance Review

Associated Standard	Description of Files
Standard IV—Coverage and Authorization of Services	Service Authorization Denials
Standard V—Provider Selection	Individual Practitioner Credentialing
Standard V—Provider Selection	Organizational Credentialing
Standard VII—Grievance and Appeal Systems	Member Grievances
Standard VII—Grievance and Appeal Systems	Member Appeals
Standard VIII—Subcontractual Relationships and Delegation	Subcontractors (delegated entities)

Network Adequacy Validation

HSAG collaborated with MDHHS to design annual NAV tasks pertinent to Medicaid services and LTSS covered by the MI Health Link program and that complemented the annual CMS NAV without duplication. As such, HSAG conducted two SFY 2021 activities assessing different aspects of the ICOs' network adequacy:

1. A NAV analysis of ICOs' alignment with minimum time and distance network requirements and minimum provider capacity network requirements applicable to 25 Medicaid and LTSS provider types.
2. Development and implementation of a telephone survey among PCPs contracted with one or more ICOs to serve individuals enrolled in the MI Health Link program (i.e., the secret shopper survey).

To initiate the NAV activity, each ICO submitted member and network provider data files to HSAG during an October 2020 pilot phase and a February 2021 initial validation phase. Following the initial validation analyses, HSAG requested that applicable ICOs submit additional data files or exception/extension[3-4] requests during April and May 2021 to address potential network deficiencies among the Medicaid and LTSS provider types. The provider types included in the validation are displayed in Table 3-6.

Table 3-6—MI Health Link Provider Types

Provider Type
Provider Types With Travel Time and Distance Requirements
Adult Day Program
Dental (preventive and restorative)
Eye Examinations (provided by optometrists)
Eye Wear (providers dispensing eyeglasses and contact lenses)
Hearing Examinations
Hearing Aids
Maternal Infant Health Program (MIHP) Agency
Provider Types Rendering Home-Based Services
Adaptive Medical Equipment and Supplies
Assistive Technology Devices
Assistive Technology Van Lifts and Tie Downs
Chore Services
Community Transition Services
Environmental Modifications
Expanded Community Living Supports
Fiscal Intermediary
Home-Delivered Meals
Medical Supplies
Non-Emergency Medical Transportation
Non-Medical Transportation (waiver service only)
Personal Care Services (non-agency and agency)

[3-4] MDHHS allowed ICOs to request exceptions or extensions to the minimum network requirements for any provider types for which region-specific results failed to meet the minimum network requirement. Exception requests were allowed when the ICO had contracted to the fullest extent of the available providers but was unable to meet the minimum network requirements. Extension requests were allowed when the ICO had not contracted all potentially available providers and was pursuing further contracting opportunities at the time of validation in an attempt to meet the minimum network requirements.

Provider Type
Personal Emergency Response System
Preventive Nursing Services (non-agency and agency)
Private Duty Nursing (non-agency and agency)
Respite
Skilled Nursing Home

Secret Shopper Survey

During May and June 2021, HSAG completed a secret shopper telephone survey of PCPs' offices contracted with one or more ICOs under the MI Health Link program to collect appointment availability information for routine well-checks and nonurgent, problem-focused ("symptomatic") visits for ICOs' new MI Health Link members.

A secret shopper is a person employed to pose as a patient to evaluate the validity of available provider information (e.g., accurate ICO and program affiliation information). The secret shopper telephone survey allows for objective data collection from healthcare providers while minimizing potential bias introduced by knowing the identity of the surveyor. Specific survey objectives included the following:

1. Determine whether PCP service locations accepted patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligned with the ICOs' provider data
2. Determine whether PCP service locations accepting MI Health Link for the requested ICO accepted new patients and the degree to which new patient acceptance aligned with the ICOs' provider data
3. Determine appointment availability with the sampled PCP service locations for routine well-checks and nonurgent symptomatic visits

Several limitations and analytic considerations must be noted when reviewing the results of the secret shopper telephone surveys. These limitations are located in Appendix A. External Quality Review Activity Methodologies.

Consumer Assessment of Healthcare Providers and Systems Analysis

CAHPS Home and Community Based Services Survey

For SFY 2021, HSAG administered the CAHPS Home and Community Based Services Survey (HCBS CAHPS Survey) to adult members enrolled in the ICOs who received a qualifying personal care service or were currently enrolled in the MI Health Link HCBS waiver. The primary objective of the HCBS CAHPS Survey is to effectively and efficiently obtain information on members' experiences with the LTSS they receive. Sampled adult members completed the survey from May to July 2021 over the telephone in either English or Spanish. For purposes of reporting members' experience with care results, CMS requires a minimum of 11 respondents per measure (i.e., a minimum cell size of 11). Due to the low number of respondents for each ICO and CMS suppression rules, HSAG could not present individual plan-level results for the HCBS CAHPS Survey measures; therefore, results are only presented for the MI Health Link program in Section 5. Integrated Care Organization Comparative Information.

External Quality Review Activity Results

Aetna Better Health of Michigan

Validation of Quality Improvement Projects

Performance Results

Table 3-7 displays the overall validation status; the baseline, Remeasurement 1, and Remeasurement 2 results; and the ICO-designated goal for the QIP study indicator. A validation rating of *Not Met* indicates that either (1) all critical elements (elements pivotal to the QIP process) were *Met*, but less than 60 percent of all evaluation elements were *Met* across all activities; or (2) one or more critical elements were *Not Met*.

Table 3-7—Overall Validation Rating for AET

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	Improve the percentage of follow-up visits within 30 days with a mental health practitioner after discharge from an acute hospitalization with mental illness diagnosis.	47.1%	54.9% ⇔	44.5% ⇔	56%

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

Table 3-8 displays the interventions implemented to address the barriers identified by the ICO using QI and causal/barrier analysis processes.

Table 3-8—Remeasurement 2 Interventions for AET

Intervention Descriptions	
Worked with members and their providers to improve communication and schedule integrated care team (ICT) meetings regularly.	Received weekly reports on inpatient admissions from the PIHPs and used internal inpatient alerts to outreach to members as soon as notification of an inpatient admission was received.
Addressed behavioral health needs during the COVID-19 pandemic via telehealth and behavioral health support phone lines.	Provided members with education and support regarding the importance of taking their medication.
Assessed for SDOH such as homelessness, familial and/or natural supports, and community-based supports. Worked with the PIHPs and community-based partners to identify SDOH, triggers/barriers, and assisted members with housing needs.	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan had opportunities for improvement related to accurate statistical testing used to compare the Remeasurement 2 results to the baseline results and the evaluation of its interventions. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Aetna Better Health of Michigan met only 33 percent of the requirements for data analysis and implementation of improvement strategies.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** develop evaluation methods for each intervention to demonstrate its effectiveness on the study indicator outcomes and to guide decisions for QI efforts.

Weakness #2: Aetna Better Health of Michigan demonstrated a decrease in the percentage of members receiving follow-up care with a mental health practitioner within 30 days of discharge for a hospitalization for mental illness during the second remeasurement period as compared to the baseline measurement period. [**Quality, Timeliness**, and **Access**]

Why the weakness exists: Aetna Better Health of Michigan noted that the COVID-19 pandemic impacted its members' access to behavioral health providers.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.

Performance Measure Validation

Performance Results

HSAG evaluated **Aetna Better Health of Michigan**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system; medical services data system (e.g., claims and encounters); care coordination system (i.e., tracking and management of care transition record transmissions); medication reconciliation system (i.e., tracking and management of medication reviews); hybrid data collection; or data integration.

Aetna Better Health of Michigan received a measure designation of *Reportable (R)* for all measures, signifying that **Aetna Better Health of Michigan** had reported the measures in compliance with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-9—Measure-Specific Validation Designation for AET

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
MI2.6: *Timely Transmission of Care Transition Record to Health Care Professional*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI5.6: *Care for Adults—Medication Review*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-10 shows each of **Aetna Better Health of Michigan**'s audited HEDIS measures, rates for HEDIS MY 2018 and HEDIS MY 2020 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2020 with HEDIS MY 2018, and the HEDIS MY 2020 MI Health Link statewide average performance rates. Of note, based on CMS' suspension of all MMP reporting of HEDIS MY 2019 rates due to the COVID-19 pandemic public health emergency (PHE), HEDIS MY 2019 rates are not displayed in Table 3-10, as data were not reported for MY 2019. HEDIS MY 2020 measure rates performing better than the statewide average are notated by green font.

Table 3-10—Measure-Specific Percentage Rates for AET

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening[1]	54.82	50.55	-4.27	56.31
COL—Colorectal Cancer Screening[1]	41.12	46.23	+5.11	56.77
COA—Care for Older Adults—Advance Care Planning	54.99	44.28	-10.71	42.46
COA—Care for Older Adults—Medication Review	59.12	46.23	-12.89	66.63
COA—Care for Older Adults—Functional Status Assessment[1]	61.80	63.50	+1.70	53.52

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
COA—Care for Older Adults—Pain Assessment	65.69	46.72	-18.97	67.04
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.45	20.14	-6.31	24.27
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	76.12	74.11	-2.01	71.84
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	86.16	89.34	+3.18	90.73
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure[2]	—	51.58	—	56.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	89.47	86.67	-2.80	89.59
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	75.79	80.76	+4.97	80.63
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	70.37	74.89	+4.52	80.11
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	87.10	78.10	-9.00	84.70
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**[1]	28.71	51.82	+23.11	44.54
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	63.26	38.69	-24.57	47.38
CDC—Comprehensive Diabetes Care—Eye Exam[1]	50.12	43.31	-6.81	55.61
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	93.19	92.46	-0.73	91.69
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg[2]	—	48.66	—	56.67
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	68.91	74.02	+5.11	76.52
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	73.11	75.53	+2.42	81.68
Musculoskeletal Conditions				
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	72.31	73.33	+1.02	71.75
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	7.69	0.00	-7.69	6.97
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	60.00	65.67	+5.67	70.43

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	43.08	56.22	+13.14	55.06
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	20.26	17.52	-2.74	29.65
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	47.06	44.53	-2.53	57.00
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[1]	21.88	41.38	+19.50	31.68
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[1]	46.88	59.48	+12.60	49.24
Medication Management and Care Coordination				
TRC—Transitions of Care—Notification of Inpatient Admission[2]	—	4.62	—	11.77
TRC—Transitions of Care—Receipt of Discharge Information[2]	—	3.41	—	11.34
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge[2]	—	71.53	—	75.36
TRC—Transitions of Care—Medication Reconciliation Post-Discharge[2]	—	17.52	—	30.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	17.61	18.15	+0.54	21.36
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**[1]	42.70	33.60	-9.10	32.83
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**[2]	—	18.22	—	18.05
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	NA	5.35	—	5.37
*DAE—Use of High-Risk Medications in Older Adults—Total**	NA	21.57	—	21.46
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	82.06	78.70	-3.36	82.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	93.29	91.27	-2.02	92.90
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	89.80	88.14	-1.66	89.79
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	89.55	87.38	-2.17	89.49
IET—Initiation of Alcohol and Other Drug Dependence Treatment[2]	—	41.81	—	37.65
IET—Engagement of Alcohol and Other Drug Dependence Treatment[2]	—	9.26	—	6.59

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Risk-Adjusted Utilization				
PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)[2]*	—	1.55	—	1.20
PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)[2]*	—	1.25	—	1.15

* Measures for which lower rates indicate better performance.

Note: Green indicates performance is better than the statewide average.

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending in comparison with MY 2018 be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending; therefore, comparisons to MY 2018 rates and benchmarks are not performed for this measure.

NA indicates that data were not available.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan demonstrated accuracy in its reporting of Core Measure 9.3, in alignment with the CMS MMP Core Reporting Requirements. This is especially commendable considering Core Measure 9.3 was calculated and reported for the first time by ICOs in CY 2021 for MY 2020. **Aetna Better Health of Michigan** described a thorough, ongoing monitoring process for Core Measure 9.3 whereby its staff members monitor any individuals in an institution through a care management dashboard that is refreshed multiple times throughout each day. The dashboard includes transition of care probabilities and provides **Aetna Better Health of Michigan** with nearly real-time oversight of members' discharge statuses, as related to Core Measure 9.3. **Aetna Better Health of Michigan**'s thorough monitoring process further supports the overall quality of care for its institutional facility members and accuracy of data used for Core Measure 9.3 reporting. [**Quality**]

Strength #2: Aetna Better Health of Michigan demonstrated strength in its completeness of administrative data, as it reported a claims and encounters completeness rate of approximately 99.78 percent within 90 days of the end of MY 2020. **Aetna Better Health of Michigan** also described a thorough completeness factor calculation process, which assured that **Aetna Better Health of Michigan**'s Core Measure 9.1 and Core Measure 9.3 data are accurate, since both are dependent on claims data. It is also critical that administrative data are complete for Core Measure 9.3 so that

Aetna Better Health of Michigan can readily identify any claims within 60 days of a member's discharge to the community (i.e., readmission to an institution, hospital admission, or claims for continued nursing facility stays), further assuring the accuracy of data element B (total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission). Sufficient oversight of timely and complete claims and encounter data helps support the overall quality of administrative data used for performance measure reporting. [**Quality** and **Timeliness**]

Strength #3: In the Behavioral Health domain, **Aetna Better Health of Michigan**'s rate for the *AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment* measure indicator increased more than 13 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in continuous medication treatment for members with a diagnosis of major depression. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[3-5] [**Quality** and **Access**]

Strength #4: In the Behavioral Health domain, **Aetna Better Health of Michigan**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* and *30 Days* measure indicators both increased more than 12 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest strength and improvement in timely follow-up care with a mental health provider for members with a diagnosis of mental illness following inpatient discharge. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.[3-6] [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan identified that it had initially incorrectly drawn the hybrid sample for MI5.6, which resulted in **Aetna Better Health of Michigan** redrawing a subsequent corrected sample and resubmitting it to the Financial Alignment Initiative (FAI) Data Collection System (DCS). [**Quality**]

Why the weakness exists: Due to a manual sorting error, **Aetna Better Health of Michigan** had sorted its MI5.6 data by member identification number instead of by member name, as required according to the Michigan-Specific Reporting Requirements.

Recommendation: As discussed during PMV, HSAG recommends that **Aetna Better Health of Michigan** continue working with its certified HEDIS software vendor to explore programming

3-5 National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 4, 2022.

3-6 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Feb 4, 2022.

MI5.6 sample logic into its annual hybrid sample process, which is already used for **Aetna Better Health of Michigan**'s HEDIS reporting. **Aetna Better Health of Michigan** should improve the accuracy of its sampling process by removing the manual sorting step. If the vendor is unable to accommodate this request, HSAG further recommends that **Aetna Better Health of Michigan** add an additional level of review to confirm the accuracy of the sampling process prior to finalizing the sample for medical record retrieval. A thorough sampling and validation process is crucial for ensuring the quality and accuracy of hybrid performance measure reporting.

Weakness #2: **Aetna Better Health of Michigan** had a low MI5.6 rate in comparison to the other ICOs' reported rates. [**Quality** and **Timeliness**]

Why the weakness exists: **Aetna Better Health of Michigan** indicated a process-related MI5.6 impact as a result of the COVID-19 PHE, as providers completed medication reviews virtually instead of in person. **Aetna Better Health of Michigan** did not, however, attribute its lower rate to COVID-19, as the rate was consistent with prior years, and therefore did not identify a root cause for the lower rate.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** explore options to increase the medication reviews conducted by clinical pharmacists and prescribing practitioners by evaluating the MY 2020 medical record review (MRR) findings to determine if opportunities exist for targeted provider education. **Aetna Better Health of Michigan** should use findings from the MRR to identify trends in numerator-negative cases, which can assist in determining if the targeted provider education should focus on the clinical importance of completing medication reviews or the medical record documentation required to demonstrate completion of a medication review. Timely medication reconciliation and care coordination following discharge is important, as it helps to avoid negative consequences that may impact quality of life.

Weakness #3: For 33 of the 46 reported HEDIS measures (72 percent), **Aetna Better Health of Michigan**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization. [**Quality**]

Why the weakness exists: Over half of the measures included in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization domains demonstrated worse performance than the statewide average, indicating **Aetna Better Health of Michigan** was not performing as well as the other ICOs in some measures within these domains.

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

Weakness #4: In the Prevention and Screening domain, **Aetna Better Health of Michigan**'s rate for the *COA—Care for Older Adults—Advance Care Planning*, *Medication Review*, and *Pain Assessment* measure indicators decreased more than 10 percentage points from MY 2018 to MY

2020, with two indicators falling below the HEDIS MY 2020 MI Health Link statewide average (i.e., *Medication Review* and *Pain Assessment*), indicating that adult members 66 years of age and older were not always having advance care planning, medication reviews, and pain assessments conducted to help optimize quality of life. As the population ages, physical and cognitive function can decline and pain becomes more prevalent. Older adults may also have more complex medication regimens. Consideration should be given to an individual's own choices about end-of-life care; advance care plans should be executed.[3-7] [**Quality** and **Access**]

Why the weakness exists: The rate for the *COA—Care for Older Adults—Advance Care Planning*, *Medication Review*, and *Pain Assessment* measure indicators decreasing more than 10 percentage points from MY 2018 to MY 2020 suggests that barriers exist for having medications reviewed, advanced care planning, and pain assessments during the measurement year for some adults 66 years of age and older.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some adults 66 years and older are not having medication reviews, advanced care planning, and pain assessments completed. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *COA—Care for Older Adults—Advance Care Planning*, *Medication Review*, and *Pain Assessment* measure indicators. **Aetna Better Health of Michigan** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education). Additionally, **Aetna Better Health of Michigan** should identify factors related to the COVID-19 PHE and its impact on conducting medication reviews, advanced care planning, and pain assessments.

Weakness #5: In the Diabetes domain, **Aetna Better Health of Michigan**'s rate for the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator significantly decreased more than 24 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest that fewer adult members with diabetes had controlled blood glucose levels. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. [3-8] [**Quality** and **Access**]

Why the weakness exists: The rate for the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator decreasing more than 24 percentage points from MY 2018 to MY 2020 suggests that barriers exist for effective diabetes management among adult members.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some adult members with diabetes were unable to effectively manage their blood glucose levels. Upon identification of a root cause, **Aetna Better**

3-7 National Committee for Quality Assurance. Care for Older Adults (COA). Available at: https://www.ncqa.org/hedis/measures/care-for-older-adults/. Accessed on: Feb 4, 2022.

3-8 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 7, 2022.

Health of Michigan should implement appropriate interventions to improve the performance related to the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator. **Aetna Better Health of Michigan** should consider the nature and scope of the issue (e.g., whether the issues related to accessing care, patient and provider education, or a lack of service providers). Additionally, **Aetna Better Health of Michigan** should identify factors related to the COVID-19 PHE and its impact on diabetes management.

Compliance Review

Performance Results

Table 3-11 presents an overview of the results of the SFY 2021 focused compliance review for **Aetna Better Health of Michigan**, which consisted exclusively of case file reviews in certain program areas, and associated information system reviews. The table identifies all program areas that were reviewed and those that required a CAP due to noncompliance with State and federal requirements.

Table 3-11—Case File Review Overall Findings for AET

Associated Standard	Description of Files	CAP Not Required	CAP Required
IV	Service Authorization Denials		✓
V	Individual Practitioner Credentialing		✓
V	Organizational Credentialing		✓
VII	Member Grievances		✓
VII	Member Appeals		✓
VIII	Subcontractors (delegated entities)	✓	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan's oversight of its delegates included evidence of periodic formal reviews of all delegated functions; development of CAPs, when necessary; and regular meetings with the delegates which included performance metric reviews. Robust oversight and monitoring of delegated entities strengthen program integrity efforts. This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS and/or identifies poor performance which may require remediation. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan and its dental delegate did not consistently adhere to the Coverage and Authorization of Services requirements under 42 CFR §438.210. Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a denied service in easily understood language and have access to their appeal and SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that IDNs generated by **Aetna Better Health of Michigan** or its dental delegate did not consistently include the specific citation of the policy or criteria used in rendering the adverse benefit determination (ABD). Additionally, the IDNs included repetitive language, grammatical errors, were incomplete, or not completed within the time frame for expedited requests. Within **Aetna Better Health of Michigan**'s CAP, the overall root cause was identified as a lack of oversight of the ICO's and dental delegates' denials letters.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna Better Health of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set coverage and authorization of services standards.

Weakness #2: Aetna Better Health of Michigan did not consistently adhere to the Provider Selection individual practitioner credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS individual credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that **Aetna Better Health of Michigan** did not consistently obtain disclosure of ownership and control interest forms; verify a provider's Drug Administration Enforcement (DEA) and Controlled Dangerous Substances (CDS) certifications; or conduct all required Medicare and Medicaid exclusion checks. Additionally, for one provider there was a five-year gap between credentialing cycles. The ICO's CAP suggested that the root cause of the deficiencies included, but was not limited to, differences in commercial, Medicare, Medicaid, and NCQA requirements; human error; and substitution of exclusion and sanction database sources in lieu of all database sources required by contract.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna Better Health of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set individual practitioner credentialing standards.

Weakness #3: Aetna Better Health of Michigan did not consistently adhere to the Provider Selection organizational credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS organizational requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that recredentialing case files did not consistently include evidence that a disclosure of ownership and control interest was obtained during the recredentialing process. Through its CAP, **Aetna Better Health of Michigan**

reported that providers initially contracted for commercial and Medicare lines of business (LOBs), wherein the disclosure of ownership form is not required by CMS or NCQA, did not have the forms collected as part of the credentialing/recredentialing process when the Medicaid LOB was added to their contract.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna Better Health of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set organizational credentialing standards.

Weakness #4: Aetna Better Health of Michigan did not consistently adhere to the Grievance Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is essential to maintain high-quality care and services and to ensure member retention and engagement in care. [**Quality** and **Timeliness**]

Why the weakness exists: Case files reviewed by HSAG identified that **Aetna Better Health of Michigan**'s PIHP delegate did not consistently acknowledge grievances within **Aetna Better Health of Michigan**'s policy of three business days. Additionally, it was unclear how the PIHP was reporting standard and expedited resolution time frames or how **Aetna Better Health of Michigan** monitored adherence to resolution time frames. Through its CAP, **Aetna Better Health of Michigan** reported a lack of effective communication of requirements to the PIHPs as the root cause of the deficiencies.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna Better Health of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards.

Weakness #5: Aetna Better Health of Michigan did not consistently adhere to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintaining member access to high-quality care and services. Additionally, the notice to the member about an appeal should be written at the appropriate reading grade level for members to understand the action and their SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that **Aetna Better Health of Michigan** did not consistently obtain written consent from the member for a provider to file an appeal on the member's behalf, or sent acknowledgement letters outside the ICO's policy of three business days. Additionally, resolution letters were incomplete, had grammatical errors, were not consistently written in easily understood and plain language or at the state-required reading grade level, did not include the service being appealed or the reason for the appeal decision; or included an inaccurate time frame for members to continue services. Through its CAP, **Aetna Better Health of Michigan** reported that the root cause of the deficiencies was related to staff not following standard processes, staff following Medicare guidance for Medicaid services, use of an older version of acknowledgment letters, and lack of an established quality assurance process for resolution letters.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna Better Health of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

Network Adequacy Validation

Performance Results

HSAG's NAV results indicated that **Aetna Better Health of Michigan** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. For Region 4, **Aetna Better Health of Michigan** submitted additional data updates and final requests for exceptions and extensions to address unmet minimum network requirements. MDHHS approved **Aetna Better Health of Michigan**'s requested exception for the Adult Day Program provider type and extensions for the Hearing Aids and MIHP Agency provider types.

Table 3-12 presents **Aetna Better Health of Michigan**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception and extension determinations.

Table 3-12—SFY 2021 NAV Results for AET, by Region and Provider Type

Provider Type	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time and Distance Requirements			
Adult Day Program	Exception Granted	Met	Met
Dental (preventive and restorative)	Met	Met	Met
Eye Examinations (provided by optometrists)	Met	Met	Met
Eye Wear (providers dispensing eyeglasses and contact lenses)	Met	Met	Met
Hearing Examinations	Met	Met	Met
Hearing Aids	Extension Granted	Met	Met
MIHP Agency	Extension Granted	Met	Met
Provider Types Rendering Home-Based Services			
Adaptive Medical Equipment and Supplies	Met	Met	Met
Assistive Technology Devices	Met	Met	Met
Assistive Technology Van Lifts and Tie Downs	Met	Met	Met
Chore Services	Met	Met	Met
Community Transition Services	Met	Met	Met
Environmental Modifications	Met	Met	Met

Provider Type	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
Expanded Community Living Supports	Met	Met	Met
Fiscal Intermediary	Met	Met	Met
Home-Delivered Meals	Met	Met	Met
Medical Supplies	Met	Met	Met
Non-Emergency Medical Transportation	Met	Met	Met
Non-Medical Transportation (waiver service only)	Met	Met	Met
Personal Care Services (non-agency and agency)	Met	Met	Met
Personal Emergency Response System	Met	Met	Met
Preventive Nursing Services (non-agency and agency)	Met	Met	Met
Private Duty Nursing (non-agency and agency)	Met	Met	Met
Respite	Met	Met	Met
Skilled Nursing Home	Met	Met	Met
Percent of Total Provider Types Meeting Minimum Network Requirements	**88%**	**100%**	**100%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan met all Medicaid and LTSS minimum network requirements for Region 7, indicating that **Aetna Better Health of Michigan** maintained an adequate network for MI Health Link members in this region. [**Access**]

Strength #2: Aetna Better Health of Michigan met all Medicaid and LTSS minimum network requirements for Region 9, indicating that **Aetna Better Health of Michigan** maintained an adequate network for MI Health Link members in this region. [**Access**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan failed to meet all Medicaid and LTSS minimum network requirements for Region 4, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. [**Access**]

Why the weakness exists: MDHHS approved **Aetna Better Health of Michigan**'s extension requests for the Hearing Aids and MIHP Agency provider types in Region 4, as **Aetna Better Health of Michigan** had not yet contracted with all available providers in the region.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** identify and contract with all available Hearing Aid and MIHP Agency providers in Region 4 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region. Updated compliance for Hearing Aid and MIHP Agency provider types in Region 4 will be evaluated in the SFY 2022 NAV.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 670 sampled PCP locations (i.e., "cases") for **Aetna Better Health of Michigan**, with an overall response rate of 56.5 percent (188 cases) for routine well-check visits and 56.1 percent (189 cases) for nonurgent symptomatic visits among **Aetna Better Health of Michigan**'s three MI Health Link regions. Region 4 had the highest response rate among cases asking for a routine well-check appointment, and Region 9 had the highest response rate among cases asking for a nonurgent symptomatic appointment.

Table 3-13 and Table 3-14 summarize the SFY 2021 secret shopper survey response rates by visit scenario for **Aetna Better Health of Michigan**, and for each of **Aetna Better Health of Michigan**'s contracted MI Health Link regions.

Table 3-13—Summary of AET Secret Shopper Survey Results for Routine Well-Check Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 4	75	43	38	33	28
Region 7	141	79	71	67	63
Region 9	117	66	58	50	48
AET Total	**333**	**188**	**167**	**150**	**139**

Table 3-14—Summary of AET Secret Shopper Survey Results for Nonurgent Symptomatic Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 4	76	37	29	21	19
Region 7	143	81	68	37	37
Region 9	118	71	60	32	31
AET Total	**337**	**189**	**157**	**90**	**87**

Table 3-15 displays the number of cases in which the survey respondent offered appointments to new patients for routine services and nonurgent symptomatic visits, as well as summary wait time statistics for **Aetna Better Health of Michigan**, and for each of **Aetna Better Health of Michigan**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location. Of cases in which the survey respondent reported that the provider location accepted **Aetna Better Health of Michigan**, the MI Health Link program, and new patients, appointment availability was reported for 56.8 percent (n=79) and 73.6 percent (n=64) of routine and symptomatic cases, respectively.

Table 3-15—Summary of AET Secret Shopper Survey Appointment Availability Results, by Region

Region	Routine Well-Check					Nonurgent Symptomatic Visit				
	Number of Cases Offered an Appointment	Wait Time in Calendar Days				Number of Cases Offered an Appointment	Wait Time in Calendar Days			
		Min	Max	Average	Median		Min	Max	Average	Median
Region 4	13	0	42	15.2	4.0	13	0	20	2.8	1.0
Region 7	38	0	39	6.9	4.5	30	0	56	7.2	3.0
Region 9	28	0	52	9.4	5.5	21	0	70	8.0	2.0
AET Total	**79**	**0**	**52**	**9.2**	**5.0**	**64**	**0**	**70**	**6.6**	**2.0**

In follow-up to the secret shopper survey findings, MDHHS required **Aetna Better Health of Michigan** to develop a CAP to address the deficiencies identified during the survey. **Aetna Better Health of Michigan** was also expected to extend any training and oversight activities implemented for the CAP to providers not included in the survey sample. MDHHS' CAP requirements are detailed in Appendix A.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the secret shopper activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified

strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ICO-specific strengths were not identified because a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from **Aetna Better Health of Michigan**'s provider data files.

Weaknesses and Recommendations

Weakness #1: Over 64 percent of sampled provider locations were unable to be reached, did not accept **Aetna Better Health of Michigan**, or did not accept and/or recognize the MI Health Link program. [**Quality** and **Access**]
Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **Aetna Better Health of Michigan**'s PCP data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program.
Recommendation: HSAG recommends that **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies. Additionally, as MDHHS required **Aetna Better Health of Michigan** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Weakness #2: A limited number of callers were offered appointment dates and times. [**Access**]
Why the weakness exists: Of cases in which the survey respondent reported that the provider location accepted **Aetna Better Health of Michigan**, the MI Health Link program, and new patients, appointment availability was reported for 56.8 percent and 73.6 percent of routine and symptomatic cases, respectively. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included members needing to designate the provider as their PCP before scheduling an appointment, being required to complete pre-registration or provide additional personal information to schedule an appointment, and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.
Recommendation: HSAG recommends that **Aetna Better Health of Michigan** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Aetna Better Health of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

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

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Aetna Better Health of Michigan** about the quality, timeliness, and accessibility of care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Aetna Better Health of Michigan** across all EQR activities to identify common themes within **Aetna Better Health of Michigan** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that while **Aetna Better Health of Michigan** generally performed well in some areas impacting the quality and timeliness of, and access to care, the ICO has several opportunities for improvement. While **Aetna Better Health of Michigan** used appropriate QI tools to conduct a causal/barrier analysis for its *Follow-Up After Hospitalization for Mental Illness* QIP, the study indicator showed a decrease in the percentage of follow-up visits within 30 days with a mental health practitioner after a discharge from an acute hospitalization with a mental illness diagnosis, and **Aetna Better Health of Michigan** did not reach its goal [**Quality**, **Timeliness**, and **Access**]. **Aetna Better Health of Michigan** reported improving its collaboration efforts with the PIHPs by holding regular meetings and exchanging weekly reports but continued to demonstrate opportunities for improvement related to its causal/barrier analysis and evaluating the effectiveness of each intervention. These results were further supported by the PMV activity as **Aetna Better Health of Michigan**'s indicator rates for the *Follow-Up After Hospitalization for Mental Illness* measure fell below the statewide average [**Timeliness** and **Access**]. **Aetna Better Health of Michigan** reported implementing additional interventions to improve this measure such as organizing a behavioral health workgroup, conducting MRRs, and conducting member and provider education.

Aetna Better Health of Michigan demonstrated strengths in the behavioral health program area through the PMV activity. Four of six rates in the Behavioral Health domain increased, with three of those rates exceeding the statewide average. All four indicator rates demonstrated improvement for the *Antidepressant Medication Management* and *Follow-Up After Emergency Department Visit for Mental Illness* measures, which increased by approximately 6 to 20 percentage points [**Quality**, **Timeliness**, and **Access**].

The combined results of EQR activities presented mixed findings regarding access to care. Through the results of the NAV activity, **Aetna Better Health of Michigan** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9, indicating an adequate network of providers in these geographical areas; however, **Aetna Better Health of Michigan** failed to meet the minimum network

requirement for two provider types in Region 4 that had additional providers available to contract with [**Access**]. Additionally, the results of the secret shopper activity suggested that members may have experienced barriers to accessing providers, as a high percentage of sampled provider locations were unable to be reached, did not accept **Aetna Better Health of Michigan**, or did not accept and/or recognize the MI Health Link program [**Access**]. The PMV activity further suggested that members may be experiencing barriers to primary care and services through measure results within the Prevention and Screening, Diabetes, and Access/Availability of Care domains. While two indicator rates in the Prevention and Screening domain exceeded the statewide average, four of the six indicator rates experienced declines ranging from approximately 4 to 19 percentage points. Four of the indicator rates in the Diabetes domain also experienced declines ranging from approximately 1 to 25 percentage points, and one rate (an inverse measure) increased more than 23 percentage points (indicating worse performance). All four indicator rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure within the Access/Availability of Care domain also decreased, although the differences were relatively minimal. These findings indicate that fewer members received breast cancer screenings; fewer older adults received advance care planning, medication reviews, and pain assessments; fewer members received proper diabetes care management; and fewer adults accessed preventive or ambulatory care.

Aetna Better Health of Michigan's results for the compliance review activity identified several process deficiencies across the service authorization denials, individual practitioner credentialing, organizational credentialing, member grievances, and member appeals program areas [**Quality**, **Timeliness**, and **Access**]. Of particular note, member-facing materials such as service authorization IDNs and member appeal resolution letters were not consistently written in easily understood language or did not include the required content. Adequate written member materials are essential to ensure members are receiving all necessary information to make informed choices regarding their healthcare and services and accessing their appeal and SFH rights. **Aetna Better Health of Michigan** completed a root cause analysis and developed a remediation plan for all deficiencies, which should support more effective member communication and administrative procedures to effectively support the delivery of quality, accessible, and timely services [**Quality**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

AmeriHealth Caritas

Validation of Quality Improvement Projects

Performance Results

Table 3-16 displays the overall validation status and the baseline, Remeasurement 1, and Remeasurement 2 results for the QIP study indicator. **AmeriHealth Caritas** did not select a plan-specific goal for the study indicator, as this was not a requirement for the QIP. A validation rating of *Not Met* indicates that either (1) all critical elements (elements pivotal to the QIP process) were *Met*, but less than 60 percent of all evaluation elements were *Met* across all activities; or (2) one or more critical elements were *Not Met*.

Table 3-16—Overall Validation Rating for AMI

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	The percentage of discharges for members 21 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses on or between January 1 and December 1 and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	35.1%	46.8% ⇔	39.1% ⇔	

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

Table 3-17 displays the interventions implemented to address the barriers identified by the ICO using QI and causal/barrier analysis processes.

Table 3-17—Remeasurement 2 Interventions for AMI

Intervention Descriptions	
Established a process to provide timely notification to care coordinators of behavioral health inpatient care and set the expectation that members are included in the transition of care process.	Created and implemented a process to improve notification and acknowledgement of information from the PIHPs.
Educated members via direct mail, website, and phone calls regarding telehealth options.	Educated providers via fax, website, and phone calls regarding expanded telehealth services based on CMS guidance.
Scheduled regular meetings between the ICO care coordinators and each PIHP to improve collaboration and focus on members with transitions of care.	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: AmeriHealth Caritas designed a methodologically sound QIP. [**Quality**]

Strength #2: AmeriHealth Caritas used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Although **AmeriHealth Caritas** demonstrated improvement in the study indicator outcome for the second remeasurement as compared to the baseline, the goal of significant improvement was not achieved. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: AmeriHealth Caritas noted that the COVID-19 pandemic impacted members' access to care due to restrictions on in-person medical care and the ICO's ability to carry out many interventions during the remeasurement period.

Recommendation: HSAG recommends that **AmeriHealth Caritas** revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.

Performance Measure Validation

Performance Results

HSAG evaluated **AmeriHealth Caritas**' data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system; medical services data system (e.g., claims and encounters); care coordination system (i.e., tracking and management of care transition record transmissions); medication reconciliation system (i.e., tracking and management of medication reviews); hybrid data collection; or data integration. Although HSAG did not identify any general concerns with **AmeriHealth Caritas**' data integration and measure data reporting processes, HSAG identified concerns with the accuracy of reported Core Measure 9.3 data, resulting in a required resubmission of the measure.

AmeriHealth Caritas received a measure designation of *Reportable (R)* for all measures, signifying that **AmeriHealth Caritas** had reported the measures in compliance with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-18—Measure-Specific Validation Designation for AMI

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
MI2.6: *Timely Transmission of Care Transition Record to Health Care Professional*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI5.6: *Care for Adults—Medication Review*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-19 shows each of **AmeriHealth Caritas**' audited HEDIS measures, rates for HEDIS MY 2018 and HEDIS MY 2020 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2020 with HEDIS MY 2018, and the HEDIS MY 2020 MI Health Link statewide average performance rates. Of note, based on CMS' suspension of all MMP reporting of HEDIS MY 2019 rates due to the COVID-19 PHE, HEDIS MY 2019 rates are not displayed in Table 3-19, as data were not reported for MY 2019. HEDIS MY 2020 measure rates performing better than the statewide average are notated by green font.

Table 3-19—Measure-Specific Percentage Rates for AMI

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening[1]	47.51	50.86	+3.35	56.31
COL—Colorectal Cancer Screening[1]	37.23	50.85	+13.62	56.77
COA—Care for Older Adults—Advance Care Planning	18.98	21.90	+2.92	42.46
COA—Care for Older Adults—Medication Review	47.93	44.77	-3.16	66.63
COA—Care for Older Adults—Functional Status Assessment[1]	39.90	52.80	+12.90	53.52
COA—Care for Older Adults—Pain Assessment	43.07	60.58	+17.51	67.04
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	25.81	23.88	-1.93	24.27

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	59.22	65.38	+6.16	71.84
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	79.61	96.15	+16.54	90.73
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure[2]	—	51.82	—	56.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	81.82	100.00	+18.18	89.59
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	80.65	76.70	-3.95	80.63
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	77.33	75.95	-1.38	80.11
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	85.89	80.78	-5.11	84.70
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**[1]	51.82	42.34	-9.48	44.54
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	38.93	50.12	+11.19	47.38
CDC—Comprehensive Diabetes Care—Eye Exam[1]	62.04	53.28	-8.76	55.61
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	90.51	91.73	+1.22	91.69
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg[2]	—	51.82	—	56.67
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	73.64	78.19	+4.55	76.52
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	71.05	75.79	+4.74	81.68
Musculoskeletal Conditions				
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	63.33	68.42	+5.09	71.75
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	25.00	0.00	-25.00	6.97
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	56.04	73.61	+17.57	70.43

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	43.96	59.72	+15.76	55.06
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	10.81	15.22	+4.41	29.65
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	35.14	39.13	+3.99	57.00
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[1]	15.09	22.22	+7.13	31.68
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[1]	32.08	41.67	+9.59	49.24
Medication Management and Care Coordination				
TRC—Transitions of Care–Notification of Inpatient Admission[2]	—	11.68	—	11.77
TRC—Transitions of Care–Receipt of Discharge Information[2]	—	10.46	—	11.34
TRC—Transitions of Care–Patient Engagement After Inpatient Discharge[2]	—	72.75	—	75.36
TRC—Transitions of Care–Medication Reconciliation Post-Discharge[2]	—	45.50	—	30.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	15.74	18.36	+2.62	21.36
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**[1]	36.14	32.48	-3.66	32.83
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**[2]	—	10.05	—	18.05
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	NA	4.78	—	5.37
*DAE—Use of High-Risk Medications in Older Adults—Total**	NA	13.52	—	21.46
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	80.75	76.66	-4.09	82.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	90.36	90.28	-0.08	92.90
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	85.73	85.48	-0.25	89.79
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	86.29	85.49	-0.80	89.49

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
IET—Initiation of Alcohol and Other Drug Dependence Treatment[2]	—	42.33	—	37.65
IET—Engagement of Alcohol and Other Drug Dependence Treatment[2]	—	9.82	—	6.59
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[2]	—	1.09	—	1.20
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[2]	—	1.61	—	1.15

* Measures for which lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending in comparison with MY 2018 be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending; therefore, comparisons to MY 2018 rates and benchmarks are not performed for this measure.
NA indicates that data were not available.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: AmeriHealth Caritas established robust care coordination processes with its PIHP delegates. These processes included routine use and maintenance of PIHP contacts designated for ED admission notifications; conducting ICT meetings; holding routine operational meetings to discuss performance measurement; using daily admission, discharge, and transfer (ADT) reports to identify behavioral health ED visits; and providing its PIHPs with same-day ED admission notifications. Patient care coordinators continued daily follow-up with members who were identified as having a biharmonical health ED visit as well. **AmeriHealth Caritas** indicated that these PIHP processes assured timely follow-up with members after behavioral health ED visits. Timely follow-up care after behavioral health ED visits helps to avoid high-cost readmissions and helps promote quality patient care. [**Quality** and **Timeliness**]

Strength #2: AmeriHealth Caritas demonstrated a general strength in its completeness of administrative data, as it reported a typical clean claims processing timeliness standard of 95 to 99 percent within 30 days. Ensuring timely claims adjudication assures that **AmeriHealth Caritas**'

Core Measure 9.1 and Core Measure 9.3 data are accurate, since both are dependent on claims data. It is also critical to have complete claims data for Core Measure 9.3 so that **AmeriHealth Caritas** can ensure it is able to readily identify any claims within 60 days of a member's discharge to the community (i.e., readmission to an institution, hospital admission, or claims for continued nursing facility stays), further assuring the accuracy of data element B (total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission). Sufficient oversight of timely and complete claims and encounter data helps support the overall quality of administrative data used for performance measure reporting. [**Quality** and **Timeliness**]

Strength #3: In the Respiratory Conditions domain, **AmeriHealth Caritas**' rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measure indicator increased more than 16 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in adult members being dispensed a bronchodilator within 30 days of an acute inpatient discharge for COPD. Appropriate and timely prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD.[3-9] [**Quality**, **Access**, and **Timeliness**]

Strength #4: In the Cardiovascular Conditions domain, **AmeriHealth Caritas**' rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator increased more than 18 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in adult members who were hospitalized and discharged with a diagnosis of acute myocardial infarction receiving persistent beta-blocker treatment for six months after discharge. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-10] [**Quality**, **Access**, and **Timeliness**]

Strength #5: In the Diabetes domain, **AmeriHealth Caritas**' rate for the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator increased more than 11 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest strength and improvement in adult members with diabetes having controlled blood glucose levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-11] [**Quality** and **Access**]

[3-9] National Committee for Quality Assurance. Pharmacotherapy Management of COPD Exacerbation (PCE). Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-management-of-copd-exacerbation/. Accessed on: Feb 8, 2022.

[3-10] National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/. Accessed on: Feb 8, 2022.

[3-11] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 7, 2022.

Strength #6: In the Behavioral Health domain, **AmeriHealth Caritas**' rate for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators increased more than 15 percentage points from MY 2018 to MY 2020, and both exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in members with a diagnosis of major depression receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.[3-12] [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG identified during primary source verification (PSV) (and during subsequent follow-up) that **AmeriHealth Caritas** was unable to identify the absence of institutional facility or inpatient hospital claims for two cases reported in Core Measure 9.3, data element B (total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission). **[Quality]**

Why the weakness exists: HSAG identified during PSV of the selected cases for Core Measure 9.3 during the virtual review that two cases reported in data element B were actually continued nursing facility stays instead of discharges to the community. **AmeriHealth Caritas** reviewed these cases and indicated these inaccuracies were a result of a source code error in its identification of data element A (total number of admissions to institutional facilities), as the institutional facility admissions (IFAs) were inappropriately reported in data element A. This was because **AmeriHealth Caritas**' programming logic relied on discharge status codes submitted on claims by nursing facilities, instead of relying on **AmeriHealth Caritas**' identification of pre- and post-discharge claims. HSAG requested that **AmeriHealth Caritas** revise its source code to fully comply with the Core Measure 9.3 reporting requirements which indicate the ICO should use paid claims for identification of data elements A and B.

Recommendation: HSAG recommends that **AmeriHealth Caritas** implement more stringent validation checks prior to data submission. These checks should include reviewing the source system (i.e., Facets) to ensure the absence of institutional facility and hospital claims within 60 days of discharge for cases included in Core Measure 9.3 data element B, as well as reviewing a sample of cases reported in data element A to ensure the admission was not actually a continued nursing facility stay. HSAG further recommends that **AmeriHealth Caritas** put quality checks in place to ensure that programming logic used for future data submissions are in alignment with the reporting requirements and that programming logic is inclusive of all associated value set codes and avoids limiting parameters. Having adequate validation checks, programming logic quality checks, and sample selections further ensures the quality and accuracy of reported data.

[3-12] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 4, 2022.

Weakness #2: **AmeriHealth Caritas** had a low MI2.6 rate in comparison to the other ICOs' reported rates. [**Quality** and **Timeliness**]

Why the weakness exists: **AmeriHealth Caritas** indicated no MI2.6 impact as a result of the COVID-19 pandemic PHE; however, it relied solely on administrative data for reporting MI2.6.

Recommendation: HSAG recommends that **AmeriHealth Caritas** explore whether its low MI2.6 rate was due to the transition records not transmitting or due to relying on administrative data for reporting the measure. If the low rate was due to relying on administrative data, HSAG recommends that **AmeriHealth Caritas** consider reporting MI2.6 following hybrid methodology in future years. If **AmeriHealth Caritas** identifies that the low rate reflected a true lack of timely transmissions of member transition records, HSAG recommends that **AmeriHealth Caritas** take a proactive approach to transmit its available transition records directly to providers rather than waiting to receive the discharge summaries or continuity of care document files, since **AmeriHealth Caritas** may be missing opportunities to complete the timely transmission due to relying on these data sources. Timely transition record transmission and care coordination following discharge is important, as it helps to improve patient outcomes and quality of life.

Weakness #3: For 29 of the 46 reported HEDIS measures (63 percent), **AmeriHealth Caritas**' rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care. [**Quality**]

Why the weakness exists: Over half of the measures included in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care domains demonstrated worse performance than the statewide average, indicating **AmeriHealth Caritas** was not performing as well as the other ICOs in some measures within these domains.

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

Weakness #4: In the Musculoskeletal Conditions domain, **AmeriHealth Caritas**' rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreased by 25 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest that women who suffered a fracture did not receive a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and

treatment, the risk of future osteoporosis-related fractures can be reduced.[3-13] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreased by 25 percentage points from MY 2018 to MY 2020, suggesting barriers exist for women to receive timely bone mineral density tests or prescriptions to treat osteoporosis within six months of a fracture.

Recommendation: HSAG recommends that **AmeriHealth Caritas** conduct a root cause analysis or focused study to determine why women were not always receiving timely bone mineral density tests or a prescription to treat osteoporosis within six months of a fracture. Upon identification of a root cause, **AmeriHealth Caritas** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **AmeriHealth Caritas** should consider the nature and scope of the issue (e.g., whether the issues related to patient and provider education or barriers to accessing care). Additionally, **AmeriHealth Caritas** should identify factors related to the COVID-19 PHE and its impact on the management and treatment of women with fractures.

Compliance Review

Performance Results

Table 3-20 presents an overview of the results of the SFY 2021 focused compliance review for **AmeriHealth Caritas**, which consisted exclusively of case file reviews in certain program areas, and associated information system reviews. The table identifies all program areas that were reviewed and those that required a CAP due to noncompliance with State and federal requirements.

Table 3-20—Case File Review Overall Findings for AMI

Associated Standard	Description of Files	CAP Not Required	CAP Required
IV	Service Authorization Denials		✓
V	Individual Practitioner Credentialing		✓
V	Organizational Credentialing	✓	
VII	Member Grievances		✓
VII	Member Appeals		✓
VIII	Subcontractors (delegated entities)	✓	

[3-13] National Committee for Quality Assurance. Osteoporosis Management In Women Who Had a Fracture (OMW). Available at: https://www.ncqa.org/hedis/measures/osteoporosis-management-in-women-who-had-a-fracture-omw/. Accessed on: Feb 8, 2022.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: AmeriHealth Caritas consistently adhered to organizational credentialing requirements including, but not limited to, demonstrating that providers were in good standing with State and federal regulatory agencies and confirming providers were not excluded from Medicare and Medicaid, ensuring organizational providers were accredited or that site visits were conducted, obtaining receipt of disclosure of ownership and control interest forms, and adhering to recredentialing time frames. Adherence to federal and MDHHS organizational requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. **[Quality]**

Strength #2: AmeriHealth Caritas' oversight of the two subcontractors reviewed included evidence of periodic formal reviews that comprised a review of all delegated functions and case file reviews to determine implementation; development of CAPs, when necessary; and regular meetings with the delegate which included performance metric reviews. Robust oversight and monitoring of delegated entities strengthen program integrity efforts. This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS and/or identifies poor performance which may require remediation. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: AmeriHealth Caritas and its dental delegate did not consistently adhere to the Coverage and Authorization of Services requirements under 42 CFR §438.210. Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a denied service in easily understood language and have access to their appeal and SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that some IDNs generated by **AmeriHealth Caritas** and/or its dental delegate did not provide the specific citation to the regulation, policy, criteria, or guideline that supported the ABD; did not meet the contractually required reading grade level and included grammatical and professional errors; and did not include information related to the expedited appeal process. Additionally, **AmeriHealth Caritas** had yet to begin using the 2021 version of the IDN. **AmeriHealth Caritas**' CAP indicated that the root cause of the deficiencies included, but was not limited to, a lack of staff communication of requirements, a lack of a process to check reading grade level of IDNs, and the most recent IDN template was not appropriately distributed for upload into the ICO's or delegate's system.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **AmeriHealth Caritas** should continually evaluate its processes, procedures, and

monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set coverage and authorization of services standards.

Weakness #2: AmeriHealth Caritas did not consistently adhere to the Provider Selection individual practitioner credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS individual credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that **AmeriHealth Caritas** did not consistently obtain disclosure of ownership and control interest forms; conduct all required Medicare and Medicaid exclusion checks; or conduct provider-specific performance reviews at the time of recredentialing. **AmeriHealth Caritas**' CAP indicated that the root cause of the deficiencies was related to its recredentialing procedure which did not require ownership and disclosure forms to be collected, miscommunication of processes during the site review, and a prior workplan to consider provider-specific performance reviews at the time of recredentialing was not executed due to changes in leadership.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **AmeriHealth Caritas** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set individual practitioner credentialing standards.

Weakness #3: AmeriHealth Caritas did not consistently adhere to the Grievance Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is essential to maintain high-quality care and services and to ensure member retention. [**Quality** and **Timeliness**]

Why the weakness exists: Case files reviewed by HSAG identified that **AmeriHealth Caritas** verbally informed members that the grievance would be routed for review; however, **AmeriHealth Caritas** staff members explained that written acknowledgement is required. Additionally, several significant concerns were identified with the case files:

- Time frame gaps were found in the processing of member grievances and in the documentation of late notes.
- One grievance was not appropriately investigated or resolved.
- Some case files documented a Plan Resolution Date several weeks after the last activity or resolution of the grievance.
- Some case files included a note suggesting that a resolution letter was sent to the member; however, no resolution letter was provided to the member.
- One letter included an incorrect grievance receipt date.
- Another letter included spelling/punctuation errors.

Additionally, **AmeriHealth Caritas** explained that member grievances are to be investigated and resolved within 30 calendar days; however, for those grievances classified as a Plan Initiated Investigation, **AmeriHealth Caritas**' process allowed for a 90-calendar-day resolution. **AmeriHealth Caritas**' CAP indicated that the root cause of the deficiencies was related to a lack of adherence to departmental policy and procedure, a lack of departmental monitoring, staff attrition, and the existence of plan-initiated investigations which allowed a 90-calendar-day resolution time frame.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **AmeriHealth Caritas** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards.

Weakness #4: AmeriHealth Caritas did not consistently adhere to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintain access to high-quality care and services and to ensure members are informed of and can understand the reasons for ABDs and their SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that **AmeriHealth Caritas** did not consistently provide acknowledgement of the appeal or did not acknowledge the appeal in a timely manner; and did not resolve appeals in a timely manner. Additionally, significant time frame gaps in the processing of member appeals were identified; resolution letters were not written in easily understood and plain language and did not meet the required reading grade level; and **AmeriHealth Caritas** referenced Medicare guidelines as the basis for the appeal decision for a Medicaid covered service. **AmeriHealth Caritas** CAP indicated that the root cause of the deficiencies was related to lack of adherence to departmental policy and procedure, lack of departmental monitoring, and staff attrition.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **AmeriHealth Caritas** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

Network Adequacy Validation

Performance Results

HSAG's NAV results indicated that **AmeriHealth Caritas** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9.

Table 3-21 presents **AmeriHealth Caritas**' region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception and extension determinations.

Table 3-21—SFY 2021 NAV Results for AMI, by Region and Provider Type

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time and Distance Requirements		
Adult Day Program	Met	Met
Dental (preventive and restorative)	Met	Met
Eye Examinations (provided by optometrists)	Met	Met
Eye Wear (providers dispensing eyeglasses and contact lenses)	Met	Met
Hearing Examinations	Met	Met
Hearing Aids	Met	Met
MIHP Agency	Met	Met
Provider Types Rendering Home-Based Services		
Adaptive Medical Equipment and Supplies	Met	Met
Assistive Technology Devices	Met	Met
Assistive Technology Van Lifts and Tie Downs	Met	Met
Chore Services	Met	Met
Community Transition Services	Met	Met
Environmental Modifications	Met	Met
Expanded Community Living Supports	Met	Met
Fiscal Intermediary	Met	Met
Home-Delivered Meals	Met	Met
Medical Supplies	Met	Met
Non-Emergency Medical Transportation	Met	Met
Non-Medical Transportation (waiver service only)	Met	Met
Personal Care Services (non-agency and agency)	Met	Met
Personal Emergency Response System	Met	Met
Preventive Nursing Services (non-agency and agency)	Met	Met

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Private Duty Nursing (non-agency and agency)	Met	Met
Respite	Met	Met
Skilled Nursing Home	Met	Met
Percent of Total Provider Types Meeting Minimum Network Requirements	**100%**	**100%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: AmeriHealth Caritas met all Medicaid and LTSS minimum network requirements for Region 7, indicating that **AmeriHealth Caritas** maintains an adequate network for MI Health Link members in this region. [**Access**]

Strength #2: AmeriHealth Caritas met all Medicaid and LTSS minimum network requirements for Region 9, indicating that **AmeriHealth Caritas** maintains an adequate network for MI Health Link members in this region.

Weaknesses and Recommendations

Weakness #1: HSAG identified no specific weaknesses for **AmeriHealth Caritas** based on the SFY 2021 NAV results.

Why the weakness exists: Not applicable.

Recommendation: AmeriHealth Caritas should continue to monitor its Medicaid and LTSS providers, including verification of provider data accuracy using external data sources, to ensure an adequate network for MI Health Link members in Region 7 and Region 9.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 458 sampled PCP locations (i.e., "cases") for **AmeriHealth Caritas**, with an overall response rate of 59.6 percent (136 cases) for routine well-check visits and 69.1 percent (159 cases) for nonurgent symptomatic visits among **AmeriHealth Caritas**' two MI Health Link regions. Region 9 had the highest response rate for both routine well-check and nonurgent symptomatic appointments.

Table 3-22 and Table 3-23 summarize the SFY 2021 secret shopper survey response rates by visit for **AmeriHealth Caritas**, and for each of **AmeriHealth Caritas**' contracted MI Health Link regions.

Table 3-22—Summary of AMI Secret Shopper Survey Results for Routine Well-Check Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 7	161	92	57	51	47
Region 9	67	44	31	26	26
AMI Total	**228**	**136**	**88**	**77**	**73**

Table 3-23—Summary of AMI Secret Shopper Survey Results for Nonurgent Symptomatic Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 7	163	107	56	39	38
Region 9	67	52	27	13	13
AMI Total	**230**	**159**	**83**	**52**	**51**

Table 3-24 displays the number of cases in which the survey respondent offered appointments to new patients for routine services and nonurgent symptomatic visits, as well as summary wait time statistics for **AmeriHealth Caritas**, and for each of **AmeriHealth Caritas**' contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location. Of cases in which the survey respondent reported that the provider location accepted **AmeriHealth Caritas**, the MI Health Link program, and new patients, appointment availability was reported for 57.5 percent (n=42) and 56.9 percent (n=29) of routine and symptomatic cases, respectively.

Table 3-24—Summary of AMI Secret Shopper Survey Appointment Availability Results, by Region

Region	Routine Well-Check					Nonurgent Symptomatic Visit				
	Number of Cases Offered an Appointment	Wait Time in Calendar Days				Number of Cases Offered an Appointment	Wait Time in Calendar Days			
		Min	Max	Average	Median		Min	Max	Average	Median
Region 7	27	0	83	13.6	8.0	23	0	89	10.7	4.0
Region 9	15	1	33	11.0	7.0	6	0	40	10.7	6.5
AMI Total	**42**	**0**	**83**	**12.7**	**7.0**	**29**	**0**	**89**	**10.7**	**4.0**

In follow-up to the secret shopper survey findings, MDHHS required **AmeriHealth Caritas** to develop a CAP to address the deficiencies identified during the survey. **AmeriHealth Caritas** was also expected to extend any training and oversight activities implemented for the CAP to providers not included in the survey sample. MDHHS' CAP requirements are detailed in Appendix A.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the secret shopper activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ICO-specific strengths have not been identified because a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the **AmeriHealth Caritas**' provider data files.

Weaknesses and Recommendations

Weakness #1: Over 71 percent of sampled provider locations were unable to be reached, did not accept **AmeriHealth Caritas**, or did not accept and/or recognize the MI Health Link program. [**Access**]

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **AmeriHealth Caritas**' PCP data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends that **AmeriHealth Caritas** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies. Additionally, as MDHHS required **AmeriHealth Caritas** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Weakness #2: A limited number of callers were offered appointment dates and times. [**Access**]

Why the weakness exists: Of cases in which the survey respondent reported that the provider location accepted **AmeriHealth Caritas**, the MI Health Link program, and new patients, appointment availability was reported for 57.5 percent and 56.9 percent of routine and symptomatic cases, respectively. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. Considerations included members needing to designate the provider as their PCP before scheduling an appointment, being required to complete pre-registration or

provide additional personal information to schedule an appointment, and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **AmeriHealth Caritas** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **AmeriHealth Caritas** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

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

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **AmeriHealth Caritas** about the quality, timeliness, and accessibility of care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **AmeriHealth Caritas** across all EQR activities to identify common themes within **AmeriHealth Caritas** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that while **AmeriHealth Caritas** generally performed well in some areas impacting the quality and timeliness of, and access to care, the ICO has several opportunities for improvement. **AmeriHealth Caritas** designed a methodologically sound QIP, used appropriate QI tools to conduct a causal/barrier analysis, and prioritized the identified barriers for its *Follow-Up After Hospitalization for Mental Illness* QIP. The study indicator also showed an increase in the percentage of discharges for members 21 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health practitioner within 30 days of discharge during Remeasurement 2 from the baseline measurement. However, the goal of a statistically significant increase was not met, and the Remeasurement 2 rate decreased compared to Remeasurement 1 [**Quality**, **Timeliness**, and **Access**]. **AmeriHealth Caritas** continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps. These results were further supported by the PMV activity as while **AmeriHealth Caritas**' indicator rates for the *Follow-Up After Hospitalization for Mental Illness* measure increased, the rates fell below the statewide average [**Timeliness** and **Access**]. **AmeriHealth Caritas** reported a lack of member engagement in telehealth due to members' reluctancy to use technology as a barrier but is continuing ongoing member education and also contracted with a specific telehealth provider in 2021. **AmeriHealth Caritas** also reported hosting regular meetings between the PIHP care team and the ICO's care coordinators to provide timely communication and collaboration

specific to members experiencing care transitions. Further, **AmeriHealth Caritas** reported a limited number of care coordinators due to open positions as a barrier; however, all opens positions have now been filled.

AmeriHealth Caritas demonstrated strengths in the behavioral health program area through the PMV activity. All six indicator rates in the Behavioral Health domain increased, with two of those rates exceeding the statewide average. While continued opportunities for improvement exist, all indicator rates for the *Antidepressant Medication Management*, *Follow-Up After Hospitalization for Mental Illness*, and *Follow-Up After Emergency Department Visit for Mental Illness* measures increased by approximately 4 to 18 percentage points [**Quality**, **Timeliness**, and **Access**].

The combined results of EQR activities presented mixed findings regarding access to care. Through the results of the NAV activity, **AmeriHealth Caritas** met all Medicaid and LTSS minimum network requirements, indicating an adequate network of providers [**Access**]. The results of the secret shopper activity, however, suggested that members may have experienced barriers to accessing providers, as a high percentage of sampled provider locations were unable to be reached, did not accept **AmeriHealth Caritas**, or did not accept and/or recognize the MI Health Link program [**Access**]. The PMV activity further suggested that members may be experiencing barriers to primary care and services through measure results within the Prevention and Screening and Access/Availability of Care domains. All four indicator rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure within the Access/Availability of Care domain declined, although the decreases were relatively minimal, and fell below the statewide average [**Access**]. Additionally, all six indicator rates under the Prevention and Screening domain fell below the statewide average and have continued opportunities for improvement [**Quality** and **Access**]. However, **AmeriHealth Caritas** is making progress in this domain as five indicator rates increased. **AmeriHealth Caritas** reported it had expanded member and provider outreach and education, provided monthly care gap reports to PCPs, and established nonstandard supplemental data processes to support program improvement for most measures within this domain. The indicator rates suggest that **AmeriHealth Caritas**' interventions were successful in increasing the number of members who received breast cancer and colorectal cancer screenings; and older adults who received advance care planning, a functional status assessment, and a pain assessment [**Quality** and **Access**].

Additionally, **AmeriHealth Caritas** is demonstrating progress within the Diabetes domain as five indicator rates indicated better performance; three of these rates exceeded the statewide average while one rate (an inverse measure) fell below the statewide average, indicating better performance [**Quality** and **Access**]. These findings indicate that fewer members diagnosed with diabetes had poor HbA1c control and more members diagnosed with diabetes had HbA1c control, received medical attention for diabetic nephropathy, and received statin therapy [**Quality** and **Access**].

AmeriHealth Caritas' results for the compliance review activity identified several process deficiencies across the service authorization denials, individual practitioner credentialing, member grievances, and member appeals program areas [**Quality**, **Timeliness**, and **Access**]. Of particular note, member-facing materials such as service authorization IDNs and member appeal resolution letters were not consistently written in easily understood language or did not include the required content. Member appeals were also not consistently resolved in a timely manner. Timely and adequate written member materials are

essential to ensure members are receiving all necessary information to make informed choices regarding their healthcare and services and accessing their appeal and SFH rights. **AmeriHealth Caritas** completed a root cause analysis and developed a remediation plan for all deficiencies, which should support more effective member communication and administrative procedures to effectively support the delivery of quality, accessible, and timely services [**Quality**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

HAP Empowered

Validation of Quality Improvement Projects

Performance Results

Table 3-25 displays the overall validation status; the baseline, Remeasurement 1, and Remeasurement 2 results; and the ICO-designated goal for the QIP study indicator. A validation rating of *Not Met* indicates that either (1) all critical elements (elements pivotal to the QIP process) were *Met*, but less than 60 percent of all evaluation elements were *Met* across all activities; or (2) one or more critical elements were *Not Met*.

Table 3-25—Overall Validation Rating for HAP

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	Percentage of members who had a follow-up visit within 30 days of a discharge for selected mental illness or intentional self-harm.	53.8%	38.2% ⇔	37.7% ⇔	56%

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

Table 3-26 displays the interventions implemented to address the barriers identified by the ICO using QI and causal/barrier analysis processes.

Table 3-26—Remeasurement 2 Interventions for HAP

Intervention Descriptions	
Established a process for the care coordinator assistant to review hospitalization notifications from the PIHPs weekly and send to the care coordinators.	Clarified the expectation that care coordinators need to follow up with members with a behavioral health hospitalization.
Completed data validation on hospitalization reports from 2019. This process drove the focus of coordination meetings with PIHPs in 2020 to ensure coordinated follow-up with members following receipt of timely admission and discharge information on weekly behavioral health hospitalization reports.	Continued enhancing its two desk-level processes focused on data validation of behavioral health hospitalization information received from PIHPs and procedures for care coordinators to conduct follow-up with members with a hospitalization.
Created a template for hospitalization follow-up information to increase data consistency and monitor follow-up visits.	Established a process to have monthly discussions about members shared with the PIHP for care coordination of hospitalized members.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered designed a methodologically sound QIP. [**Quality**]

Strength #2: HAP Empowered met 100 percent of the requirements for data analysis and implementation of improvement strategies. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered demonstrated a non-statistically significant decline in performance for the percentage of members receiving follow-up care within 30 days of a hospital discharge for mental illness. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: HAP Empowered had a relatively small eligible population, which decreased during the second remeasurement period as compared to the baseline. A greater increase in the number of members who are numerator compliant must occur to achieve the desired goal.

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

Performance Measure Validation

Performance Results

HSAG evaluated **HAP Empowered**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system; medical services data system (e.g., claims and encounters); care coordination system (i.e., tracking and management of care transition record transmissions); medication reconciliation system (i.e., tracking and management of medication reviews); hybrid data collection; and data integration. Although HSAG did not identify any general concerns with **HAP Empowered**'s data integration and measure data reporting processes, HSAG identified reporting errors for Core Measure 9.3, resulting in a required resubmission of the measure.

HAP Empowered received a measure designation of *Reportable (R)* for all measures, signifying that **HAP Empowered** had reported the measures in compliance with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-27—Measure-Specific Validation Designation for HAP

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
MI2.6: *Timely Transmission of Care Transition Record to Health Care Professional*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI5.6: *Care for Adults—Medication Review*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-28 shows each of **HAP Empowered**'s audited HEDIS measures, rates for HEDIS MY 2018 and HEDIS MY 2020 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2020 with HEDIS MY 2018, and the HEDIS MY 2020 MI Health Link statewide average performance rates. Of note, based on CMS' suspension of all MMP reporting of HEDIS MY 2019 rates due to the COVID-19 PHE, HEDIS MY 2019 rates are not displayed in Table 3-28, as data were not reported for MY 2019. HEDIS MY 2020 measure rates performing better than the statewide average are notated by green font.

Table 3-28—Measure-Specific Percentage Rates for HAP

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening[1]	57.61	57.11	-0.50	56.31
COL—Colorectal Cancer Screening[1]	50.12	60.98	+10.86	56.77
COA—Care for Older Adults—Advance Care Planning	25.06	55.23	+30.17	42.46
COA—Care for Older Adults—Medication Review	61.31	62.53	+1.22	66.63
COA—Care for Older Adults—Functional Status Assessment[1]	45.26	62.53	+17.27	53.52
COA—Care for Older Adults—Pain Assessment	55.23	78.83	+23.60	67.04
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	32.71	25.22	-7.49	24.27

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	70.49	69.74	-0.75	71.84
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	90.98	94.74	+3.76	90.73
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure[2]	—	59.61	—	56.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	88.89	92.86	+3.97	89.59
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	79.65	84.41	+4.76	80.63
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	73.37	76.43	+3.06	80.11
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	78.28	87.83	+9.55	84.70
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**[1]	80.17	47.45	-32.72	44.54
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	15.84	45.74	+29.90	47.38
CDC—Comprehensive Diabetes Care—Eye Exam[1]	52.47	55.47	+3.00	55.61
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	91.61	92.46	+0.85	91.69
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg[2]	—	54.99	—	56.67
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	76.01	80.36	+4.35	76.52
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	70.36	81.23	+10.87	81.68
Musculoskeletal Conditions				
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	59.52	72.97	+13.45	71.75
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	22.22	0.00	-22.22	6.97
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	52.38	71.20	+18.82	70.43

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	40.00	48.80	+8.80	55.06
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	22.50	14.75	-7.75	29.65
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	53.75	37.70	-16.05	57.00
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[1]	12.07	21.13	+9.06	31.68
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[1]	32.76	38.03	+5.27	49.24
Medication Management and Care Coordination				
TRC—Transitions of Care–Notification of Inpatient Admission[2]	—	12.17	—	11.77
TRC—Transitions of Care–Receipt of Discharge Information[2]	—	8.76	—	11.34
TRC—Transitions of Care–Patient Engagement After Inpatient Discharge[2]	—	73.48	—	75.36
TRC—Transitions of Care–Medication Reconciliation Post-Discharge[2]	—	35.04	—	30.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	21.16	22.44	+1.28	21.36
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**[1]	37.05	28.47	-8.58	32.83
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**[2]	—	21.04	—	18.05
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	NA	4.33	—	5.37
*DAE—Use of High-Risk Medications in Older Adults—Total**	NA	23.64	—	21.46
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	81.88	82.56	+0.68	82.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	92.55	91.82	-0.73	92.90
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	88.22	88.31	+0.09	89.79
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	88.48	88.50	+0.02	89.49
IET—Initiation of Alcohol and Other Drug Dependence Treatment[2]	—	37.73	—	37.65

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
IET—Engagement of Alcohol and Other Drug Dependence Treatment[2]	—	7.27	—	6.59
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[2]	—	1.07	—	1.20
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[2]	—	1.19	—	1.15

* Measures for which lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending in comparison with MY 2018 be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending; therefore, comparisons to MY 2018 rates and benchmarks are not performed for this measure.
NA indicates that data were not available.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered met monthly with its delegates to discuss identified service data concerns such as volume, errors, and timely corrections. **HAP Empowered** indicated that this monthly review process allowed the ICO to significantly improve encounter timeliness. Consistent collaboration with delegates and oversight of timely and complete claims and encounter data helps support the overall quality of administrative data used for performance measure reporting. [**Quality** and **Timeliness**]

Strength #2: HAP Empowered participated in monthly MI Health Link quality measure focused workgroups and collaborated and devised comprehensive strategies to target ongoing barriers and interventions to improve measure outcomes (reviewing performance data, identifying areas of improvement, identifying evidence-based interventions, monitoring intervention performance and outcomes, etc.). Core Measure 9.1, Core Measure 9.3, MI2.6, and MI5.6 were all included in discussion during these workgroups. Collaboration and participation in workgroups with MDHHS further ensures the quality of performance measure data and improvement in the accuracy of performance measure reporting. [**Quality**]

Strength #3: In the Prevention and Screening domain, **HAP Empowered**'s rate for the *COL—Colorectal Cancer Screening* measure indicator increased by nearly 11 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest strength and improvement in adults having an appropriate screening for colorectal cancer. Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after five years. However, more than a third of adults 50–75 years of age do not get recommended screenings. Colorectal cancer screening of asymptomatic adults can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.[3-14] [**Quality** and **Access**]

Strength #4: In the Prevention and Screening domain, **HAP Empowered**'s rate for the *COA—Care for Older Adults—Advance Care Planning*, *Functional Status Assessment*, and *Pain Assessment* measure indicators increased more than 17 percentage points from MY 2018 to MY 2020, and all measure indicators exceeded the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for one of the measure indicators (i.e., *Functional Status Assessment*), the results suggest strength and improvement in adult members 66 years of age and older receiving advanced care planning, functional status assessments, and pain assessments. As the population ages, physical and cognitive function can decline and pain becomes more prevalent. Consideration should be given to an individual's own choices about end-of-life care; advance care plans should be executed.[3-15] [**Quality** and **Access**]

Strength #5: In the Behavioral Health domain, **HAP Empowered**'s rate for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator increased by nearly 19 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in members with a diagnosis of major depression receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[3-16] [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG identified during PSV that **HAP Empowered** was not capturing the appropriate discharge dates in its member-level data reported to HSAG. [**Quality**]

Why the weakness exists: HSAG identified during PSV that, of the selected cases for Core Measure 9.3 during the virtual review, the documented discharge date for one case within the claims data system, Facets, did not match the discharge date listed in the member-level detail file provided to

[3-14] National Committee for Quality Assurance. Colorectal Cancer Screening (COL). Available at: https://www.ncqa.org/hedis/measures/colorectal-cancer-screening/. Accessed on: Feb 9, 2022.

[3-15] National Committee for Quality Assurance. Care for Older Adults (COA). Available at: https://www.ncqa.org/hedis/measures/care-for-older-adults/. Accessed on: Feb 4, 2022.

[3-16] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 4, 2022.

HSAG. **HAP Empowered** indicated this was due to billing anomalies between vendors and the need to derive a discharge date for skilled nursing facility claims since many institutional billers submit claims wherein the service from and service to date are identical, even though the claim is for more than one day. For this one case, there was a calculation error when determining the length of stay. **HAP Empowered** indicated that the issue had since been corrected in November 2021 as a result of the finding. HSAG requested that **HAP Empowered** review the remaining cases in Core Measure 9.3 to ensure that the discharge date issue did not impact any additional cases and requested that **HAP Empowered** provide a revised member-level detail file submission with corrected discharge dates. **HAP Empowered** provided a revised member-level detail file submission and noted that 53 discharge dates were corrected when the data were re-run following the new process implemented in November 2021.

Recommendation: As a result of this finding, HSAG recommends that **HAP Empowered** implement more stringent validation checks prior to data submission. The validation could include selecting cases with identical *service from* and *service to* dates as part of a sample to ensure that the appropriate discharge dates are captured within the data output. Additionally, HSAG recommends that **HAP Empowered** continue to monitor the new process implemented as a result of the finding and continue to improve processes, as appropriate, to ensure accuracy of data. Having adequate validation checks, programming logic quality checks, and sample selections further supports the quality of member-level data used for reporting.

Weakness #2: It was identified that **HAP Empowered** deviated from the measure specifications and Institutional Facility value set codes for Core Measure 9.3 for data element A (total number of admissions to institutional facilities). [**Quality**]

Why the weakness exists: It was identified that **HAP Empowered**'s programming logic was locating IFAs for data element A using only the Institutional Facility value set code bill types starting with "02." While the type of bill codes **HAP Empowered** used were included within the Core Measure 9.3 Institutional Facility value set, the value set also includes revenue codes, which caused a narrower universe of claims to be reported than was intended according to the measure steward. HSAG requested that **HAP Empowered** revise and resubmit its programming logic to include all Institutional Facility value set codes, in alignment with the MMP Core Reporting Requirements.

Recommendation: As a result of this finding, HSAG recommends that **HAP Empowered** put quality checks in place to ensure that programming logic used for future data submissions are in alignment with the reporting requirements and that programming logic is inclusive of all associated value set codes and avoids limiting parameters.

Weakness #3: HSAG identified that **HAP Empowered** was incorrectly reporting IFAs from its previous claims data system in the data count for Core Measure 9.3 for data element A. [**Quality**]

Why the weakness exists: **HAP Empowered** indicated that this was due to a mismatch between its previous claims data system, MC400, and the current claims data system, Facets. MC400 stored all institutional facility claims for service dates prior to July 1, 2019. Any institutional facility claims stored in MC400 that were not closed out yet were reported as new IFAs in data element A, when they should not have been included in the data element A count. **HAP Empowered** noted that this

was a one-time issue stemming from switching claims data systems and that going forward all Core Measure 9.3 data would be pulled from Facets and the enterprise data warehouse.

Recommendation: As a result of this finding, HSAG recommends that **HAP Empowered** implement validation checks beyond the Millman MedInsight system, which was used to compare institutional counts at a high level for data element A. While HSAG noted that the issue should no longer occur in future reporting, it is important that sufficient validation checks are in place in order to confirm appropriate IFAs are included in reporting, as this also impacts reporting for subset data elements B (total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission) and C (total number of expected discharges to the community).

Weakness #4: In the Musculoskeletal Conditions domain, **HAP Empowered**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreased more than 22 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest that women who suffered a fracture did not receive a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.[3-17] [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: The rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreasing more than 22 percentage points from MY 2018 to MY 2020 suggests that barriers exist for women to receive timely bone mineral density tests or prescriptions to treat osteoporosis within six months of a fracture.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why women were not always receiving timely bone mineral density tests or a prescription to treat osteoporosis within six months of a fracture. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **HAP Empowered** should consider the nature and scope of the issue (e.g., whether the issues related to patient and provider education or barriers to accessing care). Additionally, **HAP Empowered** should identify factors related to the COVID-19 PHE and its impact on the management and treatment of women with fractures.

Weakness #5: In the Behavioral Health domain, **HAP Empowered**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator decreased more than 16 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link

[3-17] National Committee for Quality Assurance. Osteoporosis Management In Women Who Had a Fracture (OMW). Available at: https://www.ncqa.org/hedis/measures/osteoporosis-management-in-women-who-had-a-fracture-omw/. Accessed on: Feb 8, 2022.

statewide average; although NCQA cautioned trending for this measure indicator, the results suggest that some members with a diagnosis of mental illness or intentional self-harm were not always receiving follow-up care with a mental health provider within 30 days of inpatient discharge. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-18] [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: The rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator decreasing more than 16 percentage points from MY 2018 to MY 2020 suggests that barriers exist for members diagnosed with mental illness or intentional self-harm to receive timely follow-up care with a mental health provider following inpatient discharge.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some members diagnosed with mental illness or intentional self-harm were not receiving timely follow-up care with a mental health provider following inpatient discharge. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions, or expand on interventions currently in place, to improve performance related to the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator. **HAP Empowered** should consider the nature and scope of the issue (e.g., whether the issues related to patient and provider education, lack of service providers, or barriers to accessing care). Additionally, **HAP Empowered** should identify factors related to the COVID-19 PHE and its impact on accessing timely follow-up care with a mental health provider.

[3-18] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Feb 9, 2022.

Compliance Review

Performance Results

Table 3-29 presents an overview of the results of the SFY 2021 focused compliance review for **HAP Empowered**, which consisted exclusively of case file reviews in certain program areas, and associated information system reviews. The table identifies all program areas that were reviewed and those that required a CAP due to noncompliance with State and federal requirements.

Table 3-29—Case File Review Overall Findings for HAP

Associated Standard	Description of Files	CAP Not Required	CAP Required
IV	Service Authorization Denials		✓
V	Individual Practitioner Credentialing		✓
V	Organizational Credentialing		✓
VII	Member Grievances		✓
VII	Member Appeals		✓
VIII	Subcontractors (delegated entities)	✓	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered's written contracts with its delegates included all required contract language; evidence of periodic formal reviews that included a review of all delegated functions and case file reviews to determine implementation; development of CAPs, when necessary; and regular meetings with the delegate which included performance metric reviews. Robust oversight and monitoring of delegated entities strengthen program integrity efforts. This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS and/or identifies poor performance which may require remediation. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered and its dental delegate did not consistently adhere to the Coverage and Authorization of Services requirements under 42 CFR §438.210. Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a

denied service in easily understood language and have access to their appeal and SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that **HAP Empowered**'s IDNs were not written at or below the required reading grade level. **HAP Empowered**'s CAP indicated that the root cause of the deficiency was related to clinicians being most comfortable documenting explanations using professional medical terminology and hesitant to use simpler nonmedical terms. Additionally, **HAP Empowered**'s dental delegate does not require prior authorization for any dental service and instead reviews claims submitted after a service is rendered to approve or deny the service.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP Empowered** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set coverage and authorization of services standards. Additionally, **HAP Empowered** should work with its dental delegate to ensure appropriate prior authorization policies and procedures are in place and followed.

Weakness #2: HAP Empowered did not consistently adhere to the Provider Selection individual practitioner credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS individual credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that **HAP Empowered** did not consistently obtain disclosure of ownership and control interest forms or conduct all required Medicare and Medicaid exclusion checks. **HAP Empowered**'s CAP indicated that the root cause of the deficiencies was related to staff misunderstanding of the requirements of the Three-Way Contract, and that several credentialing files the ICO submitted for review were not contracted for the MMP LOB.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP Empowered** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set individual practitioner credentialing standards.

Weakness #3: HAP Empowered did not consistently adhere to the Provider Selection organizational credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS organizational requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that one case file included an expired accreditation, three case files included Medicare/Medicaid sanctions checks in which the organization names were spelled incorrectly, and **HAP Empowered** did not consistently obtain disclosure of ownership and control interest forms. **HAP Empowered**'s CAP indicated that the root cause of the deficiencies was related to human error and that the credentialing files submitted for review by the ICO were not contracted for the MMP LOB.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, should continually evaluate its processes, procedures, and monitoring efforts to

ensure compliance with all federal and State obligations specific to MDHHS-set organizational credentialing standards.

Weakness #4: HAP Empowered did not consistently adhere to the Grievance Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is essential to maintain high-quality care and services and to ensure member retention. [**Quality** and **Timeliness**]

Why the weakness exists: Case files reviewed by HSAG identified that one grievance was not resolved in a timely manner and resolution letters contained poor grammar, incomplete sentences, incorrect punctuation, and incorrect spelling. **HAP Empowered**'s CAP indicated that the root cause of the deficiencies was related to the ICO not following internal processing requirements, and that analysts were not proofreading or using a tool to verify correctness and accuracy of correspondence to the member.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP Empowered** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards.

Weakness #5: HAP Empowered did not consistently adhere to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintaining member access to high-quality care and services. Additionally, the notice to the member about an appeal should be written at the appropriate reading grade level for members to understand the action and their rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that **HAP Empowered**'s universe file included only two case files, and from those case files it was determined that the ICO did not consistently obtain member written consent when a provider filed an appeal on the member's behalf; send appeal acknowledgement letters to the member; resolve appeals in a timely manner; write resolution letters in easily understood, plain language or at the state-required reading grade level; or include the appropriate citation supporting the action. **HAP Empowered**'s CAP indicated that the root cause of the deficiencies included, but was not limited to, an analyst not appropriately tracking and calculating due dates, a lack of an appropriate aging report or tool, manual errors, letters not being sent to a QA reviewer, and not clearly delineating that a provider requires member authorization to file an appeal on the member's behalf.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP Empowered** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

Network Adequacy Validation

Performance Results

Following HSAG's initial NAV results, **HAP Empowered** submitted additional data updates and final exception and extension requests to address unmet minimum network requirements in Region 7 and Region 9. MDHHS approved **HAP Empowered**'s requested extension for Personal Emergency Response System (PERS) providers.

Table 3-30 presents **HAP Empowered**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception and extension determinations.

Table 3-30—SFY 2021 NAV Results for HAP Empowered, by Region and Provider Type

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time and Distance Requirements		
Adult Day Program	Met	Met
Dental (preventive and restorative)	Met	Met
Eye Examinations (provided by optometrists)	Met	Met
Eye Wear (providers dispensing eyeglasses and contact lenses)	Met	Met
Hearing Examinations	Met	Met
Hearing Aids	Met	Met
Maternal Infant Health Program Agency	Met	Met
Provider Types Rendering Home-Based Services		
Adaptive Medical Equipment and Supplies	Met	Met
Assistive Technology Devices	Met	Met
Assistive Technology Van Lifts and Tie Downs	Met	Met
Chore Services	Met	Met
Community Transition Services	Met	Met
Environmental Modifications	Met	Met
Expanded Community Living Supports	Met	Met
Fiscal Intermediary	Met	Met
Home-Delivered Meals	Met	Met
Medical Supplies	Met	Met
Non-Emergency Medical Transportation	Met	Met
Non-Medical Transportation (waiver service only)	Met	Met
Personal Care Services (non-agency and agency)	Met	Met

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Personal Emergency Response System	Extension Granted	Extension Granted
Preventive Nursing Services (non-agency and agency)	Met	Met
Private Duty Nursing (non-agency and agency)	Met	Met
Respite	Met	Met
Skilled Nursing Home	Met	Met
Percent of Total Provider Types Meeting Minimum Network Requirements	**96%**	**96%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered met 96 percent of the Medicaid and LTSS minimum network requirements for Region 7, indicating that **HAP Empowered** maintains an adequate network for MI Health Link members in this region, except for Personal Emergency Response System (PERS) services. [**Access**]

Strength #2: HAP Empowered met 96 percent of the Medicaid and LTSS minimum network requirements for Region 9, indicating that **HAP Empowered** maintains an adequate network for MI Health Link members in this region, except for PERS services. [**Access**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered failed to meet all Medicaid and LTSS minimum network requirements for Region 7, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. [**Access**]

Why the weakness exists: MDHHS approved **HAP Empowered**'s extension request for the PERS provider type in Region 7, as **HAP Empowered** had not contracted with all available providers in the region.

Recommendation: HSAG recommends that **HAP Empowered** identify and contract with at least two PERS providers in Region 7 to offer members a choice and improve compliance with Medicaid and LTSS minimum network standards and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 7 will be evaluated in the SFY 2022 NAV.

Weakness #2: HAP Empowered failed to meet all Medicaid and LTSS minimum network requirements for Region 9, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. [**Access**]

Why the weakness exists: MDHHS approved **HAP Empowered**'s extension request for the PERS provider type in Region 9, as **HAP Empowered** had not contracted with all available providers in the region.

Recommendation: HSAG recommends that **HAP Empowered** identify and contract with at least two PERS providers in Region 9 to offer members a choice and improve compliance with Medicaid and LTSS minimum network standards and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 9 will be evaluated in the SFY 2022 NAV.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 673 sampled PCP locations (i.e., "cases") for **HAP Empowered**, with an overall response rate of 57.0 percent (191 cases) for routine well-check visits and 60.1 percent (203 cases) for nonurgent symptomatic visits among **HAP Empowered**'s two MI Health Link regions. Region 9 had the highest response rate for nonurgent symptomatic appointments, and Region 7 had a slightly higher response rate than Region 9 for routine well-check appointments.

Table 3-31 and Table 3-32 summarize the SFY 2021 secret shopper survey response rates by visit for **HAP Empowered**, and for each of **HAP Empowered**'s contracted MI Health Link regions.

Table 3-31—Summary of HAP Secret Shopper Survey Results for Routine Well-Check Visit, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 7	182	104	95	72	68
Region 9	153	87	71	49	49
HAP Total	**335**	**191**	**166**	**121**	**117**

Table 3-32—Summary of HAP Secret Shopper Survey Results for Nonurgent Symptomatic Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 7	183	103	82	73	70
Region 9	155	100	77	65	61
HAP Total	**338**	**203**	**159**	**138**	**131**

Table 3-33 displays the number of cases in which the survey respondent offered appointments to new patients for routine services and nonurgent symptomatic visits, as well as summary wait time statistics for **HAP Empowered**, and for each of **HAP Empowered**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location. Of cases in which the survey respondent reported that the provider location accepted **HAP Empowered**, the MI Health Link program, and new patients, appointment availability was reported for 60.7 percent (n=71) and 61.8 percent (n=81) of routine and symptomatic cases, respectively.

Table 3-33—Summary of HAP Secret Shopper Survey Appointment Availability Results, by Region

Region	Routine Well-Check					Nonurgent Symptomatic Visit				
	Number of Cases Offered an Appointment	Wait Time in Calendar Days[1]				Number of Cases Offered an Appointment	Wait Time in Calendar Days			
		Min	Max	Average	Median		Min	Max	Average	Median
Region 7	41	0	99	11.9	5.0	44	0	55	11.9	7.0
Region 9	30	1	112	19.1	8.0	37	0	64	11.6	7.0
HAP Total	**71**	**0**	**112**	**14.9**	**7.0**	**81**	**0**	**64**	**11.7**	**7.0**

[1] The appointment wait time summary excludes one Region 9 case that reported an appointment wait time greater than 140 days. Information on this case was included in the analytic data file for HAP's reference.

In follow-up to the secret shopper survey findings, MDHHS required **HAP Empowered** to develop a CAP to address the deficiencies identified during the survey. **HAP Empowered** was also expected to extend any training and oversight activities implemented for the CAP to providers not included in the survey sample. MDHHS' CAP requirements are detailed in Appendix A.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: ICO-specific strengths have not been identified because a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICO's provider data files.

Weaknesses and Recommendations

Weakness #1: Over 61 percent of sampled provider locations were unable to be reached, did not accept **HAP Empowered**, or did not accept and/or recognize the MI Health Link program. [**Quality** and **Access**]

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **HAP Empowered**'s PCP data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends that **HAP Empowered** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies. Additionally, as MDHHS required **HAP Empowered** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Weakness #2: A limited number of callers were offered appointment dates and times. [**Access**]

Why the weakness exists: Of cases in which the survey respondent reported that the provider location accepted **HAP Empowered**, the MI Health Link program, and new patients, appointment availability was reported for 60.7 percent and 61.8 percent of routine and symptomatic cases, respectively. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. Considerations included members needing to designate the provider as their PCP before scheduling an appointment, being required to complete pre-registration or provide additional personal information to schedule an appointment, and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **HAP Empowered** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **HAP Empowered** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

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

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **HAP Empowered** about the quality, timeliness, and accessibility of care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **HAP Empowered** across all EQR activities to identify common themes within **HAP Empowered** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that while **HAP Empowered** generally performed well in some areas impacting the quality and timeliness of, and access to care, the ICO had several opportunities for improvement. **HAP Empowered** designed a methodologically sound improvement project and met all requirements for data analysis and implementation of improvement strategies for its *Follow-Up After*

Hospitalization for Mental Illness QIP. However, **HAP Empowered** demonstrated a decline in performance for the percentage of members receiving follow-up care within 30 days of a hospital discharge for mental illness from the baseline rate and did not meet its goal [**Quality**, **Timeliness**, and **Access**]. These results were further supported by the PMV activity as **HAP Empowered**'s indicator rates for the *Follow-Up After Hospitalization for Mental Illness* measure fell below the statewide average and decreased by approximately 8 to 16 percentage points. [**Timeliness** and **Access**]. **HAP Empowered** reported implementing interventions through PIHP collaboration and care coordination processes and experienced barriers such as incorrect contact information for members or being unable to contact members, members did not recognize the need for or importance of a follow-up visit, and having manual processes for tracking and following up with members.

HAP Empowered demonstrated strengths in the behavioral health program area through the PMV activity. While only one indicator rate exceeded the statewide average, four of the six rates in the Behavioral Health domain increased. While continued opportunities for improvement exist, all indicator rates for the *Antidepressant Medication Management* and *Follow-Up After Emergency Department Visit for Mental Illness* measures increased by approximately 5 to 19 percentage points, indicating **HAP Empowered** is making progress within the Behavioral Health domain [**Quality**, **Timeliness**, and **Access**].

The combined results of EQR activities presented mixed findings regarding access to care. Through the results of the NAV activity, while **HAP Empowered** met most Medicaid and LTSS minimum network requirements indicating an adequate network of providers overall, **HAP Empowered** failed to meet minimum network requirements for one provider type [**Access**]. The results of the secret shopper activity suggested that members may have experienced barriers to accessing providers, as a high percentage of sampled provider locations were unable to be reached, did not accept **HAP Empowered**, or did not accept and/or recognize the MI Health Link program [**Access**]. The PMV activity, however, suggested that members are accessing primary care and services through measure results within the Prevention and Screening, and Cardiovascular Conditions domains. Five of the six indicator rates in the Prevention and Screening domain increased by approximately 1 to 30 percentage points, and five of the indicator rates exceeded the statewide average [**Quality** and **Access**]. Further, in the Cardiovascular Conditions domain, three of the four indicator rates increased, and three rates exceeded the statewide average. These findings support that more of **HAP Empowered**'s members are receiving colorectal cancer screenings; more older adults are receiving advance care planning, functional status assessments, and pain assessments; and more adults had controlled blood pressure, received persistent beta-blocker treatment after a heart attack, and received statin therapy for cardiovascular disease. **HAP Empowered** also demonstrated overall improvement in the Diabetes domain as seven indicator rates indicated better performance; six rates increased by approximately 1 to 30 percentage points, and the remaining rate (an inverse measure) decreased by approximately 33 percentage points, also indicating better performance.

HAP Empowered's results for the compliance review activity identified several process deficiencies across the service authorization denials, individual practitioner credentialing, organizational credentialing, member grievances, and member appeals program areas [**Quality**, **Timeliness**, and **Access**]. Of particular note, member-facing materials such as service authorization IDNs and member grievance and appeal resolution letters were not consistently written in easily understood language.

Member appeals were also not consistently resolved in a timely manner. Timely and adequate written member materials are essential to ensure members are receiving all necessary information to make informed choices regarding their healthcare and services and accessing their appeal and SFH rights. **HAP Empowered** completed a root cause analysis and developed a remediation plan for all deficiencies, which should support more effective member communication and administrative procedures to effectively support the delivery of quality, accessible, and timely services [**Quality**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Meridian Health Plan

Validation of Quality Improvement Projects

Performance Results

Table 3-34 displays the overall validation status and the baseline, Remeasurement 1, and Remeasurement 2 results for the QIP study indicator. **Meridian Health Plan** did not select a plan-specific goal for the study indicator, as this was not a requirement for the QIP.

Table 3-34—Overall Validation Rating for MER

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Met*	The percentage of discharges for members 21 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses on or between January 1 and December 1 and who had a follow-up visit with a mental health practitioner within 30 days of discharge.	23.1%	67.3% ↑	59.3% ↑	

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

Table 3-35 displays the interventions implemented to address the barriers identified by the ICO using QI and causal/barrier analysis processes.

Table 3-35—Remeasurement 2 Interventions for MER

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

Intervention Descriptions	
Attempted to obtain updated member demographic information from the PIHP, member services, members' PCP, members' pharmacy, or the State's Care Connect 360 system.	Educated providers to notify the PIHP when a member is inpatient, worked with the member's case manager to schedule follow-up appointments, and addressed SDOH.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan met 100 percent of the requirements for data analysis and implementation of improvement strategies. [**Quality**, **Timeliness**, **and Access**]

Strength #2: Meridian Health Plan achieved the goal of statistically significant improvement over the baseline rate for the first and second remeasurement periods. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no significant identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Meridian Health Plan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The ICO should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measure Validation

Performance Results

HSAG evaluated **Meridian Health Plan**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system; medical services data system (e.g., claims and encounters); medication reconciliation system (i.e., tracking and management of medication reviews); hybrid data collection; and data integration. Although HSAG did not identify any general concerns with **Meridian Health Plan**'s data integration and reporting processes, HSAG identified reporting errors for Core Measure 9.3 that resulted in resubmission of the measure. In addition, HSAG identified significant concerns with **Meridian Health Plan**'s care coordination system (i.e., tracking and management of care transition record transmissions). **Meridian Health Plan** relied on its subcontractor, H3 Management Services

(H3), for MI2.6 reporting in 2020. **Meridian Health Plan** indicated that H3 was unable to provide a report confirming transition of care activities, including care transition record transmission to the provider. Therefore, **Meridian Health Plan** was unable to provide accurate data counts for MI2.6. Therefore, the rate for MI2.6 was considered to be materially biased to an unknown extent and received a *Do Not Report (DNR)* designation, as the rate should not be reported.

Meridian Health Plan received a measure designation of *Reportable (R)* for Core Measure 9.1, Core Measure 9.3, and MI5.6, signifying that **Meridian Health Plan** had reported these measures in compliance with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. However, **Meridian Health Plan** received a *Do Not Report (DNR)* designation for MI2.6, signifying that **Meridian Health Plan** did not report this measure in compliance with the Michigan-Specific Reporting Requirements and that the rate should not be reported.

Table 3-36—Measure-Specific Validation Designation for MER

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
MI2.6: *Timely Transmission of Care Transition Record to Health Care Professional*	**DO NOT REPORT (DNR)** The ICO rate was materially biased and should not be reported.
MI5.6: *Care for Adults—Medication Review*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-37 shows each of **Meridian Health Plan**'s audited HEDIS measures, rates for HEDIS MY 2018 and HEDIS MY 2020 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2020 with HEDIS MY 2018, and the HEDIS MY 2020 MI Health Link statewide average performance rates. Of note, based on CMS' suspension of all MMP reporting of HEDIS MY 2019 rates due to the COVID-19 PHE, HEDIS MY 2019 rates are not displayed in Table 3-37, as data were not reported for MY 2019. HEDIS MY 2020 measure rates performing better than the statewide average are notated by green font.

Table 3-37—Measure-Specific Percentage Rates for MER

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening[1]	64.40	55.29	-9.11	56.31
COL—Colorectal Cancer Screening[1]	60.86	59.21	-1.65	56.77
COA—Care for Older Adults—Advance Care Planning	39.66	20.92	-18.74	42.46
COA—Care for Older Adults—Medication Review	83.45	74.94	-8.51	66.63
COA—Care for Older Adults—Functional Status Assessment[1]	64.23	22.63	-41.60	53.52
COA—Care for Older Adults—Pain Assessment	81.75	73.24	-8.51	67.04
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	18.26	26.17	+7.91	24.27
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	75.68	72.25	-3.43	71.84
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	89.53	86.13	-3.40	90.73
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure[2]	—	62.77	—	56.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	100.00	88.89	-11.11	89.59
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	77.43	80.09	+2.66	80.63
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	78.89	81.36	+2.47	80.11
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	92.46	86.37	-6.09	84.70
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**[1]	35.04	40.63	+5.59	44.54
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	56.93	51.34	-5.59	47.38
CDC—Comprehensive Diabetes Care—Eye Exam[1]	79.32	60.34	-18.98	55.61
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	93.29	92.46	-0.83	91.69
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg[2]	—	62.29	—	56.67
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	72.50	76.95	+4.45	76.52
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	76.78	83.76	+6.98	81.68

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Musculoskeletal Conditions				
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	80.39	95.65	+15.26	71.75
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	33.33	33.33	0.00	6.97
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	65.33	71.57	+6.24	70.43
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	48.00	54.82	+6.82	55.06
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	3.85	18.60	+14.75	29.65
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	23.08	59.30	+36.22	57.00
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[1]	35.90	41.07	+5.17	31.68
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[1]	49.36	50.00	+0.64	49.24
Medication Management and Care Coordination				
TRC—Transitions of Care–Notification of Inpatient Admission[2]	—	6.57	—	11.77
TRC—Transitions of Care–Receipt of Discharge Information[2]	—	10.95	—	11.34
TRC—Transitions of Care–Patient Engagement After Inpatient Discharge[2]	—	74.70	—	75.36
TRC—Transitions of Care–Medication Reconciliation Post-Discharge[2]	—	33.82	—	30.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	21.74	14.65	-7.09	21.36
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**[1]	47.97	33.33	-14.64	32.83
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**[2]	—	19.29	—	18.05
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	NA	7.21	—	5.37
*DAE—Use of High-Risk Medications in Older Adults—Total**	NA	23.81	—	21.46
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	88.52	84.36	-4.16	82.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	96.26	94.55	-1.71	92.90

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	95.58	93.43	-2.15	89.79
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	94.34	92.07	-2.27	89.49
IET—Initiation of Alcohol and Other Drug Dependence Treatment[2]	—	50.00	—	37.65
IET—Engagement of Alcohol and Other Drug Dependence Treatment[2]	—	8.98	—	6.59
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[2]	—	1.13	—	1.20
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[2]	—	0.84	—	1.15

* Measures for which lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending in comparison with MY 2018 be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending; therefore, comparisons to MY 2018 rates and benchmarks are not performed for this measure.

NA indicates that data were not available.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan implemented various interventions to improve performance measure rates. **Meridian Health Plan** held monthly market engagement meetings with corporate partners to help identify best practices and review performance. In addition, monthly HEDIS action plan and prioritization workgroups were initiated with quality teams to continuously review performance and prioritize interventions. Lastly, **Meridian Health Plan** collaborated with other Centene Corporation markets on barriers and best practices for quality measures through measure-specific workgroups. [**Quality**]

Strength #2: In the Musculoskeletal Conditions domain, **Meridian Health Plan**'s rate for the *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* measure indicator increased more than 15 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY

2020 MI Health Link statewide average, suggesting strength and improvement in adults diagnosed with rheumatoid arthritis being dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD). Rheumatoid arthritis is progressive, but early intervention with DMARDs can help preserve function and prevent further damage to joints.[3-19] [**Quality** and **Access**]

Strength #3: In the Behavioral Health domain, **Meridian Health Plan**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator increased more than 36 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest strength and improvement in members with a diagnosis of mental illness or intentional self-harm receiving follow-up care with a mental health provider within 30 days of inpatient discharge. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-20] [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan was unable to provide accurate data counts for MI2.6. Therefore, the rate for MI2.6 was considered to be materially biased to an unknown extent and received a *DNR* designation. [**Quality**]

Why the weakness exists: Meridian Health Plan was reliant on H3 for MI2.6 reporting in 2020. **Meridian Health Plan** indicated that H3 was unable to provide a report confirming transition of care activities, including care transition record transmission to the provider. Therefore, **Meridian Health Plan** was unable to provide accurate data counts for MI2.6.

Recommendation: While **Meridian Health Plan** indicated that it has since transitioned care coordination in-house beginning in 2021 and begun the process of requesting internal access to hospital system records and restructuring the MI2.6 process for 2021, HSAG recommends that **Meridian Health Plan** also consider using the hybrid methodology for future reporting of MI2.6 to further ensure quality and completeness of data. The hybrid methodology has the potential for improving the performance measure rate and capturing more accurate and complete data for reporting. HSAG further recommends that **Meridian Health Plan** oversee and evaluate new processes that are implemented in order to monitor effectiveness and whether the processes are leading to expected results. The ICO should take a proactive approach to ensure timely identification of any additional system or process changes that should be implemented.

[3-19] National Committee for Quality Assurance. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis. Available at: https://www.ncqa.org/hedis/measures/disease-modifying-anti-rheumatic-drug-therapy-for-rheumatoid-arthritis/. Accessed on: Feb 9, 2022.

[3-20] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Feb 9, 2022.

Weakness #2: The member-level data provided to HSAG for PMV contained errors that resulted in resubmission of Core Measure 9.3. [**Quality**]

Why the weakness exists: It was identified in **Meridian Health Plan**'s member-level data submitted for Core Measure 9.3 that 16 members were reported in data element B (total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission) with no discharge date listed in the member-level detail file. **Meridian Health Plan** indicated that these members were reported in data element B in error and that they should have only been reported in data element A (total number of admissions to institutional facilities). HSAG asked **Meridian Health Plan** to remove these members from data element B and provide a revised member-level detail file. Additionally, HSAG noted that the data count for data element A did not align between **Meridian Health Plan**'s member-level detail file submission and the rate template provided to HSAG. **Meridian Health Plan** indicated that both the member-level detail file submission and rate template needed to be updated to include the correct data element A count and resubmitted both files.

Recommendation: HSAG recommends that **Meridian Health Plan** implement more stringent validation checks prior to data submission. These checks should include reviewing the member-level data against the source system, selecting sample cases from each data element to ensure proper categorization of members based on the reporting requirements, and thoroughly checking the member-level data to ensure accuracy of member-level data and data counts. Additionally, a final check should be in place prior to submission to ensure that the final member-level data counts are in alignment with the final data counts reported to the CMS Health Plan Management System. A thorough sampling and validation process is crucial for ensuring the quality and accuracy of performance measure reporting.

Weakness #3: In the Prevention and Screening domain, **Meridian Health Plan**'s rate for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators decreased more than 18 percentage points from MY 2018 to MY 2020, with both indicators falling below the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for one of the measure indicators (i.e., *Functional Status Assessment*), the results suggest that adult members 66 years of age and older were not always having advance care planning or functional status assessments completed to help optimize quality of life. As the population ages, physical and cognitive function can decline and pain becomes more prevalent. Consideration should be given to an individual's own choices about end-of-life care; advance care plans should be executed.[3-21] [**Quality** and **Access**]

Why the weakness exists: The rate for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators decreasing more than 18 percentage points from MY 2018 to MY 2020 suggests that barriers exist for having advanced care planning and functional status assessments completed during the measurement year for some adults 66 years of age and older.

[3-21] National Committee for Quality Assurance. Care for Older Adults (COA). Available at: https://www.ncqa.org/hedis/measures/care-for-older-adults/. Accessed on: Feb 4, 2022.

Recommendation: HSAG recommends that **Meridian Health Plan** conduct a root cause analysis or focused study to determine why some adults 66 years of age and older are not always having advanced care planning and functional status assessments completed. Upon identification of a root cause, **Meridian Health Plan** should implement appropriate interventions to improve performance related to the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators. **Meridian Health Plan** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education). Additionally, **Meridian Health Plan** should identify factors related to the COVID-19 PHE and its impact on conducting advance care planning and functional status assessments.

Weakness #4: In the Cardiovascular Conditions domain, **Meridian Health Plan**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased more than 11 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link statewide average, indicating that some adults who were hospitalized and discharged with a diagnosis of acute myocardial infarction were not always receiving persistent beta-blocker treatment for six months. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-22] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreasing more than 11 percentage points from MY 2018 to MY 2020 suggests that barriers exist for some adults to receive persistent beta-blocker treatment for six months following inpatient discharge for acute myocardial infarction.

Recommendation: HSAG recommends that **Meridian Health Plan** conduct a root cause analysis or focused study to determine why some adults did not receive persistent beta-blocker treatment for six months following inpatient discharge for acute myocardial infarction. Upon identification of a root cause, **Meridian Health Plan** should implement appropriate interventions to improve the performance related to the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator. **Meridian Health Plan** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as patient and provider communication or provider education). Additionally, **Meridian Health Plan** should identify factors related to the COVID-19 PHE and its impact on adults receiving persistent beta-blocker treatment following inpatient discharge for acute myocardial infarction.

[3-22] National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/. Accessed on: Feby 10, 2022.

Compliance Review

Performance Results

Table 3-38 presents an overview of the results of the SFY 2021 focused compliance review for **Meridian Health Plan**, which consisted exclusively of case file reviews in certain program areas, and associated information system reviews. The table identifies all program areas that were reviewed and those that required a CAP due to noncompliance with State and federal requirements.

Table 3-38—Case File Review Overall Findings for MER

Associated Standard	Description of Files	CAP Not Required	CAP Required
IV	Service Authorization Denials		✓
V	Individual Practitioner Credentialing		✓
V	Organizational Credentialing		✓
VII	Member Grievances		✓
VII	Member Appeals		✓
VIII	Subcontractors (delegated entities)		✓

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: No significant strengths were identified for **Meridian Health Plan**.

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan and its dental delegate did not consistently adhere to the Coverage and Authorization of Services requirements under 42 CFR §438.210. Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a denied service in easily understood language and have access to their appeal and SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that several IDNs did not include the regulation citation that supported the action; included repetitive language; and the IDNs issued to members by **Meridian Health Plan**'s dental delegate in 2021 were not the most current version updated by MDHHS in 2021. **Meridian Health Plan**'s CAP indicated that the root cause of

the deficiency was related to the ICO's dental delegate not following appropriate processes for accurate IDN template setup and build, and the ICO did not share the current IDN template with its dental delegate.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set coverage and authorization of services standards.

Weakness #2: Meridian Health Plan did not consistently adhere to the Provider Selection individual practitioner credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS individual credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that **Meridian Health Plan** did not consistently obtain disclosure of ownership and control interest forms as part of the individual practitioner credentialing process. **Meridian Health Plan**'s CAP indicated that the root cause of the deficiency was related to the ICO's acquisition by WellCare Health Plan, which decommissioned its credentialing database and resulted in a limited dataset being imported into the corporate provider database. **Meridian Health Plan** also lost numerous staff during the acquisition.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set individual practitioner credentialing standards.

Weakness #3: Meridian Health Plan did not consistently adhere to the Provider Selection organizational credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS organizational requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that **Meridian Health Plan** did not consistently obtain disclosure of ownership and control interest forms as part of the organizational credentialing process. **Meridian Health Plan**'s CAP indicated that the root cause of the deficiency was related to the ICO's acquisition by WellCare Health Plan, which decommissioned its credentialing database and resulted in a limited dataset being imported into the corporate provider database. **Meridian Health Plan** also lost numerous staff during the acquisition.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set organizational credentialing standards.

Weakness #4: Meridian Health Plan did not consistently adhere to the Grievance Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is

essential to maintain high-quality care and services and to ensure member retention. [**Quality** and **Timeliness**]

Why the weakness exists: Case files reviewed by HSAG identified that member grievances were not always acknowledged or were not acknowledged in a timely manner. **Meridian Health Plan**'s CAP indicated that the root cause of the deficiency was related to system integration processes and that its corporate team was initially not equipped to meet the 48-hour requirement.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards.

Weakness #5: Meridian Health Plan did not consistently adhere to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintaining member access to high-quality care and services. Additionally, the notice to the member about an appeal should be written at the appropriate reading grade level for members to understand the action and their rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that appeals were not always acknowledged or were not acknowledged in a timely manner, and that **Meridian Health Plan** did not always obtain consent from the member when the appeal was filed by the provider on the member's behalf. **Meridian Health Plan**'s CAP indicated that the root cause of the deficiencies included, but was not limited to, the process an individual appeals coordinator used when initiating an appeal.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

Weakness #6: Meridian Health Plan did not consistently adhere to the Subcontractual Relationships and Delegation requirements under 42 CFR §438.230 and MDHHS-specific requirements. Robust oversight and monitoring of delegated entities is essential to strengthen program integrity efforts. This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS and/or identifies poor performance which may require remediation. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that **Meridian Health Plan**'s written agreements with delegates did not always include all required language under 42 CFR §438.230(c)(3)(i–iv), including that the "right to audit" will exist through 10 years from the final date of the contract period or from the date of completion of any audit. **Meridian Health Plan** reported in its CAP that its delegate contract had missing or incorrect federal language.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to delegation standards.

Network Adequacy Validation

Performance Results

Following HSAG's initial NAV results, **Meridian Health Plan** submitted additional data updates and final exception and extension requests to address unmet minimum network requirements in Region 4. MDHHS approved **Meridian Health Plan**'s requested exceptions for Adult Day Program and MIHP Agency provider types and **Meridian Health Plan**'s requested extensions for the hearing examinations and hearing aids provider types.

Table 3-39 presents **Meridian Health Plan's** region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception and extension determinations.

Table 3-39—SFY 2021 NAV Results for MER, by Region and Provider Type

Provider Type	Region 4 Validation Result
Provider Types With Travel Time and Distance Requirements	
Adult Day Program	Exception Granted
Dental (preventive and restorative)	Met
Eye Examinations (provided by optometrists)	Met
Eye Wear (providers dispensing eyeglasses and contact lenses)	Met
Hearing Examinations	Extension Granted
Hearing Aids	Extension Granted
MIHP Agency	Exception Granted
Provider Types Rendering Home-Based Services	
Adaptive Medical Equipment and Supplies	Met
Assistive Technology Devices	Met
Assistive Technology Van Lifts and Tie Downs	Met
Chore Services	Met
Community Transition Services	Met
Environmental Modifications	Met
Expanded Community Living Supports	Met
Fiscal Intermediary	Met
Home-Delivered Meals	Met
Medical Supplies	Met
Non-Emergency Medical Transportation	Met
Non-Medical Transportation (waiver service only)	Met
Personal Care Services (non-agency and agency)	Met

Provider Type	Region 4 Validation Result
Personal Emergency Response System	Met
Preventive Nursing Services (non-agency and agency)	Met
Private Duty Nursing (non-agency and agency)	Met
Respite	Met
Skilled Nursing Home	Met
Percent of Total Provider Types Meeting Minimum Network Requirements	**84%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan met 84 percent of the Medicaid and LTSS minimum network requirements for Region 4, indicating that **Meridian Health Plan** maintains a generally adequate network for MI Health Link members in this region, with exceptions indicating that **Meridian Health Plan** has contracted all available Adult Day Program and MIHP Agency provider types. [**Access**]

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan failed to meet all Medicaid and LTSS minimum network requirements for Region 4, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. [**Access**]

Why the weakness exists: MDHHS approved **Meridian Health Plan**'s extension request for the Hearing Examinations and Hearing Aids provider types in Region 4, as **Meridian Health Plan** had not contracted with all available providers in the region.

Recommendation: HSAG recommends that **Meridian Health Plan** identify and contract with additional Hearing Examinations and Hearing Aids provider types in Region 4 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 4 will be evaluated during the SFY 2022 NAV.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 113 sampled provider locations (i.e., "cases") for **Meridian Health Plan**, with an overall response rate of 83.9 percent (47 cases) for routine well-check visits and 77.2 percent (44 cases) for nonurgent symptomatic visits.

Table 3-40 and Table 3-41 summarize the SFY 2021 secret shopper survey response rates by visit scenario for **Meridian Health Plan**, and for **Meridian Health Plan**'s contracted MI Health Link region.

Table 3-40—Summary of MER Secret Shopper Survey Results for Routine Well-Check Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 4	56	47	41	30	24
MER Total	**56**	**47**	**41**	**30**	**24**

Table 3-41—Summary of MER Secret Shopper Survey Results for Nonurgent Symptomatic Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 4	57	44	38	30	27
MER Total	**57**	**44**	**38**	**30**	**27**

Table 3-42 displays the number of cases in which the survey respondent offered appointments to new patients for routine services and nonurgent symptomatic visits, as well as summary wait time statistics for all ICOs, for **Meridian Health Plan**, and for **Meridian Health Plan**'s contracted MI Health Link region. Note that potential appointment dates may have been offered with any practitioner at the sampled location. Of cases in which the survey respondent reported that the provider location accepted **Meridian Health Plan**, the MI Health Link program, and new patients, appointment availability was reported for 70.8 percent (n=17) and 48.1 percent (n=13) of routine and symptomatic cases, respectively.

Table 3-42—Summary of MER Secret Shopper Survey Appointment Availability Results, by Region

Region	Routine Well-Check					Nonurgent Symptomatic Visit				
	Number of Cases Offered an Appointment	Wait Time in Calendar Days				Number of Cases Offered an Appointment	Wait Time in Calendar Days			
		Min	Max	Average	Median		Min	Max	Average	Median
Region 4	17	0	66	30.5	32.0	13	0	31	6.4	1.0
MER Total	**17**	**0**	**66**	**30.5**	**32.0**	**13**	**0**	**31**	**6.4**	**1.0**

In follow-up to the secret shopper survey findings, MDHHS required **Meridian Health Plan** to develop a CAP to address the deficiencies identified during the survey. **Meridian Health Plan** was also expected to extend any training and oversight activities implemented for the CAP to providers not included in the survey sample. MDHHS' CAP requirements are detailed in Appendix A.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the secret shopper activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ICO-specific strengths have not been identified because a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICO's provider data files.

Weaknesses and Recommendations

Weakness #1: Approximately 47 percent of sampled provider locations were unable to be reached, did not accept **Meridian Health Plan**, or did not accept and/or recognize the MI Health Link program.

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **Meridian Health Plan**'s PCP data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends that **Meridian Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies. Additionally, as MDHHS required **Meridian Health Plan** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Weakness #2: A limited number of callers were offered appointment dates and times. [**Access**]

Why the weakness exists: Of cases in which the survey respondent reported that the provider location accepted **Meridian Health Plan**, the MI Health Link program, and new patients, appointment availability was reported for 70.8 percent and 48.1 percent of routine and symptomatic cases, respectively. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. Considerations included members needing to designate the provider as their PCP before scheduling an appointment, being required to complete pre-registration or provide additional personal information to schedule an appointment, and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Meridian Health Plan** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Meridian Health Plan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

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

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Meridian Health Plan** about the quality, timeliness, and accessibility of care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Meridian Health Plan** across all EQR activities to identify common themes within **Meridian Health Plan** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that while **Meridian Health Plan** generally performed well in some areas impacting the quality and timeliness of, and access to care, the ICO has several opportunities for improvement. **Meridian Health Plan** met all requirements for data analysis and implementation of improvement strategies and achieved the goal of statistically significant improvement over the baseline rate for the first remeasurement period for its *Follow-Up After Hospitalization for Mental Illness* QIP [**Quality**, **Timeliness**, and **Access**]. These results were further supported by the PMV activity as **Meridian Health Plan**'s indicator rate for *Follow-Up After Hospitalization for Mental Illness—30 Days* measure exceeded the statewide average and increased by approximately 36 percentage points [**Timeliness** and **Access**], indicating that the interventions implemented through PIHP

collaboration were successful. While the *Follow-Up After Hospitalization for Mental Illness—7 Days* measure also increased, the rate ranked below the statewide average.

Meridian Health Plan demonstrated strength in the behavioral health program area through the PMV activity. All six indicator rates in the Behavioral Health domain increased, with four of those rates ranking above the statewide average. All indicator rates for the *Antidepressant Medication Management*, *Follow-Up After Hospitalization for Mental Illness*, and *Follow-Up After Emergency Department Visit for Mental Illness* measures improved, with increases ranging from approximately 1 to 36 percentage points [**Quality**, **Timeliness**, and **Access**].

The combined results of EQR activities present mixed findings regarding access to care. Through the results of the NAV activity, **Meridian Health Plan** failed to meet Medicaid and LTSS minimum network requirements for two provider types that had available providers in its region with which to contract. Additionally, the results of the secret shopper activity suggested that members may have experienced barriers to accessing providers, as a high percentage of sampled provider locations were unable to be reached, did not accept **Meridian Health Plan**, or did not accept and/or recognize the MI Health Link program [**Access**]. However, the PMV activity suggested that **Meridian Health Plan**'s members are accessing primary care and services at a higher rate than the MI Health Link program in general as demonstrated through the results within the Prevention and Screening, Diabetes, and Access/Availability of Care domains. Three of the six indicator rates within the Prevention and Screening domain exceeded the statewide average; all eight indicator rates within the Diabetes domain indicated better performance than the statewide average; and all six indicator rates within the Access/Availability domain exceeded the statewide average. When compared to the statewide averages, **Meridian Health Plan** performed well; however, most of the indicator rates demonstrated a decline in performance, indicating continued opportunities for improving adult access to preventive and screening services, and appropriate diabetes management.

Meridian Health Plan's results of the compliance review activity identified several process deficiencies across the service authorization denials, individual practitioner credentialing, organizational credentialing, member grievances, member appeals, and subcontractors and delegation oversight program areas [**Quality**, **Timeliness**, and **Access**]. Of particular note, member-facing materials such as service authorization IDNs and member appeal resolution letters were not consistently written in easily understood language or did not include the required content. Adequate written member materials are essential to ensure members are receiving all necessary information to make informed choices regarding their healthcare and services and accessing their appeal and SFH rights. **Meridian Health Plan** completed a root cause analysis and developed a remediation plan for all deficiencies, which should support more effective member communication and administrative procedures to effectively support the delivery of quality, accessible, and timely services [**Quality**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Michigan Complete Health

Validation of Quality Improvement Projects

Performance Results

Table 3-43 displays the overall validation status; the baseline, Remeasurement 1, and Remeasurement 2 results; and the ICO-designated goal for the QIP study indicator. A validation rating of *Not Met* indicates that either (1) all critical elements (elements pivotal to the QIP process) were *Met*, but less than 60 percent of all evaluation elements were *Met* across all activities; or (2) one or more critical elements were *Not Met*.

Table 3-43—Overall Validation Rating for MCH

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.	41.5%	40.4% ⇔	49.3% ⇔	56%

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

Table 3-44 displays the interventions implemented to address the barriers identified by the ICO using QI and causal/barrier analysis processes.

Table 3-44—Remeasurement 2 Interventions for MCH

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an

identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Michigan Complete Health met 100 percent of the requirements for data analysis and implementation of improvement strategies. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Although **Michigan Complete Health** demonstrated improvement in the study indicator outcomes for the second remeasurement, the goal of significant improvement was not achieved. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Michigan Complete Health had a relatively small eligible population. A greater increase in the number of members who are numerator compliant must occur to achieve the desired goal.

Recommendation: Michigan Complete Health members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Performance Measure Validation

Performance Results

HSAG evaluated **Michigan Complete Health**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system; medical services data system (e.g., claims and encounters); care coordination system (i.e., tracking and management of care transition record transmissions); medication reconciliation system (i.e., tracking and management of medication reviews); hybrid data collection; and data integration. Although HSAG did not identify any general concerns with **Michigan Complete Health**'s data integration and measure data reporting processes, HSAG identified reporting errors for Core Measure 9.3, resulting in a required resubmission of the measure.

Michigan Complete Health received a measure designation of *Reportable (R)* for all measures, signifying that **Michigan Complete Health** had reported the measures in compliance with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-45—Measure-Specific Validation Designation for MCH

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

Performance Measure	Validation Designation
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
MI2.6: *Timely Transmission of Care Transition Record to Health Care Professional*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI5.6: *Care for Adults—Medication Review*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-46 shows each of **Michigan Complete Health**'s audited HEDIS measures, rates for HEDIS MY 2018 and HEDIS MY 2020 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2020 with HEDIS MY 2018, and the HEDIS MY 2020 MI Health Link statewide average performance rates. Of note, based on CMS' suspension of all MMP reporting of HEDIS MY 2019 rates due to the COVID-19 PHE, HEDIS MY 2019 rates are not displayed in Table 3-46, as data were not reported for MY 2019. HEDIS MY 2020 measure rates performing better than the statewide average are notated by green font.

Table 3-46—Measure-Specific Percentage Rates for MCH

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening[1]	53.81	52.94	-0.87	56.31
COL—Colorectal Cancer Screening[1]	39.66	41.36	+1.70	56.77
COA—Care for Older Adults—Advance Care Planning	33.82	29.44	-4.38	42.46
COA—Care for Older Adults—Medication Review	96.35	83.21	-13.14	66.63
COA—Care for Older Adults—Functional Status Assessment[1]	67.40	40.63	-26.77	53.52
COA—Care for Older Adults—Pain Assessment	67.88	43.07	-24.81	67.04
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	23.40	18.00	-5.40	24.27
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	66.07	56.72	-9.35	71.84
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	87.50	80.60	-6.90	90.73

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure[2]	—	41.12	—	56.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	100.00	60.00	-40.00	89.59
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	78.46	72.73	-5.73	80.63
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	74.51	72.92	-1.59	80.11
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	91.26	78.10	-13.16	84.70
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**[1]	46.72	70.07	+23.35	44.54
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	45.08	26.52	-18.56	47.38
CDC—Comprehensive Diabetes Care—Eye Exam[1]	59.02	37.71	-21.31	55.61
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	91.80	89.29	-2.51	91.69
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg[2]	—	39.66	—	56.67
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	77.33	77.31	-0.02	76.52
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	82.76	85.63	+2.87	81.68
Musculoskeletal Conditions				
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	60.00	45.45	-14.55	71.75
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	25.00	0.00	-25.00	6.97
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	83.52	69.12	-14.40	70.43
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	58.24	61.76	+3.52	55.06
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	32.08	28.36	-3.72	29.65
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	41.51	49.25	+7.74	57.00
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[1]	21.43	19.05	-2.38	31.68
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[1]	35.71	38.10	+2.39	49.24

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Medication Management and Care Coordination				
TRC—Transitions of Care–Notification of Inpatient Admission[2]	—	2.43	—	11.77
TRC—Transitions of Care–Receipt of Discharge Information[2]	—	2.92	—	11.34
TRC—Transitions of Care–Patient Engagement After Inpatient Discharge[2]	—	64.72	—	75.36
TRC—Transitions of Care–Medication Reconciliation Post-Discharge[2]	—	16.55	—	30.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	21.67	23.56	+1.89	21.36
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**[1]	31.79	17.39	-14.40	32.83
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**[2]	—	6.96	—	18.05
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	NA	4.99	—	5.37
*DAE—Use of High-Risk Medications in Older Adults—Total**	NA	10.89	—	21.46
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	74.73	73.37	-1.36	82.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	90.42	87.31	-3.11	92.90
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	82.59	82.71	+0.12	89.79
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	83.66	82.38	-1.28	89.49
IET—Initiation of Alcohol and Other Drug Dependence Treatment[2]	—	37.50	—	37.65
IET—Engagement of Alcohol and Other Drug Dependence Treatment[2]	—	6.67	—	6.59
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[2]	—	1.07	—	1.20
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[2]	—	1.07	—	1.15

* Measures for which lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending in comparison with MY 2018 be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending; therefore, comparisons to MY 2018 rates and benchmarks are not performed for this measure.

NA indicates that data were not available.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Michigan Complete Health implemented various performance measure interventions to improve rates and identify best practices. Monthly market engagement meetings were held with corporate partners to review performance and share best practices. Additionally, a monthly HEDIS action plan and prioritization group was initiated with participation from quality teams to review performance and prioritize interventions. **Michigan Complete Health** also collaborated with other Centene Corporation markets on barriers and best practices through measure-specific workgroups. [**Quality**]

Strength #2: Michigan Complete Health had support in care gap closure from its partner Evolve Pharmacy Solutions. Evolve Pharmacy Solutions provided comprehensive medication reviews to its members, which were shared with **Michigan Complete Health**. **Michigan Complete Health** reported one of the highest rates among other ICOs for MI5.6, demonstrating that partnering with Evolve Pharmacy Solutions made a positive impact on the overall quality and accuracy of the reported rate for MI5.6. [**Quality**]

Strength #3: In the Overuse/Appropriateness domain, **Michigan Complete Health**'s rate for the *DDE—Potentially Harmful Drug-Disease Interactions in Older Adults* measure indicator decreased more than 14 percentage points from MY 2018 to MY 2020 and was below the HEDIS MY 2020 MI Health Link statewide average, indicating better performance; although NCQA cautioned trending for this measure indicator, the results suggest strength and improvement in lowering the number of prescriptions dispensed for adults 65 years of age and older that could potentially exacerbate their specific disease or condition. Prescription drug use by older adults can often result in adverse drug events that contribute to hospitalization, increased duration of illness, nursing home placement, falls, and fractures. Despite widely accepted medical consensus that certain drugs increase the risk of harm to older adults, these drugs continue to be prescribed.[3-23] [**Quality]**

[3-23] National Committee for Quality Assurance. Medication Management in Older Adults (DAE/DDE). Available at: https://www.ncqa.org/hedis/measures/medication-management-in-the-elderly/. Accessed on: Feb 10, 2022.

Weaknesses and Recommendations

Weakness #1: It was identified that **Michigan Complete Health** was inaccurately reporting members in data element B (total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission) for Core Measure 9.3. [**Quality** and **Timeliness**]

Why the weakness exists: It was identified for Core Measure 9.3 for three of the selected cases for PSV that **Michigan Complete Health** was reporting members in data element B (discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission) when they were hospitalized within 60 days of an institutional facility discharge. According to the MMP Core Reporting Requirements, members hospitalized within 60 days of the institutional facility discharge are to be removed from data element B.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #2: It was identified that **Michigan Complete Health** was limiting its data element A (total number of admissions to institutional facilities—i.e., denominator count) for Core Measure 9.3 to members with the following discharge status codes and location descriptions: 01 – Home, 06 – Home Health Service, and 07 – AMA. [**Quality**]

Why the weakness exists: HSAG noted a small number of IFAs reported for Core Measure 9.3 data element A, which resulted in an overall high reported rate for the measure. **Michigan Complete Health** confirmed that this was to be expected. However, due to the low IFA count, HSAG requested that **Michigan Complete Health** provide a comparison of six months of data with the counts and supporting raw data of IFAs that occurred between July 1, 2019, and December 31, 2019, as well as between July 1, 2020, and December 31, 2020. **Michigan Complete Health** provided the raw data files, and HSAG noted after reviewing the raw data that both the 2019 and 2020 data tabs within the file only included IFAs with these discharge status codes and location descriptions: 01 – Home, 06 – Home Health Service, and 07 – AMA. Additionally, on further review of source code that was provided for Core Measure 9.3, it appeared that there was a limitation on discharge status code and bill type for data element A. HSAG asked **Michigan Complete Health** to confirm if data element A was being limited to specific discharge status codes for Core Measure 9.3, which **Michigan Complete Health** confirmed.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #3: For 35 of the 46 reported HEDIS measures (76 percent) **Michigan Complete Health**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care. [**Quality**]

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

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #4: In the Prevention and Screening domain, **Michigan Complete Health**'s rate for the *COA—Care for Older Adults—Pain Assessment* and *Functional Status Assessment* measure indicators decreased more than 24 percentage points from MY 2018 to MY 2020, with both indicators falling below the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for one of the measure indicators (i.e., *Functional Status Assessment*), the results suggest that adult members 66 years of age and older were not always having pain assessments or functional status assessments completed to help optimize quality of life. As the population ages, physical and cognitive function can decline and pain becomes more prevalent.[3-24] [**Quality** and **Access**]

Why the weakness exists: The rate for the *COA—Care for Older Adults—Pain Assessment* and *Functional Status Assessment* measure indicators decreasing more than 24 percentage points from MY 2018 to MY 2020 suggests that barriers exist for having pain assessments and functional status assessments completed during the measurement year for some adults 66 years of age and older.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #5: In the Cardiovascular Conditions domain, **Michigan Complete Health**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased by 40 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link statewide average, indicating that some adults who were hospitalized and discharged with a diagnosis of acute myocardial infarction were not always receiving persistent beta-blocker treatment for six months. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-25] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreasing 40 percentage points from MY 2018 to MY 2020

[3-24] National Committee for Quality Assurance. Care for Older Adults (COA). Available at: https://www.ncqa.org/hedis/measures/care-for-older-adults/. Accessed on: Feb 4, 2022.

[3-25] National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/. Accessed on: Feb 10, 2022.

suggests that barriers exist for some adults to receive persistent beta-blocker treatment for six months following inpatient discharge for acute myocardial infarction.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #6: In the Diabetes domain, **Michigan Complete Health**'s rates for the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*, *HbA1c Testing*, and *Eye Exam* measure indicators decreased more than 13 percentage points from MY 2018 to MY 2020, and the rate for the *CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)* measure indicator increased more than 23 percentage points from MY 2018 to MY 2020 (indicating worse performance). Additionally, all *Comprehensive Diabetes Care* measure indicators except *Poor HbA1c Control (>9.0%)* fell below the HEDIS MY 2020 MI Health Link statewide average; the *Poor HbA1c Control (>9.0%)* measure indicator exceeded the statewide average, which indicated worse performance. Although NCQA cautioned trending for these measure indicators, the results suggest that more adult members with diabetes had uncontrolled blood glucose levels and that fewer HbA1c tests and eye exams were performed. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-26] [**Quality** and **Access**]

Why the weakness exists: The rates for the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*, *HbA1c Testing*, and *Eye Exam* measure indicators decreasing more than 13 percentage points from MY 2018 to MY 2020 and the rate for the *CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)* measure indicator increasing more than 23 percentage points from MY 2018 to MY 2020 suggests that barriers exist for effective diabetes management among adult members.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #7: In the Musculoskeletal Conditions domain, **Michigan Complete Health**'s rate for the *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* measure indicator decreased more than 14 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link statewide average, indicating that some adults diagnosed with rheumatoid arthritis were not being dispensed at least one ambulatory prescription for a DMARD. Rheumatoid arthritis is progressive, but early intervention with DMARDs can help preserve function and prevent further damage to joints.[3-27] [**Quality** and **Access**].

[3-26] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 7, 2022.

[3-27] National Committee for Quality Assurance. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis. Available at: https://www.ncqa.org/hedis/measures/disease-modifying-anti-rheumatic-drug-therapy-for-rheumatoid-arthritis/. Accessed on Feb 9, 2022.

Why the weakness exists: The rate for the *ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* measure indicator decreasing more than 14 percentage points from MY 2018 to MY 2020 suggests that barriers exist for some adults with rheumatoid arthritis to receive prescriptions for DMARDs.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #8: In the Musculoskeletal Conditions domain, **Michigan Complete Health**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreased by 25 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest that women who suffered a fracture did not receive a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.[3-28] [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: The rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreasing by 25 percentage points from MY 2018 to MY 2020 suggests that barriers exist for women to receive timely bone mineral density tests or prescriptions to treat osteoporosis within six months of a fracture.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #9: In the Behavioral Health domain, **Michigan Complete Health**'s rate for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator decreased more than 14 percentage points from MY 2018 to MY 2020 and fell below the HEDIS MY 2020 MI Health Link statewide average, indicating that some members with a diagnosis of major depression were not receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.[3-29] [**Quality** and **Access**]

Why the weakness exists: The rate for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator decreasing more than 14 percentage points from

[3-28] National Committee for Quality Assurance. Osteoporosis Management In Women Who Had a Fracture (OMW). Available at: https://www.ncqa.org/hedis/measures/osteoporosis-management-in-women-who-had-a-fracture-omw/. Accessed on: Feb 8, 2022.

[3-29] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 4, 2022.

MY 2018 to MY 2020 suggests that barriers exist for some members with depression to receive continuous medication treatment.

Recommendation: Michigan Complete Health members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Compliance Review

Performance Results

Table 3-47 presents an overview of the results of the SFY 2021 focused compliance review for **Michigan Complete Health**, which consisted exclusively of case file reviews in certain program areas, and associated information system reviews. The table identifies all program areas that were reviewed and those that required a CAP due to noncompliance with State and federal requirements.

Table 3-47—Case File Review Overall Findings for MCH

Associated Standard	Description of Files	CAP Not Required	CAP Required
IV	Service Authorization Denials		✓
V	Individual Practitioner Credentialing	✓	
V	Organizational Credentialing	✓	
VII	Member Grievances	✓	
VII	Member Appeals		✓
VIII	Subcontractors (delegated entities)	✓	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Michigan Complete Health consistently adhered to individual practitioner credentialing requirements including, but not limited to, PSV, verification of Medicare and Medicaid sanctions, receipt of disclosure of ownership and control forms, notice to providers, and recredentialing time frames. Adherence to federal and MDHHS individual credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Strength #2: Michigan Complete Health consistently adhered to organizational credentialing requirements including, but not limited to, demonstrating that providers were in good standing with State and federal regulatory agencies and confirming providers were not excluded from Medicare and Medicaid, obtaining receipt of disclosure of ownership and control interest forms, and adhering to recredentialing time frames. Adherence to federal and MDHHS organizational requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Strength #3: Michigan Complete Health consistently resolved each grievance within 30 calendar days or less and provided members with verbal and/or written resolution of the grievance. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is essential to maintain high-quality care and services and to ensure member retention. [**Quality**, and **Timeliness**]

Strength #4: Michigan Complete Health consistently adhered to subcontractor oversight and delegation requirements, including required contract language, evidence of periodic formal reviews that included a review of all delegated functions and case file reviews to determine implementation, development of CAPs when necessary, and regular meetings with the delegate which included performance metric reviews. Robust oversight and monitoring of delegated entities is essential to strengthen program integrity efforts. This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS and/or identifies poor performance which may require remediation. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Michigan Complete Health and its dental delegate did not consistently adhere to the Coverage and Authorization of Services requirements under 42 CFR §438.210. Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a denied service in easily understood language and have access to their appeal and SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that IDNs generated by **Michigan Complete Health**'s dental delegate did not always include the citation to the regulation supporting the action and had missing clinical information; and the dental delegate rendered IDNs within in a few days of receiving a service authorization in several cases and did not use the entire allowed time frame to render a service authorization decision. Additionally, during the interview session, a **Michigan Complete Health** dental delegate staff member verbalized that should the time frame for a service authorization be extended, the ICO would only send notice to the requesting provider but not to the member. Denial rationales used by the dental delegate also did not include the citation to the regulation supporting the action. **Michigan Complete Health** identified in its CAP that the root cause of the deficiencies were related to internal time frame processes not being followed by the dental delegate and staff were not aware of member notification requirements for service authorization review time frame extensions.

Recommendation: Michigan Complete Health members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #2: Michigan Complete Health did not consistently adhere to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintaining member access to high-quality care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that **Michigan Complete Health**'s grievance/appeal template letter did not inform the member of the right to file a grievance should the member not be in agreement with the 14-day extension as required by the federal managed care rule. **Michigan Complete Health** reported in its CAP that the extension letter provided during the compliance review was never sent on appeal and that **Michigan Complete Health** had an additional, complete letter on file that provides members with grievance rights.

Recommendation: Michigan Complete Health members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Network Adequacy Validation

Performance Results

HSAG's NAV results indicated that **Michigan Complete Health** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9.

Table 3-48 presents **Michigan Complete Health**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception and extension determinations.

Table 3-48—SFY 2021 NAV Results for MCH, by Region and Provider Type

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time and Distance Requirements		
Adult Day Program	Met	Met
Dental (preventive and restorative)	Met	Met
Eye Examinations (provided by optometrists)	Met	Met
Eye Wear (providers dispensing eyeglasses and contact lenses)	Met	Met
Hearing Examinations	Met	Met
Hearing Aids	Met	Met
MIHP Agency	Met	Met
Provider Types Rendering Home-Based Services		
Adaptive Medical Equipment and Supplies	Met	Met
Assistive Technology Devices	Met	Met
Assistive Technology Van Lifts and Tie Downs	Met	Met

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Chore Services	Met	Met
Community Transition Services	Met	Met
Environmental Modifications	Met	Met
Expanded Community Living Supports	Met	Met
Fiscal Intermediary	Met	Met
Home-Delivered Meals	Met	Met
Medical Supplies	Met	Met
Non-Emergency Medical Transportation	Met	Met
Non-Medical Transportation (waiver service only)	Met	Met
Personal Care Services (non-agency and agency)	Met	Met
Personal Emergency Response System	Met	Met
Preventive Nursing Services (non-agency and agency)	Met	Met
Private Duty Nursing (non-agency and agency)	Met	Met
Respite	Met	Met
Skilled Nursing Home	Met	Met
Percent of Total Provider Types Meeting Minimum Network Requirements	**100%**	**100%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Michigan Complete Health met all Medicaid and LTSS minimum network requirements for Region 7, indicating that **Michigan Complete Health** maintains an adequate network for MI Health Link members in this region. [**Access**]

Strength #2: Michigan Complete Health met all Medicaid and LTSS minimum network requirements for Region 9, indicating that **Michigan Complete Health** maintains an adequate network for MI Health Link members in this region. [**Access**]

Weaknesses and Recommendations

Weakness #1: HSAG identified no specific weaknesses for **Michigan Complete Health** based on the SFY 2021 NAV evaluation.

Why the weakness exists: Not applicable.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 427 sampled provider locations (i.e., "cases") for **Michigan Complete Health**, with an overall response rate of 62.4 percent (133 cases) for routine well-check visits and 60.7 percent (130 cases) for nonurgent symptomatic visits among **Michigan Complete Health**'s two MI Health Link regions. Region 7 had the highest response rate for both routine well-check and nonurgent symptomatic appointments.

Table 3-49 and Table 3-50 summarize the SFY 2021 secret shopper survey response rates by visit scenario for **Michigan Complete Health**, and for each of **Michigan Complete Health**'s contracted MI Health Link regions.

Table 3-49—Summary of MCH Secret Shopper Survey Results for Routine Well-Check Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 7	108	72	53	35	31
Region 9	105	61	39	23	21
MCH Total	**213**	**133**	**92**	**58**	**52**

Table 3-50—Summary of MCH Secret Shopper Survey Results for Nonurgent Symptomatic Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 7	109	70	56	50	45
Region 9	105	60	44	32	31
MCH Total	**214**	**130**	**100**	**82**	**76**

Table 3-51 displays the number of cases in which the survey respondent offered appointments to new patients for routine services and nonurgent symptomatic visits, as well as summary wait time statistics for **Michigan Complete Health**, and for each of **Michigan Complete Health**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location. Of cases in which the survey respondent reported that the provider location accepted **Michigan Complete Health**, the MI Health Link program, and new patients, appointment availability was reported for 88.5 percent (n=46) and 60.5 percent (n=46) of routine and symptomatic cases, respectively.

Table 3-51—Summary of MCH Secret Shopper Survey Appointment Availability Results, by Region

Region	Routine Well-Check					Nonurgent Symptomatic Visit				
	Number of Cases Offered an Appointment	Wait Time in Calendar Days				Number of Cases Offered an Appointment	Wait Time in Calendar Days			
		Min	Max	Average	Median		Min	Max	Average	Median
Region 7	30	1	61	11.4	5.0	29	0	76	9.1	1.0
Region 9	16	3	31	10.4	8.0	17	0	19	5.9	5.0
MCH Total	**46**	**1**	**61**	**11.1**	**6.0**	**46**	**0**	**76**	**8.0**	**3.0**

In follow-up to the secret shopper survey findings, MDHHS required **Michigan Complete Health** to develop a CAP to address the deficiencies identified during the survey. **Michigan Complete Health** was also expected to extend any training and oversight activities implemented for the CAP to providers not included in the survey sample. MDHHS' CAP requirements are detailed in Appendix A.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the secret shopper activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ICO-specific strengths have not been identified because a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICO's provider data files.

Weaknesses and Recommendations

Weakness #1: Over 67 percent of sampled provider locations were unable to be reached, did not accept **Michigan Complete Health**, or did not accept and/or recognize the MI Health Link program. [**Quality** and **Access**]

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **Michigan Complete Health**'s provider data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Weakness #2: A limited number of cases resulted in callers being offered appointment dates and times. [**Access**]

Why the weakness exists: Of cases in which the survey respondent reported that the provider location accepted **Michigan Complete Health**, the MI Health Link program, and new patients, appointment availability was reported for 88.5 percent and 60.5 percent of routine and symptomatic cases, respectively. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. Considerations included members needing to designate the provider as their PCP before scheduling an appointment, being required to complete pre-registration or provide additional personal information to schedule an appointment, and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG did not make any ICO-specific recommendations for program improvement.

Consumer Assessment of Healthcare Providers and Systems Analysis

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

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Michigan Complete Health** about the quality, timeliness, and accessibility of care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Michigan Complete Health** across all EQR activities to identify common themes within **Michigan Complete Health** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that while **Michigan Complete Health** generally performed well in some areas impacting the quality and timeliness of, and access to care, the ICO has several opportunities for improvement. **Michigan Complete Health** met all requirements for data analysis and implementation of improvement strategies for its *Follow-Up After Hospitalization for Mental Illness* QIP, and performance rates increased from Remeasurement 1 to Remeasurement 2. However, the goal of significant improvement was not achieved. As indicated through the PMV activity, **Michigan Complete Health**'s indicator rates for *Follow-Up After Hospitalization for Mental Illness* also fell below the statewide average [**Timeliness** and **Access**]. **Michigan Complete Health** reported implementing interventions to address transportation barriers to care and created informational materials, which may have contributed to the increase in the study indicator rate for Remeasurement 2.

Michigan Complete Health demonstrated varying results in the behavioral health program area through the PMV activity. Three indicator rates decreased while three indicator rates increased. Only one indicator rate exceeded the statewide average, indicating several opportunities to improve access to behavioral health services [**Quality**, **Timeliness**, and **Access**].

The combined results of EQR activities present mixed findings regarding access to care. Through the results of the NAV activity, **Michigan Complete Health** met all Medicaid and LTSS minimum network requirements, indicating an adequate network of providers. However, the results of the secret shopper activity suggested that members may have experienced barriers to accessing providers, as a high percentage of sampled provider locations were unable to be reached, did not accept **Michigan Complete Health**, or did not accept and/or recognize the MI Health Link program [**Access**]. The PMV activity further suggested that members may be experiencing barriers to primary care and services through measure results within the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, and Access/Availability of Care domains. Only three indicator rates within these domains improved, with minimal increases. The majority of the indicator rates showed declines in performance, indicating several opportunities for improving member access to primary and specialty care.

While **Michigan Complete Health**'s performed better than the other ICOs through the compliance review activity, some process deficiencies were identified across the service authorization denials and appeals program areas [**Quality**, **Timeliness**, and **Access**]. Of particular note, member-facing materials, such as service authorization IDNs, did not include the required content. Adequate written member materials are essential to ensure members are receiving all necessary information to make informed choices regarding their healthcare and services and accessing their appeal and SFH rights. Additionally, dental-related denials were being made prematurely and members were not adequately informed of a service authorization or appeal time frame extension or grievance rights. **Michigan Complete Health** completed a root cause analysis and developed a remediation plan for all deficiencies, which should support more effective member communication and administrative procedures to effectively support the delivery of quality, accessible, and timely services [**Quality**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Molina Healthcare of Michigan

Validation of Quality Improvement Projects

Performance Results

Table 3-52 displays the overall validation status and the baseline, Remeasurement 1, and Remeasurement 2 results for the QIP study indicator. **Molina Healthcare of Michigan** did not select a plan-specific goal for the study indicator, as this was not a requirement for the QIP.

Table 3-52—Overall Validation Rating for MOL

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Met*	The percentage of MMP [Medicare-Medicaid plan] member discharges for which the member received follow-up within 30 days of discharge.	55.6%	58.9% ⇔	68.8% ↑	

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

Table 3-53 displays the interventions implemented to address the barriers identified by the ICO using QI and causal/barrier analysis processes.

Table 3-53—Remeasurement 2 Interventions for MOL

Intervention Descriptions	
Executed monthly meetings between the ICO and PIHPs to discuss barriers, interventions, and evaluations.	Allowed for provider reimbursement of telehealth visits.
Implemented a transition of care program, telepsychiatry program, follow-up appointment reminders for members, and member outreach providing education on importance of follow-up and medication adherence.	Conducted outreach to members with a documented positive COVID-19 test to provide education on quarantine, self-care, and appropriate use of the ED.
Developed weekly data sharing reports capturing admission, discharge, and transfer data that are shared between the ICO and PIHP.	Coordinated with hospitals and inpatient facilities to start the discharge coordination planning process early in the inpatient stay.
Engaged the ICO directors to meet with key clinical leadership at each PIHP to discuss the importance of the study indicator at a peer-to-peer level.	Engaged appropriate credentialed ICO staff to perform follow-up after hospitalization services with members.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan met 100 percent of the requirements for data analysis and implementation of improvement strategies. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Molina Healthcare of Michigan achieved the goal of statistically significant improvement over the baseline rate for the second remeasurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no significant identified weaknesses.

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Molina Healthcare of Michigan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The ICO should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measure Validation

Performance Results

HSAG evaluated **Molina Healthcare of Michigan**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system; medical services data system (e.g., claims and encounters); care coordination system (i.e., tracking and management of care transition record transmissions); medication reconciliation system (i.e., tracking and management of medication reviews); hybrid data collection; and data integration. Although HSAG did not identify any general concerns with **Molina Healthcare of Michigan**'s data integration and measure data reporting processes, HSAG identified reporting errors for MI2.6, resulting in a required resubmission of the measure.

Molina Healthcare of Michigan received a measure designation of *Reportable (R)* for all measures, signifying that **Molina Healthcare of Michigan** had reported the measures in compliance with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-54—Measure-Specific Validation Designation for MOL

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
MI2.6: *Timely Transmission of Care Transition Record to Health Care Professional*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI5.6: *Care for Adults—Medication Review*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-55 shows each of **Molina Healthcare of Michigan**'s audited HEDIS measures, rates for HEDIS MY 2018 and HEDIS MY 2020 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2020 with HEDIS MY 2018, and the HEDIS MY 2020 MI Health Link statewide average performance rates. Of note, based on CMS' suspension of all MMP reporting of HEDIS MY 2019 rates due to the COVID-19 PHE, HEDIS MY 2019 rates are not displayed in Table 3-55, as data were not reported for MY 2019. HEDIS MY 2020 measure rates performing better than the statewide average are notated by green font.

Table 3-55—Measure-Specific Percentage Rates for MOL

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening[1]	60.36	58.73	-1.63	56.31
COL—Colorectal Cancer Screening[1]	56.20	63.02	+6.82	56.77
COA—Care for Older Adults—Advance Care Planning	57.66	42.09	-15.57	42.46
COA—Care for Older Adults—Medication Review	79.08	70.80	-8.28	66.63
COA—Care for Older Adults—Functional Status Assessment[1]	70.56	50.61	-19.95	53.52
COA—Care for Older Adults—Pain Assessment	84.91	71.29	-13.62	67.04
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	29.28	24.93	-4.35	24.27

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	68.67	71.73	+3.06	71.84
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	92.70	91.96	-0.74	90.73
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure[2]	—	54.50	—	56.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	94.59	91.43	-3.16	89.59
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	77.01	80.61	+3.60	80.63
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	75.15	84.74	+9.59	80.11
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	91.24	87.10	-4.14	84.70
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**[1]	33.09	41.36	+8.27	44.54
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	54.74	50.61	-4.13	47.38
CDC—Comprehensive Diabetes Care—Eye Exam[1]	67.88	61.56	-6.32	55.61
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	94.89	91.24	-3.65	91.69
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg[2]	—	56.69	—	56.67
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	72.00	76.57	+4.57	76.52
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	75.93	83.68	+7.75	81.68
Musculoskeletal Conditions				
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	67.77	66.92	-0.85	71.75
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	4.00	5.56	+1.56	6.97
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	60.92	71.31	+10.39	70.43
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	46.84	51.81	+4.97	55.06
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	28.29	40.34	+12.05	29.65
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	55.61	68.75	+13.14	57.00

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[1]	17.02	29.59	+12.57	31.68
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[1]	35.64	50.00	+14.36	49.24
Medication Management and Care Coordination				
TRC—Transitions of Care–Notification of Inpatient Admission[2]	—	7.06	—	11.77
TRC—Transitions of Care–Receipt of Discharge Information[2]	—	8.52	—	11.34
TRC—Transitions of Care–Patient Engagement After Inpatient Discharge[2]	—	77.37	—	75.36
TRC—Transitions of Care–Medication Reconciliation Post-Discharge[2]	—	21.41	—	30.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	29.45	26.40	-3.05	21.36
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**[1]	43.37	34.06	-9.31	32.83
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**[2]	—	20.33	—	18.05
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	NA	4.45	—	5.37
*DAE—Use of High-Risk Medications in Older Adults—Total**	NA	22.82	—	21.46
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	87.37	84.81	-2.56	82.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	96.47	94.96	-1.51	92.90
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	94.03	91.54	-2.49	89.79
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	93.75	91.60	-2.15	89.49
IET—Initiation of Alcohol and Other Drug Dependence Treatment[2]	—	35.23	—	37.65
IET—Engagement of Alcohol and Other Drug Dependence Treatment[2]	—	4.10	—	6.59
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[2]	—	1.12	—	1.20

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[2]	—	1.10	—	1.15

* Measures for which lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending in comparison with MY 2018 be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending; therefore, comparisons to MY 2018 rates and benchmarks are not performed for this measure.
NA indicates that data were not available.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan demonstrated a general strength in its completeness of administrative data, as it reported a typically clean claims processing timeliness rate of 100 percent three months after the close of a reporting period for 2020. Ensuring timely claims adjudication assures that **Molina Healthcare of Michigan**'s Core Measure 9.1 and Core Measure 9.3 data are accurate, since both measures depend on paid claims data for reporting. It is also critical to have complete claims data for Core Measure 9.3 so that **Molina Healthcare of Michigan** is able to readily identify any claims within 60 days of a member's discharge to the community (i.e., readmission to an institution, hospital admission, or claims for continued nursing facility stays), further assuring the accuracy of data element B (total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission). Sufficient oversight of timely and complete claims data helps support the overall quality of administrative data used for performance measure reporting. [**Quality** and **Timeliness**]

Strength #2: In the Behavioral Health domain, **Molina Healthcare of Michigan**'s rate for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator increased more than 10 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in members with a diagnosis of major depression receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being

and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.[3-30] [**Quality** and **Access**]

Strength #3: In the Behavioral Health domain, **Molina Healthcare of Michigan**'s rates for the *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days* and *30 Days* measure indicators increased more than 12 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for these measure indicators, the results suggest strength and improvement in members with a diagnosis of mental illness or intentional self-harm receiving follow-up care with a mental health provider within seven and 30 days of inpatient discharge. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-31] [**Quality**, **Timeliness**, and **Access**]

Strength #4: In the Behavioral Health domain, **Molina Healthcare of Michigan**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator increased more than 14 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest strength and improvement in timely follow-up care with a mental health provider for members with a diagnosis of mental illness following inpatient discharge. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.[3-32] [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG identified during the virtual review that **Molina Healthcare of Michigan** was automatically counting members who discharged to a skilled nursing facility, home health, or short-term general hospital in MI2.6 data element C (total number of members for whom a transition record was transmitted to the facility, primary physician, or other healthcare professional designated for follow-up care on the day of discharge or the following day). [**Quality**]

Why the weakness exists: It was identified during the virtual review that members who discharged to a skilled nursing facility, home health, or short-term general hospital were automatically included in MI2.6 data element C as discharged to the community. According to Michigan Reporting Requirements, members may be reported in data element C if the transition record was transmitted to the facility designated for follow-up care on the day of discharge through two days after discharge.

[3-30] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 4, 2022.

[3-31] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness (FUH). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Feb 9, 2022.

[3-32] National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: Feb 4, 2022.

While **Molina Healthcare of Michigan** had processes in place to confirm skilled nursing facility, home health, and short-term general hospital care transitions occurred, by documenting the date the transition occurred and entering a system attribute when completing the prior authorization for the transfer, it did not have any processes in place to validate the transition records transmission timeliness requirement for these members.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** implement a process for checking the timeliness requirement for MI2.6 data element C for members discharged to a skilled nursing facility, home health, or short-term general hospital, so that transition record transmissions for these members on the day of discharge through two days after discharge are able to be included in reporting. Incorporating a timeliness criteria check for these members would improve performance measure rates in future reporting of MI2.6, and would increase the quality and accuracy of reported performance measure data.

Weakness #2: Molina Healthcare of Michigan did not provide details in its original ISCAT submission regarding subcontracted PIHPs' encounter data processes. [**Quality**]

Why the weakness exists: Molina Healthcare of Michigan used PIHP encounter data in Core Measure 9.1 reporting and therefore should have provided details regarding its subcontracted PIHP encounter data processes in the ISCAT submission.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** ensure future ISCAT submissions and supporting documentation include all pertinent details regarding its subcontractors involved in the processes related to the measures under the scope of the validation.

Weakness #3: In the Prevention and Screening domain, **Molina Healthcare of Michigan**'s rate for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators decreased more than 15 percentage points from MY 2018 to MY 2020, with both indicators falling below the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for one of the measure indicators (i.e., *Functional Status Assessment*), the results suggest that adult members 66 years of age and older were not always having advance care planning or functional status assessments completed to help optimize quality of life. As the population ages, physical and cognitive function can decline and pain becomes more prevalent. Consideration should be given to an individual's own choices about end-of-life care; advance care plans should be executed.[3-33] [**Quality** and **Access**]

Why the weakness exists: The rate for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators decreasing more than 15 percentage points from MY 2018 to MY 2020 suggests that barriers exist for having advanced care planning and functional status assessments completed during the measurement year for some adults 66 years of age and older.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some adults 66 years of age and older are not always

[3-33] National Committee for Quality Assurance. Care for Older Adults (COA). Available at: https://www.ncqa.org/hedis/measures/care-for-older-adults/. Accessed on: Feb 4, 2022.

having advanced care planning and functional status assessments completed. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators. **Molina Healthcare of Michigan** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education). Additionally, **Molina Healthcare of Michigan** should identify factors related to the COVID-19 PHE and its impact on conducting advance care planning and functional status assessments.

Compliance Review

Performance Results

Table 3-56 presents an overview of the results of the SFY 2021 focused compliance review for **Molina Healthcare of Michigan**, which consisted exclusively of case file reviews in certain program areas, and associated information system reviews. The table identifies all program areas that were reviewed and those that required a CAP due to noncompliance with State and federal requirements.

Table 3-56—Case File Review Overall Findings for MOL

Associated Standard	Description of Files	CAP Not Required	CAP Required
IV	Service Authorization Denials		✓
V	Individual Practitioner Credentialing		✓
V	Organizational Credentialing		✓
VII	Member Grievances		✓
VII	Member Appeals		✓
VIII	Subcontractors (delegated entities)	✓	

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan's oversight of its delegates included evidence of periodic formal reviews that included a review of all delegated functions; development of CAPs, when necessary; and regular meetings with the delegates which included performance metric reviews. Robust oversight and monitoring of delegated entities strengthen program integrity efforts.

This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS and/or identifies poor performance which may require remediation. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan and its dental delegate did not consistently adhere to the Coverage and Authorization of Services requirements under 42 CFR §438.210. Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a denied service in easily understood language and have access to their appeal and SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that IDNs did not consistently include the citation supporting the action; the dental delegate's IDNs included repetitive language; **Molina Healthcare of Michigan**'s pharmacy department used the incorrect version of the IDN, which was also not written in the correct reading grade level; and IDNs did not consistently include the correct time frame for resolving a standard appeal. **Molina Healthcare of Michigan** reported that the incorrect IDN was created and edited manually. Additionally, **Molina Healthcare of Michigan**'s administrative process did not clearly provide IDN examples for staff, and the annual letter modifications were not communicated to the pharmacy team.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina Healthcare of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set coverage and authorization of services standards.

Weakness #2: Molina Healthcare of Michigan did not consistently adhere to the Provider Selection individual practitioner credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS individual credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that **Molina Healthcare of Michigan** did not consistently obtain disclosure of ownership and control interest forms as part of its individual practitioner credentialing process. Through its CAP, **Molina Healthcare of Michigan** reported that upon implementation of the Community Health Automated Medicaid Processing System (CHAMPS) by MDHHS, the ICO no longer required providers to submit a disclosure of ownership.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina Healthcare of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set individual practitioner credentialing standards.

Weakness #3: Molina Healthcare of Michigan did not consistently adhere to the Provider Selection organizational credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements. Adherence to federal and MDHHS organizational requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that **Molina Healthcare of Michigan** did not consistently include documentation that verified accreditation or that **Molina Healthcare of Michigan** conducted a site visit during the credentialing process or obtained disclosure of ownership and control interest forms. Through its CAP, the ICO reported that it erroneously included providers that were not part of the Medicaid LOB. Additionally, **Molina Healthcare of Michigan** reported that upon MDHHS' implementation of CHAMPS, the ICO no longer required providers to submit a disclosure of ownership.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina Healthcare of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set organizational credentialing standards.

Weakness #4: Molina Healthcare of Michigan did not consistently adhere to the Grievance Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is essential to maintain high-quality care and services and to ensure member retention. [**Quality**, and **Timeliness**]

Why the weakness exists: Case files reviewed by HSAG identified several discrepancies in member acknowledgement processes, and the written grievance resolution letters did not align with MDHHS' model notice. As reported in its CAP, **Molina Healthcare of Michigan** determined that grievance specialists were not completing the process to mail letters.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina Healthcare of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards.

Weakness #5: Molina Healthcare of Michigan did not consistently adhere to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintaining member access to high-quality care and services. Additionally, the notice to the member about an appeal should be written at the appropriate reading grade level for members to understand the action and their rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that acknowledgement letters were not consistently sent within the required time frame according to **Molina Healthcare of Michigan**'s policy; and resolution letters were not consistently written in easily understood, plain language or were incomplete. **Molina Healthcare of Michigan** reported in its CAP that the appeal team used dental vendor language and did not ensure the resolution letters used plain language. A lack of quality control related to the acknowledgement letters was also reported.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina Healthcare of Michigan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

Network Adequacy Validation

Performance Results

HSAG's NAV results indicated that **Molina Healthcare of Michigan** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9.

Table 3-57 presents **Molina Healthcare of Michigan**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception and extension determinations.

Table 3-57—SFY 2021 NAV Results for MOL of Michigan, by Region and Provider Type

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time and Distance Requirements		
Adult Day Program	Met	Met
Dental (preventive and restorative)	Met	Met
Eye Examinations (provided by optometrists)	Met	Met
Eye Wear (providers dispensing eyeglasses and contact lenses)	Met	Met
Hearing Examinations	Met	Met
Hearing Aids	Met	Met
MIHP Agency	Met	Met
Provider Types Rendering Home-Based Services		
Adaptive Medical Equipment and Supplies	Met	Met
Assistive Technology Devices	Met	Met
Assistive Technology Van Lifts and Tie Downs	Met	Met
Chore Services	Met	Met
Community Transition Services	Met	Met
Environmental Modifications	Met	Met
Expanded Community Living Supports	Met	Met
Fiscal Intermediary	Met	Met
Home-Delivered Meals	Met	Met
Medical Supplies	Met	Met
Non-Emergency Medical Transportation	Met	Met
Non-Medical Transportation (waiver service only)	Met	Met
Personal Care Services (non-agency and agency)	Met	Met

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Personal Emergency Response System	Met	Met
Preventive Nursing Services (non-agency and agency)	Met	Met
Private Duty Nursing (non-agency and agency)	Met	Met
Respite	Met	Met
Skilled Nursing Home	Met	Met
Percent of Total Provider Types Meeting Minimum Network Requirements	**100%**	**100%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan met all Medicaid and LTSS minimum network requirements for Region 7, indicating that **Molina Healthcare of Michigan** maintains an adequate network for MI Health Link members in this region. [**Access**]

Strength #2: Molina Healthcare of Michigan met all Medicaid and LTSS minimum network requirements for Region 9, indicating that **Molina Healthcare of Michigan** maintains an adequate network for MI Health Link members in this region. [**Access**]

Weaknesses and Recommendations

Weakness #1: HSAG identified no specific weaknesses for **Molina Healthcare of Michigan** based on the SFY 2021 NAV evaluation.

Why the weakness exists: Not applicable.

Recommendation: Molina Healthcare of Michigan should continue to monitor its Medicaid and LTSS providers, including verification of provider data accuracy using external data sources, to ensure an adequate network for MI Health Link members in Region 7 and Region 9.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 521 sampled provider locations (i.e., "cases") for **Molina Healthcare of Michigan**, with an overall response rate of 59.5 percent (154 cases) for routine well-check visits and 55.7 percent (146 cases) for nonurgent symptomatic visits among **Molina Healthcare of Michigan**'s two MI Health Link regions. Region 9 had the highest response rate for both routine well-check and nonurgent symptomatic appointments.

Table 3-58 and Table 3-59 summarize the SFY 2021 secret shopper survey response rates by visit scenario for **Molina Healthcare of Michigan**, and for each of **Molina Healthcare of Michigan**'s contracted MI Health Link regions.

Table 3-58—Summary of MOL Secret Shopper Survey Results for Routine Well-Check Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 7	158	92	88	70	61
Region 9	101	62	50	45	38
MOL Total	**259**	**154**	**138**	**115**	**99**

Table 3-59—Summary of MOL Secret Shopper Survey Results for Nonurgent Symptomatic Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 7	160	81	70	65	55
Region 9	102	65	48	44	33
MOL Total	**262**	**146**	**118**	**109**	**88**

Table 3-60 displays the number of cases in which the survey respondent offered appointments to new patients for routine services and nonurgent symptomatic visits, as well as summary wait time statistics for **Molina Healthcare of Michigan**, and for each of **Molina Healthcare of Michigan**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location. Of cases in which the survey respondent reported that the provider location accepted **Molina Healthcare of Michigan**, the MI Health Link program, and new patients, appointment availability was reported for 59.6 percent (n=59) and 63.6 percent (n=56) of routine and symptomatic cases, respectively.

Table 3-60—Summary of MOL Secret Shopper Survey Appointment Availability Results, by Region

Region	Routine Well-Check					Nonurgent Symptomatic Visit				
	Number of Cases Offered an Appointment	Wait Time in Calendar Days				Number of Cases Offered an Appointment	Wait Time in Calendar Days[1]			
		Min	Max	Average	Median		Min	Max	Average	Median
Region 7	36	0	78	13.4	7.0	35	0	27	5.3	3.0
Region 9	23	1	39	11.7	7.0	21	0	42	14.4	7.0
MOL Total	**59**	**0**	**78**	**12.8**	**7.0**	**56**	**0**	**42**	**8.7**	**4.0**

[1] The appointment wait time summary excludes one Region 7 case that reported an appointment wait time greater than 140 days. Information on this case was included in the analytic data file for MOL's reference.

In follow-up to the secret shopper survey findings, MDHHS required **Molina Healthcare of Michigan** to develop a CAP to address the deficiencies identified during the survey. **Molina Healthcare of Michigan** was also expected to extend any training and oversight activities implemented for the CAP to providers not included in the survey sample. MDHHS' CAP requirements are detailed in Appendix A.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the secret shopper activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ICO-specific strengths have not been identified because a large percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICO's provider data files.

Weaknesses and Recommendations

Weakness #1: Approximately 57 percent of sampled provider locations were unable to be reached, did not accept **Molina Healthcare of Michigan**, or did not accept and/or recognize the MI Health Link program.

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **Molina Healthcare of Michigan**'s PCP data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider

records with incorrect or disconnected telephone numbers) to address the provider data deficiencies. Additionally, as MDHHS required **Molina Healthcare of Michigan** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Weakness #2: A limited number of callers were offered appointment dates and times. [**Access**]

Why the weakness exists: Of cases in which the survey respondent reported that the provider location accepted **Molina Healthcare of Michigan**, the MI Health Link program, and new patients, appointment availability was reported for 59.6 percent and 63.6 percent of routine and symptomatic cases, respectively. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. Considerations included members needing to designate the provider as their PCP before scheduling an appointment, being required to complete pre-registration or provide additional personal information to schedule an appointment, and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Molina Healthcare of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

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

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Molina Healthcare of Michigan** about the quality, timeliness, and accessibility of care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Molina Healthcare of Michigan** across all EQR activities to identify common themes within **Molina Healthcare of Michigan** that impacted, or will have the likelihood to impact, member health outcomes.

The overarching aggregated findings show that while **Molina Healthcare of Michigan** generally performed well in some areas impacting the quality and timeliness of, and access to care, the ICO has several opportunities for improvement. **Molina Healthcare of Michigan** met all requirements for data analysis and implementation of improvement strategies and achieved the goal of statistically significant

improvement over the baseline rate for the second remeasurement period for its *Follow-Up After Hospitalization for Mental Illness* QIP. [**Quality**, **Timeliness**, and **Access**]. These results were further supported by the PMV activity as the indicator rates for *Follow-Up After Hospitalization for Mental Illness* increased and exceeded the statewide averages, indicating more members discharged from a hospitalization for mental illness received a timely follow-up visit [**Timeliness** and **Access**]. **Molina Healthcare of Michigan** reported that it has overcome most barriers and will continue to work closely with its PIHP partners; this collaboration should continue to positively impact the *Follow-Up After Hospitalization for Mental Illness* measure.

Molina Healthcare of Michigan demonstrated additional strengths in the behavioral health program area through the PMV activity. Four of the six indicator rates in the Behavioral Health domain exceeded the statewide average, and all six indicator rates increased in performance. All indicator rates for the *Antidepressant Medication Management, Follow-Up After Hospitalization for Mental Illness,* and *Follow-Up After Emergency Department Visit for Mental Illness* measures increased by approximately 5 to 14 percentage points [**Quality**, **Timeliness**, and **Access**].

The combined results of EQR activities presented mixed findings as it relates to access to care. Through the results of the NAV activity, **Molina Healthcare of Michigan** met all Medicaid and LTSS minimum network requirements, indicating an adequate network of providers [**Access**]. The results of the secret shopper activity, however, suggested that members may have experienced barriers to accessing providers, as a high percentage of sampled provider locations were unable to be reached, did not accept **Molina Healthcare of Michigan**, or did not accept and/or recognize the MI Health Link program [**Access**]. When compared to statewide performance, more **Molina Healthcare of Michigan** members are accessing primary healthcare and services as most measure rates within the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, and Access/Availability of Care domains exceeded statewide averages. However, five of the six indicator rates in the Prevention and Screening domain decreased, indicating that fewer members are receiving breast cancer screenings, and fewer older adults are received advance care planning, medication reviews, functional status assessments, and pain assessments. Five indicator rates within the Diabetes domain and four indicator rates within the Access/Availability of Care domain also indicated declines in performance, which showed continued opportunities to improve proper diabetes management and adult access to preventive and ambulatory services.

Molina Healthcare of Michigan's results of the compliance review activity identified several process deficiencies across the service authorization denials, individual practitioner credentialing, organizational credentialing, member grievances, and member appeals program areas [**Quality**, **Timeliness**, and **Access**]. Of particular note, member-facing materials such as service authorization IDNs and member appeal resolution letters were not consistently written in easily understood language or did not include the required content. Adequate written member materials are essential to ensure members are receiving all necessary information to make informed choices regarding their healthcare and services and accessing their appeal and SFH rights. **Molina Healthcare of Michigan** completed a root cause analysis and developed a remediation plan for all deficiencies, which should support more effective member communication and administrative procedures to effectively support the delivery of quality, accessible, and timely services [**Quality**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

Upper Peninsula Health Plan

Validation of Quality Improvement Projects

Performance Results

Table 3-61 displays the overall validation status and the baseline, Remeasurement 1, and Remeasurement 2 results for the QIP study indicator. **Upper Peninsula Health Plan** did not select a plan-specific goal for the study indicator, as this was not a requirement for the QIP. A validation rating of *Not Met* indicates that either (1) all critical elements (elements pivotal to the QIP process) were *Met*, but less than 60 percent of all evaluation elements were *Met* across all activities; or (2) one or more critical elements were *Not Met*.

Table 3-61—Overall Validation Rating for UPP

QIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Follow-Up After Hospitalization for Mental Illness	*Not Met*	Follow-up after hospitalization for mental illness within 30 days.	74.2%	76% ⇔	81.4% ⇔	

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

Table 3-62 displays the interventions implemented to address the barriers identified by the ICO using QI and causal/barrier analysis processes.

Table 3-62—Remeasurement 2 Interventions for UPP

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an

identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan met 100 percent of the requirements for data analysis and implementation of improvement strategies. Additionally, while **Upper Peninsula Health Plan** received an overall validation score of *Not Met*, it exceeded the CMS-established quality withhold benchmark for the *Follow-Up After Hospitalization for Mental Illness* performance measure and was the highest-performing ICO. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Although **Upper Peninsula Health Plan** demonstrated improvement in the study indicator outcomes for the second remeasurement, the goal of significant improvement was not achieved. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Upper Peninsula Health Plan had a relatively small eligible population. A greater increase in the number of members who are numerator compliant must occur to achieve the desired goal.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** revisit its causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The ICO should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

Performance Measure Validation

Performance Results

HSAG evaluated **Upper Peninsula Health Plan**'s data systems for the processing of each type of data used for reporting MDHHS performance measures and identified no concerns with the ICO's eligibility and enrollment data system; medical services data system (e.g., claims and encounters); care coordination system (i.e., tracking and management of care transition record transmissions); medication reconciliation system (i.e., tracking and management of medication reviews); hybrid data collection; and data integration. Although HSAG did not identify any general concerns with **Upper Peninsula Health Plan**'s data integration and measure data reporting processes, HSAG identified reporting errors for Core Measure 9.3, resulting in a required resubmission of the measure.

Upper Peninsula Health Plan received a measure designation of *Reportable (R)* for all measures, signifying that **Upper Peninsula Health Plan** had reported the measures in compliance with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported.

Table 3-63—Measure-Specific Validation Designation for UPP

Performance Measure	Validation Designation
Core Measure 9.1: *Emergency Department (ED) Behavioral Health Services Utilization*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
Core Measure 9.3: *Minimizing Institutional Length of Stay*	**REPORTABLE (R)** The ICO reported this measure in alignment with the MMP Core Reporting Requirements.
MI2.6: *Timely Transmission of Care Transition Record to Health Care Professional*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.
MI5.6: *Care for Adults—Medication Review*	**REPORTABLE (R)** The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements.

Performance Measure Rates

Table 3-64 shows each of **Upper Peninsula Health Plan**'s audited HEDIS measures, rates for HEDIS MY 2018 and HEDIS MY 2020 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2020 with HEDIS MY 2018, and the HEDIS MY 2020 MI Health Link statewide average performance rates. Of note, based on CMS' suspension of all MMP reporting of HEDIS MY 2019 rates due to the COVID-19 PHE, HEDIS MY 2019 rates are not displayed in Table 3-64, as data were not reported for MY 2019. HEDIS MY 2020 measure rates performing better than the statewide average are notated by green font.

Table 3-64—Measure-Specific Percentage Rates for UPP

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening[1]	66.10	66.26	+0.16	56.31
COL—Colorectal Cancer Screening[1]	64.72	64.72	+7.30	56.77
COA—Care for Older Adults—Advance Care Planning	68.61	76.16	+7.55	42.46
COA—Care for Older Adults—Medication Review	90.51	89.78	-0.73	66.63
COA—Care for Older Adults—Functional Status Assessment[1]	87.83	81.27	-6.56	53.52
COA—Care for Older Adults—Pain Assessment	92.70	92.21	-0.49	67.04
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	25.00	31.13	+6.13	24.27

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	66.67	85.00	+18.33	71.84
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	87.72	94.00	+6.28	90.73
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure[2]	—	78.10	—	56.89
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	88.24	100.00	+11.76	89.59
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	82.35	85.27	+2.92	80.63
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	75.89	86.36	+10.47	80.11
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	92.21	91.48	-0.73	84.70
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**[1]	18.98	26.03	+7.05	44.54
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	67.15	63.26	-3.89	47.38
CDC—Comprehensive Diabetes Care—Eye Exam[1]	76.40	68.86	-7.54	55.61
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	93.19	91.48	-1.71	91.69
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg[2]	—	81.51	—	56.67
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	72.24	74.40	+2.16	76.52
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	80.27	86.36	+6.09	81.68
Musculoskeletal Conditions				
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	82.05	73.33	-8.72	71.75
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	11.11	9.09	-2.02	6.97
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	62.22	72.88	+10.66	70.43
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	49.63	61.86	+12.23	55.06

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days[1]	54.84	61.11	+6.27	29.65
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	74.19	81.48	+7.29	57.00
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[1]	24.59	35.85	+11.26	31.68
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[1]	55.74	52.83	-2.91	49.24
Medication Management and Care Coordination				
TRC—Transitions of Care–Notification of Inpatient Admission[2]	—	51.34	—	11.77
TRC—Transitions of Care–Receipt of Discharge Information[2]	—	44.04	—	11.34
TRC—Transitions of Care–Patient Engagement After Inpatient Discharge[2]	—	88.56	—	75.36
TRC—Transitions of Care–Medication Reconciliation Post-Discharge[2]	—	75.67	—	30.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	13.03	19.86	+6.83	21.36
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**[1]	52.71	42.98	-9.73	32.83
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**[2]	—	19.53	—	18.05
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	NA	7.76	—	5.37
*DAE—Use of High-Risk Medications in Older Adults—Total**	NA	24.96	—	21.46
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	91.56	88.58	-2.98	82.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	95.50	94.73	-0.77	92.90
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	94.95	92.80	-2.15	89.79
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	94.54	92.81	-1.73	89.49
IET—Initiation of Alcohol and Other Drug Dependence Treatment[2]	—	18.78	—	37.65
IET—Engagement of Alcohol and Other Drug Dependence Treatment[2]	—	3.05	—	6.59

HEDIS Measure	HEDIS MY 2018 (%)	HEDIS MY 2020 (%)	HEDIS MY 2020 vs. MY 2018	Statewide Average (%)
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[2]	—	1.23	—	1.20
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[2]	—	1.23	—	1.15

* Measures for which lower rates indicate better performance.
Note: Green indicates performance is better than the statewide average.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending in comparison with MY 2018 be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending; therefore, comparisons to MY 2018 rates and benchmarks are not performed for this measure.
NA indicates that data were not available.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan remained involved in a multi-year project for MI2.6. A focus of the project was to increase timely notifications through facility engagement in the Upper Peninsula Health Information Exchange (UPHIE), which involves ADT alerts instead of manual updates. The project also focused on storing continuity of care documents in a Consolidated Clinical Document Architecture (C-CDA) format that were generated at the time of discharge for care management and provider office access. The initial project phases were heavily focused on facility engagement and data accuracy. **Upper Peninsula Health Plan** has 15 in-network hospitals within the Upper Peninsula Region, and all but one are submitting ADTs through the UPHIE portal for timely notifications. The last facility is in development. Seven of the 15 hospital facilities are submitting their continuity of care documents in C-CDA format. The third phase of the project was to connect provider practices to UPHIE in order to have access to both timely ADTs and continuity of care documents in C-CDA format. There are currently 35 in-network clinics, with 13 connected to UPHIE, and with the ability to send and receive continuity of care documents in C-CDA format. Timely notification and transmission of care transition records is crucial for ensuring the continuity of quality patient care. [**Quality** and **Timeliness**]

Strength #2: **Upper Peninsula Health Plan** demonstrated a general strength for MI5.6 reporting. **Upper Peninsula Health Plan** had a high MI5.6 rate in comparison to the other ICOs' reported rates. **Upper Peninsula Health Plan** noted that it has consistently met the benchmark for MI5.6, and as a result, quality interventions have not been necessary. Any best practices that **Upper Peninsula Health Plan** can share among ICOs would be beneficial to ICO overall performance for the measure and quality of care. [**Quality**]

Strength #3: In the Respiratory Conditions domain, **Upper Peninsula Health Plan**'s rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator increased more than 18 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in adult members being dispensed a systemic corticosteroid within 14 days of an acute inpatient discharge for COPD. Appropriate and timely prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD.[3-34] [**Quality**, **Access**, and **Timeliness**]

Strength #4: In the Cardiovascular Conditions domain, **Upper Peninsula Health Plan**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator increased by nearly 12 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in adult members who were hospitalized and discharged with a diagnosis of acute myocardial infarction receiving persistent beta-blocker treatment for six months after discharge. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-35] [**Quality**, **Access**, and **Timeliness**]

Strength #5: In the Cardiovascular Conditions domain, **Upper Peninsula Health Plan**'s rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* measure indicator increased more than 10 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in adults with clinical atherosclerotic cardiovascular disease (ASCVD) receiving and adhering to statin therapy. Statins are a class of drugs that lower blood cholesterol. American College of Cardiology and American Heart Association guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD. Guidelines also state that adherence to statins will aid in ASCVD risk reduction.[3-36] [**Quality** and **Access**]

Strength #6: In the Behavioral Health domain, **Upper Peninsula Health Plan**'s rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators increased more than 10 percentage points from

[3-34] National Committee for Quality Assurance. Pharmacotherapy Management of COPD Exacerbation (PCE). Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-management-of-copd-exacerbation/. Accessed on: Feb 8, 2022.

[3-35] National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/. Accessed on: Feb 8, 2022.

[3-36] National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/. Accessed on: Feb 8, 2022.

MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average, suggesting strength and improvement in members with a diagnosis of major depression receiving continuous medication treatment. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated as well.[3-37] [**Quality** and **Access**]

Strength #7: In the Behavioral Health domain, **Upper Peninsula Health Plan**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measure indicator increased more than 11 percentage points from MY 2018 to MY 2020 and exceeded the HEDIS MY 2020 MI Health Link statewide average; although NCQA cautioned trending for this measure indicator, the results suggest strength and improvement in timely follow-up care with a mental health provider for members with a diagnosis of mental illness following inpatient discharge. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.[3-38] [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: For Core Measure 9.3, **Upper Peninsula Health Plan** reported a member as discharged to the community in data element B (total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission) when the member exhausted the Medicare days benefit, even though the member remained in the institutional facility. [**Quality**]

Why the weakness exists: **Upper Peninsula Health Plan** provided clarification that notification is required by the facility for the Medicaid long-term care nursing facility benefit once a member's Medicare days benefit is exhausted. For this particular case, the facility notified **Upper Peninsula Health Plan** within the appropriate time frame; however, the facility continued to incorrectly bill Medicare skilled nursing facility claims. **Upper Peninsula Health Plan** indicated that in order to identify members as discharged to the community for Core Measure 9.3 data element B, its programming logic captures the absence of paid claims. Since the facility continued to bill Medicare skilled nursing facility claims rather than billing for Medicaid nursing facility benefits once the Medicare days had been exhausted, the claims were denied. Therefore, the programming logic had captured this member for reporting in data element B.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** implement more stringent validation checks prior to data submission. Since Core Measure 9.3 relies on paid claims data, it is critical to have complete claims data for Core Measure 9.3 so that **Upper Peninsula Health Plan** can ensure it is able to appropriately identify members discharged to the community,

3-37 National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: February 4, 2022.

3-38 National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/. Accessed on: February 4, 2022.

further assuring the accuracy of data element B. HSAG further recommends that **Upper Peninsula Health Plan** put quality checks in place to ensure that programming logic used for future data submissions are in alignment with the reporting requirements and that programming logic does not capture members with denied claims in data element B reporting. A thorough validation process with quality checks is crucial for ensuring the quality and accuracy of programming logic and performance measure reporting.

Compliance Review

Performance Results

Table 3-65 presents an overview of the results of the SFY 2021 focused compliance review for **Upper Peninsula Health Plan**, which consisted exclusively of case file reviews in certain program areas, and associated information system reviews. The table identifies all program areas that were reviewed and those that required a CAP due to noncompliance with State and federal requirements.

Table 3-65—Case File Review Overall Findings for UPP

Associated Standard	Description of Files	CAP Not Required	CAP Required
IV	Service Authorization Denials		✓
V	Individual Practitioner Credentialing	✓	
V	Organizational Credentialing	✓	
VII	Member Grievances		✓
VII	Member Appeals		✓
VIII	Subcontractors (delegated entities)		✓

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan consistently adhered to individual practitioner credentialing requirements including, but not limited to, PSV, verification of Medicare and Medicaid sanctions, receipt of disclosure of ownership and control forms, notice to providers, and recredentialing time frames. Adherence to federal and MDHHS individual credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Strength #2: Upper Peninsula Health Plan consistently adhered to organizational credentialing requirements including, but not limited to, demonstrating that providers were in good standing with State and federal regulatory agencies and confirming providers were not excluded from Medicare and Medicaid, obtaining receipt of disclosure of ownership and control interest forms, and adhering to recredentialing time frames. Adherence to federal and MDHHS organizational requirements ensures that ICOs maintain a provider network which provides quality care and services to its membership. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan did not consistently adhere to the Coverage and Authorization of Services requirements under 42 CFR §438.210. Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a denied service in easily understood language and have access to their appeal and SFH rights. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that **Upper Peninsula Health Plan** had not yet implemented the updated 2021 version of the IDN; and IDNs were not consistently written in an easily understood language and format, or at the state-required reading grade level. **Upper Peninsula Health Plan** reported that the clinical services manager—UM did not receive the State model notice and, therefore, was unaware there were updated notices for 2021. Additionally, **Upper Peninsula Health Plan** reported that template language to describe all services in easily understood language had not been developed.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Upper Peninsula Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set coverage and authorization of services standards.

Weakness #2: Upper Peninsula Health Plan did not consistently adhere to the Grievance Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is essential to maintain high-quality care and services and to ensure member retention. [**Quality** and **Timeliness**]

Why the weakness exists: Case files reviewed by HSAG identified that member complaints received by **Upper Peninsula Health Plan**'s dental delegate were not consistently processed as grievances in accordance with **Upper Peninsula Health Plan**'s policy and federal requirements. **Upper Peninsula Health Plan** identified in its CAP that the dental delegate included in its grievance universe instances wherein members expressed dissatisfaction but did not want to initiate a grievance. The ICO indicated the allowance of this process was based on CMS guidance communicated in the 2018 Audit Conference FAQ Document which states a plan should not process member complaints as a grievance if members subsequently state they do not want to file a grievance. The ICO further stated that CMS requires plans, in these instances, to document the call and note that the member did not want to file a grievance. Of note, the 2018 Audit Conference FAQ document referenced within the ICO's root cause analysis is specific to Medicare Advantage Plans. HSAG, with congruence from MDHHS, advised the ICO that the definition under Medicaid

managed care rule for "grievance" indicates a grievance is an expression of dissatisfaction. The expectation is that all expressions of dissatisfaction are reviewed and reported as grievances for tracking and trending, as well as to ensure member concerns are addressed by managed care entities.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Upper Peninsula Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards.

Weakness #3: Upper Peninsula Health Plan did not consistently adhere to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintaining member access to high-quality care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Case files reviewed by HSAG identified that acknowledgement letters were not consistently sent within the required time frame of five calendar days according to **Upper Peninsula Health Plan**'s policy. **Upper Peninsula Health Plan** identified in its CAP that the clinical services manager—UM did not send timely acknowledgments when covering duties for the clinical appeals lead who went out on extended leave.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Upper Peninsula Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

Weakness #4: Upper Peninsula Health Plan did not consistently adhere to the Subcontractual Relationships and Delegation requirements under 42 CFR §438.230 and MDHHS-specific requirements. Robust oversight and monitoring of delegated entities is essential to strengthen program integrity efforts. This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS and/or identifies poor performance which may require remediation. [**Quality**]

Why the weakness exists: Case files reviewed by HSAG identified that delegated entities' contracts did not consistently include language specifying the required reporting responsibilities necessary for ongoing monitoring and oversight. Additionally, a care management delegate had been contracted with **Upper Peninsula Health Plan** since 2015 to perform member assessments; however, the delegate had not been formally audited against applicable federal and State requirements. **Upper Peninsula Health Plan**'s CAP noted that required reporting responsibilities language was included in some delegated entity contracts but not all, which was an oversight. Additionally, **Upper Peninsula Health Plan** reported meeting with its dental delegate quarterly via phone conference; however, **Upper Peninsula Health Plan** did not set up any type of routine reporting requirements for review. Further, **Upper Peninsula Health Plan** confirmed that a program audit had not been scheduled since inception of the contract for one delegate.

Recommendation: In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Upper Peninsula Health Plan** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to delegation standards.

Network Adequacy Validation

Performance Results

Following HSAG's initial NAV results, **Upper Peninsula Health Plan** submitted exception and extension requests to address unmet minimum network requirements in Region 1. MDHHS approved **Upper Peninsula Health Plan**'s requested exceptions for the Adult Day Program, Dental, Hearing Examinations, Hearing Aids, MIHP Agency, and Assistive Technology Van Lifts and Tie Downs provider types.

Table 3-66 presents **Upper Peninsula Health Plan's** region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' Exception and Extension determinations.

Table 3-66—SFY 2021 NAV Results for Upper Peninsula Health Plan, by Region and Provider Type

Provider Type	Region 1 Validation Result
Provider Types with Travel Time and Distance Requirements	
Adult Day Program	Exception Granted
Dental (preventive and restorative)	Exception Granted
Eye Examinations (provided by optometrists)	Met
Eye Wear (providers dispensing eyeglasses and contact lenses)	Met
Hearing Examinations	Exception Granted
Hearing Aids	Exception Granted
MIHP Agency	Exception Granted
Provider Types Rendering Home-Based Services	
Adaptive Medical Equipment and Supplies	Met
Assistive Technology Devices	Met
Assistive Technology Van Lifts and Tie Downs	Exception Granted
Chore Services	Met
Community Transition Services	Met
Environmental Modifications	Met
Expanded Community Living Supports	Met
Fiscal Intermediary	Met
Home-Delivered Meals	Met
Medical Supplies	Met
Non-Emergency Medical Transportation	Met
Non-Medical Transportation (waiver service only)	Met

Provider Type	Region 1 Validation Result
Personal Care Services (non-agency and agency)	Met
Personal Emergency Response System	Met
Preventive Nursing Services (non-agency and agency)	Met
Private Duty Nursing (non-agency and agency)	Met
Respite	Met
Skilled Nursing Home	Met
Percent of Total Provider Types Meeting Minimum Network Requirements	**76%**

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: For all Medicaid and LTSS minimum network requirements for Region 1, **Upper Peninsula Health Plan** either met the minimum network requirements or supplied additional documentation to detail the alternative approaches used to ensure adequate services for MI Health Link members (e.g., community supports and resources). [**Access**]

Weaknesses and Recommendations

Weakness #1: HSAG identified no specific weaknesses for **Upper Peninsula Health Plan** based on the SFY 2021 NAV, as **Upper Peninsula Health Plan** demonstrated that it contracted with all available providers for the provider types that did not meet minimum network requirements and supplied evidence of additional supports (e.g., community supports and resources) to provide adequate care to MI Health Link members in Region 1.

Why the weakness exists: Not applicable.

Recommendation: **Upper Peninsula Health Plan** should maintain an internal data verification process to continually identify and contract with Adult Day Program, Dental, Hearing Examinations, Hearing Aids, MIHP Agency, and Assistive Technology Van Lifts and Tie Downs provider types as they become available in Region 1 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 125 sampled provider locations (i.e., "cases") for **Upper Peninsula Health Plan**, with an overall response rate of 95.2 percent (59 cases) for routine well-check visits and 82.5 percent (52 cases) for nonurgent symptomatic visits within Region 1. The highest response rate was for routine well-checks.

Table 3-67 and Table 3-68 summarize the SFY 2021 secret shopper survey response rates by visit scenario for **Upper Peninsula Health Plan**, and for each of **Upper Peninsula Health Plan**'s contracted MI Health Link regions.

Table 3-67—Summary of UPP Secret Shopper Survey Results for Routine Well-Check Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 1	62	59	56	54	41
UPP Total	**62**	**59**	**56**	**54**	**41**

Table 3-68—Summary of UPP Secret Shopper Survey Results for Nonurgent Symptomatic Visits, by Region

Region	Total Number of Cases	Number of Cases Responding to the Survey	Number of Cases Accepting ICO	Number of Cases Accepting MI Health Link	Number of Cases Accepting New Patients
Region 1	63	52	50	50	48
UPP Total	**63**	**52**	**50**	**50**	**48**

Table 3-69 displays the number of cases in which the survey respondent offered appointments to new patients for routine services and nonurgent symptomatic visits, as well as summary wait time statistics for all ICOs, for **Upper Peninsula Health Plan**, and for **Upper Peninsula Health Plan**'s contracted MI Health Link region. Note that potential appointment dates may have been offered with any practitioner at the sampled location. Of cases in which the survey respondent reported that the provider location accepted **Upper Peninsula Health Plan**, the MI Health Link program, and new patients, appointment availability was reported for 14.6 percent (n=6) and 52.1 percent (n=25) of routine and symptomatic cases, respectively.

Table 3-69—Summary of Secret Shopper Survey Appointment Availability Results for UPP, by Region

Region	Routine Well-Check					Nonurgent Symptomatic Visit				
	Number of Cases Offered an Appointment	Wait Time in Calendar Days				Number of Cases Offered an Appointment	Wait Time in Calendar Days			
		Min	Max	Average	Median		Min	Max	Average	Median
Region 1	6	2	35	11.2	6.5	25	0	23	4.7	2.0
UPP Total	**6**	**2**	**35**	**11.2**	**6.5**	**25**	**0**	**23**	**4.7**	**2.0**

In follow-up to the secret shopper survey findings, MDHHS required **Upper Peninsula Health Plan** to develop a CAP to address the deficiencies identified during the survey. **Upper Peninsula Health Plan** was also expected to extend any training and oversight activities implemented for the CAP to providers not included in the survey sample. MDHHS' CAP requirements are detailed in Appendix A.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the secret shopper activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ICO-specific strengths have not been identified because a moderate percentage of cases could not be contacted or had invalid ICO/MI Health Link information from the ICO's provider data files.

Weaknesses and Recommendations

Weakness #1: Over 16 percent of sampled provider locations were unable to be reached, did not accept **Upper Peninsula Health Plan**, or did not accept and/or recognize the MI Health Link program. [**Quality** and **Access**]

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **Upper Peninsula Health Plan**'s PCP data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program.

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

recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Weakness #2: A limited number of callers were offered appointment dates and times. [**Access**]

Why the weakness exists: Of cases in which the survey respondent reported that the provider location accepted **Upper Peninsula Health Plan**, the MI Health Link program, and new patients, appointment availability was reported for 14.6 percent and 52.1 percent of routine and symptomatic cases, respectively. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. Considerations included members needing to designate the provider as their PCP before scheduling an appointment, being required to complete pre-registration or provide additional personal information to schedule an appointment, and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Upper Peninsula Health Plan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

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

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

To identify strengths and weaknesses and draw conclusions for **Upper Peninsula Health Plan** about the quality, timeliness, and accessibility of care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Upper Peninsula Health Plan** across all EQR activities to identify common themes within **Upper Peninsula Health Plan** that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings show that while **Upper Peninsula Health Plan** generally performed well in some areas impacting the quality and timeliness of, and access to care, the ICO has several opportunities for improvement.

While **Upper Peninsula Health Plan** used appropriate QI tools to conduct a causal/barrier analysis for its *Follow-Up After Hospitalization for Mental Illness* QIP and demonstrated improvement in the study indicator outcomes for the second remeasurement, the goal of significant improvement was not achieved [**Quality**, **Timeliness**, and **Access**]. However, **Upper Peninsula Health Plan**'s indicator rates for the *Follow-Up After Hospitalization for Mental Illness* measures exceeded the statewide average, indicating more members discharged from a hospitalization for mental illness received a timely follow-up visit,

and **Upper Peninsula Health Plan** should continue its interventions implemented through the associated QIP to further support improvement in this performance indicator [**Quality**, **Timeliness**, and **Access**].

Upper Peninsula Health Plan also demonstrated strengths in the behavioral health program area through the PMV activity. Five of six indicator rates in the Behavioral Health domain increased, with all six rates exceeding the statewide average. All indicator rates demonstrated improvement for the *Antidepressant Medication Management*, *Follow-Up After Hospitalization for Mental Illness*, and *Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measures, with all indicators increasing by approximately 6 to 12 percentage points from MY 2018 [**Quality**, **Timeliness**, and **Access**].

The combined results of EQR activities present mixed findings regarding access to care. Through the results of the NAV activity, **Upper Peninsula Health Plan** met all Medicaid and LTSS minimum network requirements or were granted exceptions as **Upper Peninsula Health Plan** contracted with all providers in its region for the specific provider types not meeting minimum network requirements [**Access**]. However, the results of the secret shopper activity suggested that members may have experienced barriers to accessing providers, as some of the sampled provider locations were unable to be reached, did not accept **Upper Peninsula Health Plan**, or did not accept and/or recognize the MI Health Link program [**Access**]. When compared to statewide performance, more **Upper Peninsula Health Plan** members are accessing primary healthcare and services as demonstrated by most indicator rates within the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care domains exceeding statewide averages [**Quality**, **Timeliness**, and **Access**]. However, three of the six indicator rates in the Prevention and Screening domain decreased, indicating that fewer older adults received medication reviews, functional status assessments, and pain assessments [**Quality**, **Timeliness**, and **Access**]. Five indicator rates within the Diabetes domain and four indicator rates within the Access/Availability of care also indicated declines in performance, showing continued opportunities to improve proper diabetes management and adult access to preventive and ambulatory care services [**Quality**, and **Access**].

Upper Peninsula Health Plan's results of the compliance review activity identified several process deficiencies across the service authorization denials, member grievances, member appeals, and subcontractors and delegation program areas [**Quality**, **Timeliness**, and **Access**]. Of particular note, member-facing materials such as service authorization IDNs were not written in easily understood language and member appeal acknowledgement letters were not sent in a timely manner. Adequate written member materials sent in a timely manner are essential to ensure members are receiving all necessary information to make informed choices regarding their healthcare and services and accessing their appeal and SFH rights. **Upper Peninsula Health Plan** completed a root cause analysis and developed a remediation plan for all deficiencies, which should support more effective member communication and administrative procedures to effectively support the delivery of quality, accessible, and timely services [**Quality**].

Of note, the COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent services to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

4. Follow-Up on Prior External Quality Review Recommendations for Integrated Care Organizations

From the findings of each ICO's performance for the SFY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the MI Health Link program. The recommendations provided to each ICO for the EQR activities in the *State Fiscal Year 2020 External Quality Review Technical Report for Integrated Care Organizations* are summarized in Table 4-1 through Table 4-7. The ICO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-7.

Aetna Better Health of Michigan

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

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
HSAG recommended the following: • **Aetna Better Health of Michigan** should continue to identify methods to improve collaborative efforts with the PIHPs. **Aetna Better Health of Michigan** should also revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. **Aetna Better Health of Michigan** should also continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Aetna continues to hold both bi-weekly and monthly collaboration meetings with the PIHPS to discuss member status and care plans. In addition, the PIHPs provide us with weekly reports of inpatient admissions. Quarterly, the PIHPs provide performance updates based on delegated functions such as member satisfaction.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The utilization of the Integrated Care Team meetings with the PIHPs is an effective intervention. By meeting regularly, individual member cases can be discussed with the care coordinator and a collaborative approach to the member's care can be achieved.
c. Identify any barriers to implementing initiatives: • There were no barriers to implementing initiatives.

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects

HSAG's Assessment: HSAG determined that **Aetna Better Health of Michigan** partially addressed the prior year's recommendations. The ICO improved its collaboration efforts with the PIHPs, holding regular meetings and developing an intervention exchanging weekly reports. However, **Aetna Better Health of Michigan** maintained opportunities for improvement related to its causal/barrier analysis and evaluating the effectiveness of each intervention. While appropriate QI tools were initially used to identify and prioritize barriers, the ICO did not revisit its QI process for the remeasurement period or provide the evaluation results for the interventions implemented. HSAG recommends that **Aetna Better Health of Michigan** identify new or revised barriers that have prevented improvement in PIP outcomes and develop new or revised interventions to better address high-priority barriers associated with the lack of improvement. **Aetna Better Health of Michigan** should develop methods to evaluate the effectiveness of each individual intervention and report outcomes of the evaluation analysis. Decisions to continue, revise, or discontinue an intervention must be data driven.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures

HSAG recommended the following:

- Over half of the measures included in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care domains fell below the statewide average. **Aetna Better Health of Michigan** should focus on improving upon the performance for measures included in these domains.
- **Aetna Better Health of Michigan** should conduct a root cause analysis or focused study to determine why some adults 66 years and older are not always having medication review completed. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *COA—Care for Older Adults—Medication Review* measure indicator.

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

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

- In 2021, we focused on the Behavioral Health subset of measures to incorporate efforts for improvement for performance measures that fell below the statewide average. Based on the recommendation the following interventions were added:
  - Evaluation of behavioral health coordination with the PCP to the annual medical record review audit. Our Case Management Team is continuing to address behavioral health gaps in care. Organized a behavioral health workgroup to brainstorm how to improve follow up care for hospitalization for mental illness within 7 and 30 days. Educating our providers regarding the depression and follow up care after hospitalization for a mental illness practice guideline via the newsletter and provider relations site visits. Also, educating members regarding the depression and follow up care after hospitalization for a mental illness and services available via the member newsletter.
- Our Case Management team continues to education and support to our senior population of members to improve medication adherence. This includes medication reconciliation and reminders of the importance to adhere to care management plans.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We are still monitoring the results for the interventions. Data for 2021 will be reviewed when HEDIS measures are available.
c. Identify any barriers to implementing initiatives: • Barriers related to the physical medicine provider, the behavioral health provider, the member, and the health plan. Including limited access to information due to the health plan outpatient visit limitation. BH [behavioral health] prescription drugs are carved out to the MDHHS and difficult to impact members with behavioral health issues.
HSAG's Assessment: HSAG determined that **Aetna Better Health of Michigan** partially addressed the prior year's recommendations. **Aetna Better Health of Michigan** has put forth effort to improve performance for measures in the Behavioral Health and Prevention and Screening domains. In 2021, **Aetna Better Health of Michigan** implemented interventions (i.e., organizing a behavioral health workgroup, educating providers and members, and evaluating behavioral health coordination during its annual MRR audit) for the behavioral health measures that fell below the statewide average for HEDIS MY 2018. **Aetna Better Health of Michigan** also worked toward improving performance for the *COA—Care for Older Adults—Medication Review* measure indicator in the Prevention and Screening domain by working with its senior population to improve medication management and adherence to care plans through providing education and support. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *COA—Care for Older Adults—Medication Review* measure indicator, as the rate decreased by nearly 13 percentage points from MY 2018 to MY 2020. As such, HSAG recommends that **Aetna Better Health of Michigan** continue to monitor the impact of the interventions on the applicable measures within the Behavioral Health and Prevention and Screening domains to ensure improved performance. Additionally, **Aetna Better Health of Michigan** should continue to monitor and focus its efforts on improving measures in the Medication Management and Care Coordination, Respiratory Conditions, Cardiovascular Conditions, and Access/Availability of Care domains that fell below the statewide average for MY 2018 and continue to fall below the statewide average for MY 2020. This should include timely application of interventions when performance continues to be low.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Aetna Better Health of Michigan** should prioritize the remediation of the remaining two deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **Aetna Better Health of Michigan** should focus on the inclusion of a provider-specific quality data review during the recredentialing process and verify that its care management auditing process of non-waiver Integrated Individualized Care and Supports Plans (IICSPs) includes an evaluation of member outreach to confirm contacts are made in accordance with time frames required by contract.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• The remediation of the two deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS was completed. • Aetna implemented a daily operational dashboard that includes initial IICSP completions coming due/completed, as well as ongoing IICSP reviews needed based on a member's risk stratification level. Care plan dates are captured and monitored in the dashboard. There is a field for 'Care Plan Last Updated' and 'Visit Due Date' that care management staff and leadership utilize to ensure that care plans are updated and member outreach for care plan review is completed as required. • Aetna's recredentialing process includes review of information from the following sources: National Practitioner Data Bank (NPDB), member complaints, enrollee grievances, results of quality reviews, performance indicators, utilization management (UM), critical incidents, and re-verifications of hospital privileges and current licensure.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Dashboard monitoring continues daily to ensure care plans are updated as required. The recredentialing process continues to include review of data and information from various sources for consideration in the recredentialing decision.
c. Identify any barriers to implementing initiatives: • There were no barriers to implementing initiatives.
HSAG's Assessment: HSAG determined that **Aetna Better Health of Michigan** addressed the prior year's recommendations. **Aetna Better Health of Michigan**'s implementation of its initiatives will be reviewed for compliance during future compliance review activities.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Aetna Better Health of Michigan** should use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Aetna shared the case-level analytic data files containing provider deficiencies identified during the survey with our dental vendor. Our dental vendor implemented various corrective actions, such as provider training, outreach, virtual visits, network monitoring, to address the provider data deficiencies. Aetna meets regularly with our dental vendor to discuss ongoing actions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance improvement measurements are still in development and have not yet been applied to evaluate impact of implemented actions.
c. Identify any barriers to implementing initiatives: • There were no barriers to implementing actions.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG's Assessment: HSAG determined that **Aetna Better Health of Michigan** addressed the prior year's recommendations. However, **Aetna Better Health of Michigan** continues to exhibit a large percentage of sampled provider locations, other than dental providers, that could not be reached, did not accept **Aetna Better Health of Michigan**, and/or did not recognize the MI Health Link program. As such, HSAG recommends that **Aetna Better Health of Michigan** develop and implement performance improvement metrics for all provider types, regularly evaluate the impact of these efforts, make adjustments where necessary to improve the accuracy of the provider data, and ensure that provider locations are providing accurate information to members.

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
HSAG recommended the following: • None.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG's Assessment: HSAG did not identify any weaknesses and therefore did not make any recommendations to **Aetna Better Health of Michigan** for the CAHPS activity.

AmeriHealth Caritas

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

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
HSAG recommended the following: • As **AmeriHealth Caritas** progresses to the second remeasurement, the ICO should implement interventions that have the greatest impact to the study indicator outcomes. The ICO should also reassess the identified barriers to determine if new barriers exist requiring the development of interventions.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The following interventions implemented in 2019 continued throughout 2020: – Established a process to provide timely notification to care coordinators of behavioral health inpatient care and set the expectation that members are included in the transition of care (TOC) process. – Created and implemented a process to improve notification and acknowledgement of information from the PIHPs. Additional interventions: • March 2020: Member and provider education completed by AMI and PIHPs specific to telehealth options to complete the follow up visit, due to limitations on and member hesitancy to complete in person visits due to the COVID-19 Public Health Emergency (PHE). • September 2020: Completed review and validation of 2020 weekly hospitalization reports received from the PIHPs to recognize differences in the data provided, identify data needed, develop standardized report format, and improved weekly submission process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Specific to interventions #1 and #2 above: – Re-evaluation results in June 2020 for the period March-May 2020 and again in September 2020 for the period June-August 2020 identified an increase in the rate of compliance for both measures. Current processes were continued. – Re-evaluation results in December 2020 for the period September-November 2020 identified a decrease in the effectiveness of each intervention. Further analysis identified a gap in consistent adherence to the process steps, resulting from disruption in individual workflows due to process changes and resource constraints (open Care Coordinator FTEs [full-time equivalents]). Revisions to existing process steps were not completed timely to reflect the workflow changes necessary to ensure consistent notification to the Care Coordinators and account for limited AMI Care Coordinator resources (open Care Coordinator FTEs).

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
• Specific to intervention #3 above: – Members voiced reluctance to use telehealth, citing lack of familiarity with the technology and concerns regarding confidentiality, especially if via phone call only and member unable to see and verify whom they were talking to. Based on claims review, it was determined 17% of members identified in the FUH [Follow-up After Hospitalization for Mental Illness] measure numerator were compliant because of a telehealth visit. • Specific to intervention #4 above: – The Information Systems teams from AMI and the PIHPs collaborated to implement standardized report format and change from submission of report via secure email to individual AMI team members to upload of reports to shared folder via SFTP [secure file transfer protocol]. Both PIHPs were in compliance with new process as of December 2020.
c. Identify any barriers to implementing initiatives: • Lack of ability to complete timely in-person follow up visit due to restrictions on and member hesitancy to complete in-person care resulting from COVID-19 PHE. – Telehealth visits encouraged. • Lack of member engagement with telehealth due to members' reluctance to use the technology citing lack of familiarity with it and concerns regarding confidentiality, especially if via phone call only and member unable to see and verify whom they were talking with. – Ongoing member education; AMI contracted with specific telehealth provider in 2021. • Lack of formalized structure (e.g., regular meetings) between PIHP care team members and AMI Care Coordinators to provide opportunity for timely communication and collaboration specific to members with care transitions. – Regular meetings scheduled and occurring in 2021. • Limited Care Coordinator resources due to open FTEs. – All open positions filled as of April 2021.
HSAG's Assessment: HSAG determined that **AmeriHealth Caritas** addressed the prior year's recommendations. The ICO used appropriate QI methods to identify and prioritize its barriers to care and developed interventions to address those barriers. The ICO continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • Over half of the measures included in the Prevention and Screening, Respiratory Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization domains fell below the statewide average. **AmeriHealth Caritas** should focus on improving upon the performance for measures included in these domains. • **AmeriHealth Caritas** should conduct a root cause analysis or focused study to determine why some adults 40 years of age and older are not always receiving spirometry testing. Upon identification of a root cause, **AmeriHealth Caritas** should implement appropriate interventions to improve the performance related to the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)* measure indicator.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
• **AmeriHealth Caritas** should conduct a root cause analysis or focused study to determine why some adults 40 years of age and older are not always receiving appropriate medication therapy following COPD exacerbations. Upon identification of a root cause, **AmeriHealth Caritas** should implement appropriate interventions to improve the performance related to the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • AMI response for the SPR – Use of Spirometry Testing in the Assessment and Diagnosis of COPD: – Rate for HEDIS2018 (data from measurement year 2017), was based on denominator of 4 and numerator of 2. o Eligible population limited by continuous enrollment requirements. – Rate for HEDIS2019 (data from measurement year 2018), was based on denominator of 62 and numerator of 16. • The significant increase in the denominator between HEDIS2018 and HEDIS2019 was due to a specification change for the exclusion of identifying ED/observation visits that result in an inpatient stay resulting in less exclusions for the measure. For HEDIS2018 there were 91 events identified for this exclusion, and for HEDIS2019 this decreased to 44 events. • AMI Response for PCE – Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid: HEDIS2018 (data from MY2017): – Rate based on denominator of 96 and numerator of 76. o Enhanced NDC [National Drug Code] mapping (121 less NDC codes) for HEDIS2018 decreased numerator. – HEDIS2019 (data from MY2018): – Rate based on denominator of 103 and numerator of 61. o Logic was implemented to more accurately de-duplicate pharmacy claims which resulted in decreased performance for measures such as this with adherence components calculating treatment periods days' supply. • AMI selected the following measures to focus on in CY2020: – Breast and colorectal cancer screenings (BCS and COL) – Care of older adults (COA) – Comprehensive diabetes care (CDC) – Follow up after hospitalization for mental illness (FUH) – Medication reconciliation post-discharge (MRP) – Plan all-cause readmission (PCR) • BCS, CDC, COL – Expanded member and provider outreach and education, including monthly identification and reports to PCPs of care gaps and reminders of need for care gap closure. – Specific to COL, continued to offer FitKit option.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
– Pursuing contract with vendor to provide in-home testing options for CDC measures and increase support of FitKit program. • COA and MRP – Established non-standard supplemental data process (HEDIS auditor-approved) for completion and reporting of this data. Specifically, AMI Care Coordinators completed COA assessments (except for medication review) and MRP, faxed to PCP to include in member's medical record, and submitted internally for HEDIS data abstraction. • FUH – Refer to Validation of Quality Improvement Project. • PCR – Revised Transition of Care (TOC) program to improve use of information received from daily ADT report. – Enhanced follow-up/outreach to members with ED visits to encourage and assist with PCP follow-up. – Increased monitoring of members with frequent admissions, including daily TOC meetings. – Implementation of a corporate-wide TOC Workgroup.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • BCS: Rate improved 3.4%. • CDC: – Eye exam: Rate decreased 8.8% – HgbA1c testing: Rate decreased 5.1% – HgbA1c control: Rate increased 9.5% – Attention for nephrology: Rate increased 1.2% • COL: Rate improved 13.6%. • COA: – Advance care planning: Rate increased 2.9% – Functional status assessment: Rate increased 12.9% – Medication review: Rate decreased 3.2%. – Pain assessment: Rate increased 17.5 % • FUH: Rate increased 4%. • MRP: Rate increased 33.4%. • PCR: O/E ratio increased from 0.77 to 1.4.
c. Identify any barriers to implementing initiatives: • Lack of more significant improvement, especially for claims-only measures, is attributed to the COVID-19 PHE. Specifically, in-person, routine medical care was restricted March – May 2020 per Governor's executive order. Members continued to be hesitant to seek in-person care throughout the remainder of 2020. – Administrative numerator hits were at normal volume for January - March 2020, then slowed down starting in April 2020 and continued to be low through December 2020.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
– In addition, specific to CDC eye exam, there was an increase in the LIS [low-income status]/DE [dual Medicare and Medicaid eligible] denominator due to updated method of using the LIS history file to identify LIS members. • Lack of member engagement with telehealth due to members' reluctance to use the technology citing lack of familiarity with it and concerns regarding confidentiality, especially if via phone call only and member unable to see and verify whom they were talking to. – Ongoing member education; AMI contracted with specific telehealth provider in 2021. • Increase in O/E [observed to expected] ratio for PCR measure due in part to the HEDIS specification change that requires admission following observation stay to be counted as a readmission for this measure, in addition to members requiring repeat hospitalization due to a coronavirus diagnosis or complications. – Increased focus on identification and review of members with readmissions, implementation of transition of care workgroup.
HSAG's Assessment: HSAG determined that **AmeriHealth Caritas** partially addressed the prior year's recommendations. **AmeriHealth Caritas** has put forth effort to improve performance for measures in the Prevention and Screening, Diabetes, Behavioral Health, Medication Management and Care Coordination, and Risk-Adjusted Utilization domains. For measures within the Prevention and Screening and Diabetes domains, **AmeriHealth Caritas** worked toward care gap closure through expanding provider outreach and education and provided in-home testing options. A nonstandard supplemental data process was established for measures within the Prevention and Screening and Medication Management and Care Coordination domains. For the Risk-Adjusted Utilization domain, **AmeriHealth Caritas** revised its transition of care (TOC) program to improve use of information received, enhanced follow-up and outreach to members following ED visits, implemented a TOC workgroup, and increased monitoring of members with frequent admissions. However, over half of the measures in the Prevention and Screening, Behavioral Health, Medication Management and Care Coordination, and Risk-Adjusted Utilization domains remain below the statewide average for MY 2020. As such, **AmeriHealth Caritas** should continue to monitor and focus its efforts on improving measures in these domains as well as measures in the Access/Availability of Care domain that fell below the statewide average for MY 2018 and continue to fall below the statewide average for MY 2020. This should include timely application of interventions when performance continues to be low. Due to the increased O/E ratio that was noted for the *Plan All-Cause Readmissions (PCR)* measure, HSAG recommends that **AmeriHealth Caritas** continue to monitor the O/E ratio for *PCR* and the impact of the TOC workgroup that was implemented. A proactive, timely approach should be taken to prevent readmissions and increase coordination of care after discharge if the O/E ratio continues to increase. **AmeriHealth Caritas** demonstrated improved performance for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator, as its rate increased more than 6 percentage points from MY 2018 to MY 2020. Appropriate and timely prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD.[4-1]

[4-1] National Committee for Quality Assurance. Pharmacotherapy Management of COPD Exacerbation (PCE). Available at: https://www.ncqa.org/hedis/measures/pharmacotherapy-management-of-copd-exacerbation/. Accessed on: Feb 8, 2022.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
AmeriHealth Caritas continues to demonstrate low performance for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)* measure indicator, as the rate decreased by nearly 2 percentage points from MY 2018 to MY 2020. As such, HSAG recommends that **AmeriHealth Caritas** continue to perform spirometry testing for its adult members 40 years of age and older to confirm a COPD diagnosis to improve performance and help lower the negative impact of respiratory conditions, such as COPD, for its members. Earlier diagnosis using spirometry testing supports a treatment plan that may protect against worsening symptoms and decrease the number of exacerbations.[4-2] Additionally, although specification changes and programming logic updates were noted for measures within the Respiratory Conditions domain that led to a decrease in performance, HSAG recommends that **AmeriHealth Caritas** continue to focus its efforts on implementing interventions to improve overall performance for measures within the Respiratory Conditions domain.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **AmeriHealth Caritas** should prioritize the remediation of the remaining four deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **AmeriHealth Caritas** should focus on the development of a report to track staff compliance with member contact requirements and take action as necessary to improve individual staff performance; proceed with its plan to automate ABDs for the denial of payment and ensure that the notices are sent at the time of the action affecting the claims (i.e., when payment is denied); include a review, and subsequently document the review, of provider-specific quality indicators (e.g., appeal data, quality review results, UM information, and member satisfaction surveys) when determining providers' recredentialing status; and update relevant process and procedure documentation to ensure that appeals are resolved as expeditiously as the member's health condition requires and no later than the date the time frame extension expires (44 days).
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Item 1:** Compliance Review Standard III – Coordination and Continuity of Care: "on the development of a report to track staff compliance with member contact requirements and take action as necessary to improve individual staff performance" – The Plan developed a report to track contact with members by risk level to track staff compliance with member contract requirements. The report was implemented March 2021. Manual process in 4Q 2020 of identifying risk touch was challenging and accuracy was questionable. • **Item 2:** Compliance Review Standard IV – Coverage and Authorization of Services: "plan to automate adverse benefit determinations for the denial of payment and ensure that the notices are sent at the time of the action affecting the claims (i.e., when payment is denied)"

[4-2] National Committee for Quality Assurance. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR). Available at: https://www.ncqa.org/hedis/measures/use-of-spirometry-testing-in-the-assessment-and-diagnosis-of-copd/. Accessed on: Feb 17, 2022.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
– A business requirement document (BRD) was finalized by the Plan on 11/23/20, and the Plan's automated process to issue adverse benefit determinations for payment denials was implemented on 1/6/21. • **Item 3:** Compliance Review Standard V – Provider Selection: include a review, and subsequently document the review, of provider-specific quality indicators (e.g., appeal data, quality review results, utilization management [UM] information, and member satisfaction surveys) when determining providers' recredentialing status – The Plan's process includes a report of quality of care and quality of service items during each monthly Credentialing Committee. The Plan continues to work to implement this recommendation. • **Item 4:** Compliance Review Standard 7 – Grievance and Appeal Systems: "update relevant process and procedure documentation to ensure that appeals are resolved as expeditiously as the member's health condition requires and no later than the date the time frame extension expires (44 days)." – Policy AG 501.100 (Medical Services Internal Appeals Process- Standard and Expedited), as identified in the policy revision history, was revised on 11/8/19 to incorporate a "policy update from CAP." The policy notes that appeals must be resolved as expeditiously as the member's health condition requires when discussing expedited appeals in section 3(g)(i) on page three and standard appeals in section (3)(g)(iii) on page four. The requirements regarding a 14 days extension are covered in section (3)(g)(v) on page four.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Item 1:** The Plan encountered reporting issues given that this report was new, which is reflected by the March 2021 implementation date. Additionally, the Plan identified that [# here] additional hires were needed to adequately work the new report. There were (2) staff vacancies. Vacancies were filled in March 2021. • **Item 2:** Sample letters to validate a successful implementation of the new process were reviewed on 1/6/21 by the following Medicare departments: Compliance, Provider Relations, Customer Service, Administration, and Data Integrity. • **Item 3:** Not applicable. • **Item 4:** Not applicable.
c. Identify any barriers to implementing initiatives: • **Item 1:** The Plan encountered reporting issues given the new report, which is reflected by the March 2021 implementation date. • **Item 2:** Not applicable. • **Item 3:** The previous work plan to address the data to be reviewed at the time of recredentialing was not executed due to changes in Medicare Compliance leadership. • **Item 4:** Not applicable.
HSAG's Assessment: HSAG determined that **AmeriHealth Caritas** partially addressed the prior year's recommendations. The SFY 2021 Compliance Review activity identified continued deficiencies related to a review of individual provider performance data upon recredentialing and appeal resolution time frames. **AmeriHealth Caritas** developed and submitted a CAP which was approved by MDHHS/HSAG; therefore, HSAG recommends that **AmeriHealth Caritas** fully implement its CAP and the additional recommendations made by HSAG.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **AmeriHealth Caritas** should use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The Plan acknowledges that HSAG offered no ICO-specific recommendations for improvement based on the SFY 2020 NAV evaluation. • Based on HSAG and MDHHS feedback, the Plan devised and launched its own monthly Dental Shopper Survey with the first survey completed in September 2021. Any findings identified by the Plan are reviewed internally and discussed with Plan's dental delegate, Skygen, to ensure all provider data discrepancies are corrected.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • September 2021 Plan Dental Survey: Three out of 10 survey calls deemed non-compliant requiring provider data corrections. • October 2021 Plan Dental Survey: Two out of 10 survey calls deemed non-compliant requiring provider data corrections.
c. Identify any barriers to implementing initiatives: • There are no barriers to identify at this time given the successful implementation of the Plan Dental Provider Survey.
HSAG's Assessment: HSAG determined that **AmeriHealth Caritas** addressed the prior year's recommendations. However, **AmeriHealth Caritas** continues to exhibit a large percentage of sampled provider locations, other than dental providers, that could not be reached, did not accept **AmeriHealth Caritas**, and/or did not recognize the MI Health Link program. As such, HSAG recommends that **AmeriHealth Caritas** develop and implement performance improvement metrics for all provider types, regularly evaluate the impact of these efforts, make adjustments where necessary to improve the accuracy of the provider data, and ensure that provider locations are providing accurate information to members.

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
HSAG recommended the following: • None.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG's Assessment: HSAG did not identify any weaknesses and therefore did not make any recommendations to **AmeriHealth Caritas** for the CAHPS activity.

HAP Empowered

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

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
HSAG recommended the following: • As **HAP Empowered** progresses to the second remeasurement, the ICO should implement interventions that have the greatest impact to the study indicator outcomes. **HAP Empowered** should also reassess the identified barriers to determine if new barriers exist requiring the development of interventions.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • HAP Empowered continued working with a quality improvement workgroup that was established in 2017 consisting of representatives from the Quality Management, Performance Improvement/HEDIS, Outreach, and Care Management departments. This workgroup meets bimonthly to discuss ongoing barriers, interventions, and strategies to improve metrics and increase members' health outcomes. To identify initial barriers, the workgroup created and used a fishbone diagram (attached) as a QI tool. This helped to document barriers and initiate discussions for improvement. The workgroup completed the following activities throughout 2020-early 2021: – Reviewed HEDIS performance data – Identified key drivers and areas in need of improvement utilizing the initial fishbone diagram – Identified evidence-based interventions/change concepts to implement – Developed action and work plans – Monitored intervention performance and outcomes – Revised or discontinued interventions when necessary Interventions implemented below: • **PIHP Collaboration:** – HAP Empowered continues to reach out to the PIHPs to schedule ongoing care coordination and planning meetings. – In Measurement Year (MY) 2020, this activity was focused on developing more dedicated discussions about members who had a BH hospitalization. – HAP Empowered continues to validate the information received from the PIHPs regarding BH hospitalizations. • **Care Coordination Follow up** – HAP Empowered created a template for hospitalization follow-up information to increase data consistency. – HAP Empowered developed and distributed a Desk Level Procedure (DLP) during Q2 2020 to standardize the way care coordinators follow up with members who had a BH hospitalization.

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
– Quality Management monitors adherence to the DLP and modification and training is provided as needed.

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

- HAP Empowered analyzes HEDIS results to measure the effectiveness of interventions and to identify additional opportunities for improvement. The data used to support the project comes from the HEDIS software that includes claims and encounter data.
- HAP Empowered uses HEDIS results for scoring purposes and utilizes HEDIS methodology for determining the population denominators for its initiatives.
- HEDIS rates are compared to established benchmarks on an annual basis. HAP Empowered reviews and evaluates annual rates in comparison to NCQA benchmarks, as well as the performance of other health plans to determine HAP Empowered MI Health Link's ranking against peers. Intervention success is evaluated by improvement in annual rates, as well as feedback from providers, members, and internal staff. Interventions not deemed to be effective are terminated. HAP Empowered MI Health Link continues to develop and implement additional interventions as needed.
- The HEDIS Measurement Year (MY) 2020 (HEDIS 2021) FUH population was 61 members. From that total, 23 members, or 37.7%, had a follow-up visit with a mental health provider within 30 days of discharge. This did not meet the benchmark of the Quality Withhold measure, which was 56%. The goal for Remeasurement Year 3 will be to obtain statistically significant improvement. To determine statistical significance, HAP Empowered utilized the Fisher's exact test, with a two tailed P value. The P value was found to be 0.0636, which was determined to be not quite statistically significant.

Care Coordination Follow Up

HEDIS Year	Total HEDIS Denominator	Number of members had a follow up visit	FUH Rate	Number of members received follow up outreach call	Number of members who had an outreach call *and* a follow up visit
HEDIS 2019	80	43	53.8%	N/A	N/A
HEDIS 2020	68	26	38.2%	7	4
HEDIS 2021 (MY 2020)	61	23	37.7%	19	5

- Care Coordination interventions along with the PIHP files were analyzed to show which members were scheduled for a follow-up visit and of those, which members kept their appointments. For CY 2020 (HEDIS 2021), there were 61 admissions--23 admissions, or 38%, had a follow-up visit. Of the total denominator, 19, or 31%, had an outreach call from a care coordinator. Of those members, five members (26%) had both an outreach call and a follow up visit.

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects

PIHP Data Files

HEDIS Year	Total HEDIS Denominator	Received member on weekly PIHP file	# of members *scheduled* for a follow up visit	# of members that *completed* a follow up visit
HEDIS 2019	80	70	24	14
HEDIS 2020	68	63	20	6
HEDIS 2021 (MY 2020)	61	52	44	6*

*There were six members in which it was not known if their follow-up visit was completed per the PIHP weekly reports.

- For CY 2020 (HEDIS 2021), there were 61 admissions. 52 admissions, or 85%, that were received on the PIHP file. Out of the members who were received on the PIHP file, 44 members, or 85%, were scheduled for a follow-up visit, and of those scheduled, 6 members, or 14%, completed a follow-up visit per the PIHP weekly reports. In review of the PIHP weekly reports, the follow-up visit field was not consistently completed and often was blank or in unknown status. When analyzing the HEDIS data, of the 44 members scheduled for a follow-up visit, 17 (39%) were numerator compliant. Historical information will be compared to CY 2021 information and interventions will be adjusted according to trends in data.

c. Identify any barriers to implementing initiatives:

- Below are the current barriers:
  - Member Level:
    - Incorrect contact information; unable to reach members
    - Members do not recognize need/importance for follow-up visit
  - Care Coordination:
    - Incorrect contact information; unable to reach members
    - Manual process for tracking and following up with members identified on the weekly PIHP reports

HSAG's Assessment: HSAG determined that **HAP Empowered** addressed the prior year's recommendations. The ICO used appropriate QI methods to identify and prioritize its barriers to care and developed intervention efforts to address those barriers. The ICO continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures

HSAG recommended the following:

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

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
• Over half of the measures included in the Prevention and Screening, Cardiovascular Conditions, Diabetes, Behavioral Health, and Access/Availability of Care domains fell below the statewide average. **HAP Empowered** should focus on improving upon the performance for measures included in these domains.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*

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

MI 2.3

- In Q3 2020, HAP Empowered implemented a new care plan format for MMP members within the existing care management platform, CareRadius. One component of the new care plan is a mandatory section which includes a field where the care coordinator is required to document: a) a documented discussion occurred with member regarding their care goals; and b) that the member and/or guardian verbally attested that they agree to their current care goals. This is completed for every member upon initial care plan implementation, each care plan review, and annual care plan review. Additionally, upon initial care plan implementation, annual care plan review and any other significant updates to the care plan, a copy of the care plan is mailed to the member with a signature page and return envelope. Every member is encouraged by their care coordinator to return a signed copy indicating they agree with their care goals.
- Beginning Q3 2020 the methodology for tracking MI 2.3 incorporated using the new care plan fields for validation. When the member returns the signed care plan, that is used for validation as well. Below is an example from the MMP care plan of the required documentation for every MMP initial care plan, annual care plan, and care plan review.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
Prevention & Screening Preventions Improvement • HAP Empowered MI Health Link continues Quality Measure monthly workgroup meetings with efforts focused on the following: • Ongoing prospective monitoring of monthly reporting • Working closely with Pharmacy to implement comprehensive strategies to improve performance outcomes for Pharmacy related HEDIS measures (i.e. AMM, CBP, DM, TRC, COA). The following are examples of the activities employed to improve rates. – CBP – Controlling Blood Pressure o Modified supplemental data HEDIS extracts to include blood pressure readings from At-home and Telehealth visits o Investigating initiative to enhance provider portal for targeted provider use of HEDIS gaps in care – COA – Care for older Adults o Implemented a MMP Member Rewards program in 2021 (Annual Medication Review, HbA1c, and breast cancer screening) o Ongoing pharmacy outreach support to close targeted MMP Medication Review gaps – AMM – Anti-Depressant Medication Management o Developed weekly HEDIS-like reports to improve timeliness of pharmacy member outreach **FUH 30 days** • Standardized the Desk Level Procedure for Care Management targeted member outreach to improve FUH performance outcomes • Quality Management monitors adherence to the DLP and modification and training is provided to care coordinators as needed. • Enhanced Care Management collaboration efforts with PIHPs with monthly meetings, including case conferences. • Developed a standardized FUH reporting template to track and monitor outcomes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **MI 2.3** • Monthly audits of 30 unique MMP member care plans monitor member verbal attestation of agreement with care goals. • Care managers are consistently entering narrative documentation within the required care plan text boxes to indicate that a member has verbally agreed to their care goals • Overall audit score on monthly audits Oct 2020 through May 2021 has been 95% or higher • 100% of records are validated prior to submitting reporting for MI 2.3 to ensure we have a verbal attestation. **Prevention & Screening Preventions Improvement** • HAP Empowered MI Health Link conducts monthly Quality Measure workgroups to continue collaboration efforts and devise comprehensive strategies to target ongoing barriers and interventions to improve measure outcomes. Targeted HEDIS measures are included in these focused workgroups. Workgroup activities consist of the following: – Reviewing performance data

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
– Identifying key drivers and areas of improvement – Identifying evidence-based interventions/change concepts to implement – Developing action and work plan – Monitoring intervention performance and outcomes – Revise, enhance and/or discontinue interventions as deemed appropriate
c. Identify any barriers to implementing initiatives: **MI 2.3** • Despite providing a simple signature page with each mailed care plan, along with basic instructions to return the signed care plan and inclusion of a pre-paid return envelope, the overall percentage of members returning care plans with a physical signature remains small. **Prevention & Screening Preventions Improvement** • The COVID-19 pandemic has been a barrier to initiatives. Several provider offices closed for many months in 2020 limiting members' access to services and may have an impact on measurement year 2020 performance outcomes. • Barriers also include social determinants of health: Food insecurity - Additional targeted member outreach was initiated in December 2020 and continued in 2021 to address food insecurity. This outreach was gathered by using US Census data to identify zip codes where there is food insecurity, and then bumping those zip codes against HAP Empowered's membership. • Health disparities – HAP Empowered continues collaborative efforts with the Henry Ford Health System (HFHS) Workstream Group focused on improving SDoH and Health Equity by providing data and racial/ethnicity information presentations. • Additional barriers include inaccurate member contact information, ineffective outreach from physicians and the Plan, members having transportation issues, member/provider knowledge regarding incentives, vaccine hesitancy and the importance of preventive screening and/or the existence of transportation assistance.
HSAG's Assessment: HSAG determined that **HAP Empowered** partially addressed the prior year's recommendations. **HAP Empowered** has put forth effort to improve performance for measures in the Prevention and Screening, Cardiovascular Conditions, Diabetes, Behavioral Health, and Access/Availability to Care domains. For the *CBP—Controlling High Blood Pressure* measure indicator within the Cardiovascular Conditions domain, **HAP Empowered** modified its supplemental data HEDIS extracts to include at-home and telehealth visits and is looking into an initiative for enhancing its provider portal. For the Prevention and Screening domain, **HAP Empowered** implemented an MMP member rewards program in 2021 and continued to conduct pharmacy outreach to help close medication review gaps to improve performance for the *COA—Care for Older Adults* measure indicators. For the Behavioral Health domain, **HAP Empowered** developed reports to improve timely pharmacy member outreach to improve performance for the *AMM—Antidepressant Medication Management* measure indicators. Additionally, to improve performance for the *FUH—Follow-Up After Hospitalization for Mental Illness* measure indicators, **HAP Empowered** standardized its desk-level procedure for targeted member outreach, educated care coordinators as needed, collaborated with PIHPs during monthly meetings, and developed a standardized reporting template. **HAP Empowered** demonstrated improvement from MY 2018 for measures within the Prevention and Screening, Cardiovascular Conditions, and Access/Availability of Care domains, as over half of the measures no longer fell below the statewide average for MY 2020. However, HSAG recommends that **HAP Empowered**

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
continue to monitor and focus its efforts on improving measures in the Diabetes and Behavioral Health domains, as over half of the measures in these domains continue to fall below the statewide average for MY 2020. This should include timely application of interventions when performance continues to be low. As it relates to MI2.3, **HAP Empowered** implemented a new care plan format in third quarter 2020 within its existing platform, CareRadius, that requires documented discussion with members regarding their care goals and that the member verbally attested and agreed to the care plan goals. In addition, **HAP Empowered** incorporated additional validation checks and conducted monthly care plan audits to further ensure the accuracy of its reported data for MI2.3. Although MI2.3 was not included as a measure within the scope of HSAG's PMV audit for 2021, HSAG recommends that **HAP Empowered** continue to evaluate the effectiveness of the updated care plan format through validation and audit efforts to ensure verbal proxy or physical signatures are captured for all IICSPs that are included in future MI2.3 reporting.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **HAP Empowered** should prioritize the remediation of the remaining six deficiencies in the Grievance and Appeal Systems standard identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. Specifically, **HAP Empowered** should focus process and document revisions, and training efforts on the following: – When a provider requests an appeal, files a grievance, or requests a SFH on behalf of a member, **HAP Empowered** requires written consent from the member. – Any member grievances filed with a provider are forwarded to **HAP Empowered** as required in accordance with the three-way contract with the ICO, MDHHS, and CMS. – Parties to the appeal and SFH include the member and his or her representative or the legal representative of a deceased member's estate; and, in SFHs, the ICO. – The ICO's process to extend the appeal resolution time frames by up to 14 calendar days when not at the member's request must include informing the member of the right to file a grievance if he or she disagrees with the decision to extend the time frame for resolution. – If the ICO denies a request for expedited resolution of an appeal, it must transfer the appeal to the time frame for standard resolution; make reasonable efforts to give the member prompt oral notice of the denial; within two calendar days, give the member written notice of the reason for the decision to extend the time frame, and inform the member of the right to file a grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the member's health condition requires, and no later than the date the extension expires. – Accurate and comprehensive information about the grievance and appeal system must be provided to all providers and subcontractors at the time they enter into a contract. • Further, **HAP Empowered** should prioritize the remediation of the remaining deficiencies in the Provider Selection and Quality Assessment and Performance Improvement Program standards, including obtaining disclosures from all network providers and applicants in accordance with 42 CFR §455 Subpart B and 42 CFR §1002.3 and maintaining such disclosed information in a manner that can be periodically searched by the ICO for exclusions and forwarded to MDHHS as appropriate; and participating in efforts by MDHHS to prevent, detect, and remediate critical incidents by reviewing, analyzing, tracking, and trending critical incident data at the member, provider, and systemic levels.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***

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

- **Bullet #1**

  In May of 2021 the Appeals and Grievance staff underwent several days of Appeals and Grievance refresher training which covered all required steps for filing an appeal, grievance and State Fair hearing including all associated regulatory requirements. Specifically, the MMP portion of the training of the regulatory requirement to obtain the written consent from the member was reviewed. In addition, the MMP Desk Level Procedure was updated on July 30, 2021.

- **Bullet #2**

  The HAP Empowered Provider Manual was updated to address the process, requirements of the Three-Way Contract, and HAP's expectations when a member files a grievance with a provider.

- **Bullet #3**

  The MMP Appeals, and Grievance Policy and Procedure was reviewed to ensure the appeal and State fair hearing includes the member and his or her representative or the legal representative of a deceased member's estate; and, in State fair hearings, the ICO was clearly reflected in the document.

- **Bullet #4**

  The MMP Appeals Policy and Procedure indicates that when the Plan determines that a time frame needs to be extended, they inform the member verbally and in writing of the reason for the extension and of their right to file a grievance if he or she disagrees with the decision to extend the time frame for resolution. This information was including during the May 2021 Refresher Training with the Appeals &Grievances analysts.

- **Bullet #5**

  The MMP DLP was reviewed to ensure the following information was included: If the ICO denies a request for expedited resolution of an appeal, it must transfer the appeal to the time frame for standard resolution, make reasonable efforts to give the member prompt oral notice of the denial, within two calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision, and resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. The DLP cross-references instructions to refer to the Medicare Advantage DLP and the Medicaid DLP for each portion of the MMP appeal, and clearly documents the requirements noted above. Note: It appears the MA [Medicare Advantage] and Medicaid DLPs may not have been included in the previous EQHR submissions, which, in turn, caused the finding in this area.

- **Bullet #6**

  Language was added to the provider orientation checklist to include guidance of the appeals and grievances process, including when a member files a grievance directly with the provider.

- **Provider Selection and Quality Assessment and Performance Improvement**

  HAP has implemented a process whereby the provider disclosure forms are obtained during enrollment and recredentialing of a provider for participation with HAP Empowered. The information contained in the disclosure form is uploaded to a spreadsheet which can be queried and tracked for all disclosure form submissions. On a weekly basis, the spreadsheet, which includes provider and other party

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
ownership or controlling interest, is then compared against provider exclusion and sanction databases to determine if there are any matches. Once the file compare process is completed, any matches to the file and exclusion databases are shared with Credentialing who then takes appropriate action to terminate any providers that need to be terminated. The Quality Management Department in collaboration with Care Management, Health Care Management, Compliance, and the Special Investigations Unit (SIU) collects and analyzes critical incident data on a quarterly basis. A comprehensive report/dashboard with thresholds was developed for plan wide stakeholders to conduct analysis and identify provider, member and/or systemic trends. A template was created to review during quarterly meetings and findings will be reported to the Clinical Quality Management Committee (CQMC). A Critical Incident Dashboard was developed that will track data related to CIs [critical incidents]. Dashboard data will highlight the following: – Timely responses to all CIs – Investigation of CI's within required time frame – Trend common root causes and issues stemming from CIs HAP conducted training with vendor partners, MMP, and LTSS care coordinators. This assisted all stakeholders with how to recognize a critical incident and report it to HAP. HAP also added critical incidents as a standing agenda item to monthly meetings with each Area Agency on Aging (AAA) and Prepaid Inpatient Health Plans (PIHP).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Bullet #1** The Monitoring & Oversight A&G [Appeals and Grievances] representative reviews a sample of cases for accuracy. A quality review process is utilized to ensure requirements are being met, which includes written consent. Quality monitoring has revealed no instances of deviation from this requirement. • **Bullet #2** Effectiveness of our education includes a review of monthly grievance reports to identify grievances forwarded by providers. If providers are not following the process, they are contacted directly for re-education. There is not enough data to identify trends. • **Bullet #3** The Monitoring & Oversight A&G representative reviews a sample of cases for accuracy. A quality review process is utilized to ensure requirements are being met. Quality monitoring has revealed no instances of deviation from this requirement. • **Bullet #4** The Monitoring & Oversight A&G representative reviews a sample of cases for accuracy. A quality review is utilized to ensure requirements are being met, which includes extensions. Quality monitoring has revealed no instances of deviation from this requirement. • **Bullet #5** The Monitoring & Oversight A&G representative reviews a sample of cases for accuracy. A quality review process is utilized to ensure requirements are being met, which includes notification of appeal time frame. Quality monitoring has revealed no instances of deviation from this requirement.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• **Bullet #6** Effectiveness of our education includes a review of monthly grievance reports to identify grievances forwarded by providers. If providers are not following the process, they are contacted directly for re-education. There is not enough data to identify trends. • **Provider Selection and Quality Assessment and Performance Improvement** HAP will continue to monitor this process to ensure that all new HAP Empowered providers are logged onto the disclosure spreadsheet with a periodic audit comparing a sample of providers who participate with HAP Empowered. This will identify any process improvements needed to ensure the process is effective. The critical incident process flow was updated along with policies and procedures. The collaborative dashboard will allow for teams to conduct analysis and identify provider, member and/or systemic trends. Findings are reported to the Clinical Quality Management Committee.
c. Identify any barriers to implementing initiatives: • HAP Empowered has not identified any barriers to implementing any of the above initiatives.
HSAG's Assessment: HSAG determined that **HAP Empowered** partially addressed the prior year's recommendations. The SFY 2021 Compliance Review confirmed there were continued deficiencies related to obtaining member consent when a provider or other designated individual files an appeal on the member's behalf and collecting provider disclosures upon credentialing and recredentialing. **HAP Empowered** developed and submitted a CAP which was approved by MDHHS/HSAG; therefore, HSAG recommends that **HAP Empowered** fully implement its CAP and the additional recommendations made by HSAG.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **HAP Empowered** should use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • HAP Empowered, in cooperation with our dental partner, Delta Dental, has implemented additional training to ensure that HAP Empowered and MI Health Link were recognized by dental provider office staff. An initial mailing was sent to all network providers. This training will be reinforced through future quarterly mailings as well as training provided to providers newly joining the network.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HAP Empowered conducted a "Secret Shopper" audit during the Third Quarter of 2021. Results of the audit demonstrated improvements in demographic data (address, phone number, etc.) but a decline in recognition of HAP Empowered and MI Health Link. HAP is working with Delta Dental to implement further corrections/educational efforts to improve performance. HAP will continue to perform ad hoc audits to monitor Delta Dental performance and provider directory updates.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
c. Identify any barriers to implementing initiatives: • We do not anticipate any barriers in implementing the initiatives described above. The education initiative has already been implemented and the "Secret Shopper" survey is complete.
HSAG's Assessment: HSAG determined that **HAP Empowered** addressed the prior year's recommendations. However, although HSAG acknowledges that **HAP Empowered** is working with its dental partner to provide additional training to ensure that providers recognize the ICO and the MI Health Link program, **HAP Empowered** indicated that its internal secret shopper audit identified continued issues with providers recognizing the **HAP Empowered** and MI Health Link names. Because initial training mailings did not produce an increase in name recognition among contracted providers for **HAP Empowered** or MI Health Link, **HAP Empowered** should consider implementing alternative training opportunities in modes other than mailings to increase uptake and retention among providers.

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
HSAG recommended the following: • None.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG's Assessment: HSAG did not identify any weaknesses and therefore did not make any recommendations to **HAP Empowered** for the CAHPS activity.

Meridian Health Plan

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

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
HSAG recommended the following: • As **Meridian Health Plan** progresses into the second re-measurement, the ICO should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The ICO should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Prior to the second re-measurement, Meridian collaborated with our partner Southwest Michigan Behavioral health (SWMBH) through a workgroup that convened multiple times from April 2020 to September 2020 to work though identified barriers and determine if any new barriers exist that require the development of interventions. Meridian and SWMBH identified that all barriers were being addressed or were going to be addressed by the implemented and planned interventions. • Meridian reviewed and revised two interventions for the second re-measurement. Meridian intended to educate providers to notify SWMBH when a member went inpatient and work with their Case Managers to schedule a follow-up appointment for the member and address social determinants of health. This intervention was distributed to both Meridian and SWMBH's networks with the intention for both networks to receive the education annually. Additionally, Meridian hosted recurring meetings with the Pre-paid Inpatient Health Plan (PIHP) to discuss on-going collaboration, integration, and operational oversight. This has continued but operational meetings have moved to quarterly while member-specific collaborative meetings are now occurring monthly. These updates were put in place by SWMBH and Meridian jointly to address barriers due to lack of provider understanding and communication between the ICO and PIHP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian maintained a statistically significant improvement in the Follow Up after Hospitalization rate through the second re-measurement. The baseline rate was 23.1% and the second re-measurement rate was 59.3%.
c. Identify any barriers to implementing initiatives: • Meridian experienced barriers in implementing initiatives for the first re-measurement (reported previously), but not the second re-measurement.
HSAG's Assessment: HSAG determined that **Meridian Health Plan** addressed the prior year's recommendations. The ICO used appropriate QI methods to identify and prioritize its barriers to care and developed intervention efforts to address those barriers. The ICO continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **Meridian Health Plan** should implement additional validation checks to ensure that accurate initial IICSP and revised IICSP dates are reported for MI2.3.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • On January 1st, 2021, Meridian brought all care management activities back in house and are now managed under the Centene MI Market structure. Meridian's new Care Coordination team ensures accurate initial IICSP completion through an internal reporting process that captures initial care plan data as well as revised care plan data. Initial care plans are documented by recording all signed care plans, both verbal and written, in our medical record platform as well as any revisions to an already existing IICSP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian saw an increase in care plan completion rates in Q2 of 2021 due to the new processes established by the in-house Care Coordination team. Our MI 2.3 measure remains at a 100% completion rate.
c. Identify any barriers to implementing initiatives: • Due to system limitations, Meridian currently utilizes a manual process to identify revised care plans which is a barrier for ease of time in processing this report and increases the potential for manual error.
HSAG's Assessment: HSAG determined that **Meridian Health Plan** partially addressed the prior year's recommendations. **Meridian Health Plan** has put forth effort to improve the accuracy of initial and revised IICSPs included in reporting by transitioning to management under the Centene MI Market structure and bringing all care management activities in house. As such, HSAG recommends that **Meridian Health Plan** ensure stringent validation checks are in place under the new structure to ensure the accuracy of initial and revised IICSPs included in reporting for MI2.3. This should include validation of a sample of cases against the source data in the system. Additionally, a barrier noted by **Meridian Health Plan** was that it currently uses a manual process to identify revised care plans. As a result, HSAG recommends that **Meridian Health Plan** consider working with its care management system vendor on a care plan format that captures all of the necessary fields to track initial and revised IICSPs for reporting to help alleviate the potential for manual error.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Meridian Health Plan** should prioritize the remediation of the remaining deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **Meridian Health Plan** should focus on revising behavioral health and specialty provider standards for timely access to care and services to comply with contract requirements for urgent and symptomatic office visits; updating policies and procedures on standard and expedited authorization decision time frames extensions; and including provider specific reviews of quality of care events, grievances, appeals, UM, medical records reviews, members satisfaction surveys, and other performance indicators in the recredentialing decision-making process.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • *Revising behavioral health and specialty provider standards for timely access to care and services to comply with contract requirements for urgent and symptomatic office visits* – **Standard I—Availability of Services, Timely Access** Meridian's Provider Manual has been updated to reflect the requirement of 24 hours for all urgent and symptomatic office visits (page 15). Meridian will be adding a reminder for this requirement in the next Provider Newsletter, set to be distributed to our entire provider network in late-November 2020. • *Updating policies and procedures on standard and expedited authorization decision time frames extension* – On January 1st, 2021, Meridian brought all utilization management activities back in house and are now managed under the Centene Shared-Services Corporate structure. These processes now live with our Corporate UM team whose policies and procedures contain the appropriate decision time frames for standard and expedited authorization extensions. • *Including provider specific reviews of quality of care events, grievances, appeals, UM, medical records reviews, members satisfaction surveys, and other performance indicators* – The Credentialing team has implemented a recredentialing checklist report that includes member appeals.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian's Corporate UM team does not make many extensions, however this process has been streamlined with the rest of our organization. • No performance improvements have been identified at this time following the implementation of the checklist additions, however, the Credentialing team will continue to monitor for any improvements.
c. Identify any barriers to implementing initiatives: • There were no identified barriers with implementing the extension time frames as this is a standard process for our entire organization. • Credentialing did not experience any barriers in implementing the checklist.
HSAG's Assessment: HSAG determined that **Meridian Health Plan** addressed the prior year's recommendations. However, related deficiencies in the service authorization and credentialing program areas were identified during the SFY 2021 Compliance Review activity. **Meridian Health Plan** developed and submitted a CAP which was approved by MDHHS/HSAG; therefore, HSAG recommends that **Meridian Health Plan** fully implement its CAP and the additional recommendations made by HSAG.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Meridian Health Plan** should use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Meridian directed our dental partner, DentaQuest, to conduct outreach to all providers identified with a deficiency. DentaQuest collected updated information from the identified providers and made all applicable updates to their directory. The changes included contact information, office location and hours, and acceptance of Meridian and the MI Health Link program. Meridian also conducted a directory audit to confirm all deficiencies identified during the initial secret shopper survey were remediated. DentaQuest provided retraining to their entire network to ensure providers inform members that they accept MI Health Link and MeridianComplete. • As a result of these activities, Meridian implemented monthly routine provider directory monitoring. A sample size of 10 providers is selected each month and outreach is conducted to the office to confirm accuracy of their directory information. Any discrepancy identified is shared with DentaQuest for immediate follow up and remediation.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian has seen a reduction in dental complaints and escalations due to the routine provider directory monitoring and the ICO and MI Health Link program retraining • As a result of the above initiatives, Meridian's provider directory is able to have the most up to date provider information as possible. Whenever an incorrect phone number is located, this is updated within the system.
c. Identify any barriers to implementing initiatives: • Meridian currently has not experienced any barriers to implementing the above mentioned initiatives.
HSAG's Assessment: HSAG determined that **Meridian Health Plan** addressed the prior year's recommendations. **Meridian Health Plan** implemented an intervention with its dental partner DentaQuest to identify deficiencies in its online provider directory. Additionally, **Meridian Health Plan** is monitoring the online provider directory for accuracy, reviewing 10 providers per month. **Meridian Health Plan** indicated that it has retrained all network providers to ensure that providers inform members accurately if they accept MI Health Link and **Meridian Health Plan** as the ICO. Over 80 percent of sample cases could be reached, and over half of sample cases indicated accepting **Meridian Health Plan** and MI Health Link. HSAG recommends that **Meridian Health Plan** continue to monitor online provider directories, including all provider types, and increase training efforts to improve uptake and retention among providers.

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
HSAG recommended the following: • None.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG's Assessment: HSAG did not identify any weaknesses and therefore did not make any recommendations to **Meridian Health Plan** for the CAHPS activity.

Michigan Complete Health

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

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
HSAG recommended the following: • As **Michigan Complete Health** progresses to the second remeasurement, the ICO should revisit its causal/barrier analysis and develop interventions specific to age groups as appropriate. **Michigan Complete Health** should implement interventions that have the greatest impact to the study indicator outcomes.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • MCH revisited the intervention in place to address transportation barriers. MCH created an informational document that providers and partners, including Case Managers at our partnered PIHPs, could utilize to assist members with transportation. The document was not member-facing and intended for use by member-facing personnel. MCH capitalized on the opportunity to create a member-facing version of the flyer and obtained regulatory approval to share it with members. The member and provider flyers were disseminated by Quality Improvement to Care Coordination and both PIHPs for use. Evaluation of the success of this intervention will be evaluated for the third re-measurement.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In the second re-measurement, MCH achieved a rate of 49.25%, which was a 9% increase from the first re-measurement year's rate.
c. Identify any barriers to implementing initiatives: • MCH did not experience any barriers to implementing initiatives.
HSAG's Assessment: HSAG determined that **Michigan Complete Health** addressed the prior year's recommendations. The ICO used appropriate QI methods to identify and prioritize its barriers to care and developed intervention efforts to address those barriers. The ICO continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **Michigan Complete Health** should implement additional validation checks to ensure that accurate initial IICSP and revised IICSP dates are reported for MI2.3.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
• Michigan Complete Health ensures accurate initial IICSP completion through an internal reporting process that captures initial care plan data as well as revised care plan data. Initial care plans are documented by recording all signed care plans, both verbal and written, in our medical record platform as well as any revisions to an already existing IICSP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Michigan Complete Health continues score at 100% for this measure in 2021.
c. Identify any barriers to implementing initiatives: • Due to system limitations, MCH currently utilizes a manual process to identify revised care plans which is a barrier for ease of time in processing this report and increases potential for manual error.
HSAG's Assessment: HSAG determined that **Michigan Complete Health** addressed the prior year's recommendations. **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2021; therefore, HSAG has no additional recommendations.
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Michigan Complete Health** should prioritize the remediation of the remaining two deficiencies identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **Michigan Complete Health** should focus on mailing the termination, suspension, or reduction of previously authorized Medicaid-covered services ABD notices at least 10 days before the dates of action, or as indicated by the exceptions; and for the denial of payment, **Michigan Complete Health**'s process must ensure that the ABD notice be mailed at the time of the action affecting the claim (e.g., upon the decision to deny payment).
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • MCH currently mails the notification to the member more than 10 days prior to the dates of adverse benefit determination action. This process is currently seen as a best-practice used by the team and the process will be added to an existing policy.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • This process is currently a best practice used by the team that will be added to an existing policy and procedure.
c. Identify any barriers to implementing initiatives: • No barriers to implementation as this is already the best-practice followed by the team. The addition to the policy will go through committee review following the typical policy and procedure update process.
HSAG's Assessment: HSAG determined that **Michigan Complete Health** partially addressed the prior year's recommendations. **Michigan Complete Health** indicated that its policy is to send ABD notices for termination, suspension, or reduction of previously authorized services more than 10 days in advance of the action and that its policies and procedures were updated, which addressed this deficiency. However, **Michigan Complete Health** did not address how it ensures that the IDN notice is mailed at the time of the action affecting the claim. **Michigan Complete Health** members moved to **Meridian Health Plan** effective January 1, 2022; therefore, HSAG has no additional recommendations.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Michigan Complete Health** should use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • MCH directed our dental partner, Envolv Dental, to conduct outreach to all providers identified with a deficiency. Envolv collected updated information from the identified providers and made all applicable updates to their directory. The changes included contact information, office location and hours, and acceptance of MCH and the MI Health Link program. MCH also conducted a directory audit to confirm all deficiencies identified during the initial secret shopper survey were remediated. Envolv Dental provided retraining to their entire network to ensure providers inform members that they accept MI Health Link and MCH. • As a result of these activities, MCH implemented monthly routine provider directory monitoring. A sample size of 10 providers is selected each month and outreach is conducted to the office to confirm accuracy of their directory information. Any discrepancy identified is shared with Envolv for immediate follow up and remediation.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • MCH has seen a reduction in dental complaints and escalations due to the routine provider directory monitoring and the ICO and MI Health Link program retraining • As a result of the above initiatives, MCH's provider directory is able to have the most up to date provider information as possible. Whenever an incorrect phone number is located, this is updated within the system.
c. Identify any barriers to implementing initiatives: • MCH currently has not experienced any barriers to implementing the above mentioned initiatives.
HSAG's Assessment: HSAG determined that **Michigan Complete Health** addressed the prior year's recommendations. HSAG identified no specific weaknesses for **Michigan Complete Health** based on the SFY 2021 NAV evaluation.

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
HSAG recommended the following: • None.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG's Assessment: HSAG did not identify any weaknesses and therefore did not make any recommendations to **Michigan Complete Health** for the CAHPS activity.

Molina Healthcare of Michigan

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

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
HSAG recommended the following: • As **Molina Healthcare of Michigan** progresses to the second remeasurement, the ICO should revisit the causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. **Molina Healthcare of Michigan** should also continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Molina Healthcare of Michigan had one measure of focus in 2021 - Follow-Up After Hospitalization for Mental Illness (FUH) within 30 days. We have developed a multi-disciplinary workgroup with key stakeholders to study the issue and inform the improvement process. We continue to work directly with the Pre-paid Inpatient Health Programs (PIHP) to develop an approach that promotes collaboration between care delivery teams to discuss behavioral health best practices, and to design processes to ensure appropriate follow-up care for members in common. Monthly joint workgroup meetings occur with key health plan and PIHP representatives from the accompanying functional areas to review key performance indicators, determine the effectiveness of related interventions, and any additional barriers or additional interventions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The FUH measure demonstrated a statistically significant improvement and a 23.63 percent increase from the Baseline in 2018 (55.61%) to Remeasurement 2 in 2020 (68.75%). Most notable interventions introduced to influence this measure include a member telehealth option for follow-up care, a member PIHP transition of care program following hospitalization, as well as Molina's Care Coordinator Program where Nurse Practitioners and Licensed Clinical Social Workers perform follow-up after hospitalization services with members in their homes and virtually via telehealth.
c. Identify any barriers to implementing initiatives: • As the measure has improved steadily over time, Molina appears to have overcome most barriers and demonstrated improved performance over the measurement years. The ongoing challenges for behavioral health care between the health plan and the PIHPs continues to be a barrier; however, we continue to work closely with our PIHP partners through joint meetings to monitor the measure, barriers, interventions and to coordinate follow-up care for members between the two entities.
HSAG's Assessment: HSAG determined that **Molina Healthcare of Michigan** addressed the prior year's recommendations. The ICO used appropriate QI methods to identify and prioritize its barriers to care and developed intervention efforts to address those barriers. The ICO continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **Molina Healthcare of Michigan** should implement additional validation checks to ensure the accuracy of its member-level detail file and authorization file used for reporting of MI3.1. • **Molina Healthcare of Michigan** should conduct a root cause analysis or focused study to determine why some women 65 to 85 years of age are not receiving treatment within six months after a fracture. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **MI3.1** MI 3.1–Based on recommendations from the 2020 PMV Audit, an initiative was added for reporting Element A, Total number of members receiving long-term services and supports (LTSS). We updated our structured query language (SQL) code to ensure that only members that were eligible during the reporting quarter were included within Element A. The report is generated manually each quarter and the date fields updated to ensure data refreshes appropriately for the reporting period. Once the report is generated it is posted for quality validation and leadership review and approval prior to submission. • **OMW—Osteoporosis Management in Women Who Had a Fracture** Molina Healthcare of Michigan rate for Osteoporosis Management in Women Who Had a Fracture (OMW) rate dropped by 13 percent from 2018 to 2019. Molina implemented several member and provider interventions to increase the number of women receiving a bone mineral density test or prescription for a drug to treat osteoporosis within six months after a fracture. <u>Quality Interventions</u> A. Member Interventions 1. Outreach letter or email to all identified members providing education regarding the importance of following up with their physician, after the fracture, to receive a bone mineral density test or drug to treat osteoporosis. 2. Quality Dept. staff performs outreach calls to all women as they are identified as having a qualified fracture and offer assistance with scheduling an appointment with the provider. 3. Reminder/Unable to Contact (UTC) postcard are sent to women with no evidence of treatment after 90 days of the fracture. 4. Quality staff follow-up with providers regarding members who have been unable to reach to obtain current contact information and also request their assistance with contacting the member to schedule the appointment.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
B. Provider Interventions 1. Update Provider HEDIS manual to include OMW sheet of tips to improve the performance rate and distribute to providers via email. Hard copies are available upon request. 2. Provide education on the difference in measures Osteoporosis Management in Women Who Had a Fracture (OMW) and Osteoporosis Screenings in Women (OSW) during provider virtual office visits. Provider Engagement Team (PET) delivers member list via email during virtual office visits to alert office of the need to schedule members for an appointment following the qualified fracture.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **MI3.1** MI 3.1 - As a result of the SQL code update for eligibility we are now able to determine a more accurate critical incident and abuse reporting ratio overall. • **OMW—Osteoporosis Management in Women Who Had a Fracture** There was a 13 percent decline in the HEDIS reporting year rate from 17.14% in 2018 to 4.00% in 2019, however, the rate for reporting year 2020 improved to 30.00%.
c. Identify any barriers to implementing initiatives: • **MI3.1** MI 3.1–There are no known barriers for completing this update. • **OMW—Osteoporosis Management in Women Who Had a Fracture** Barriers include: – Member contact information is often invalid. – Provider engagement and accessibility to educate on any knowledge gap in measures is delayed when offices are understaffed and unable to make time to meet with Molina staff. – The shorten timeline for outreach (within the 6-month window) makes compliance more difficult if members delay following up with the provider. – Members are having delayed follow up with providers due to COVID, restrictions, or member concerns.
HSAG's Assessment: HSAG determined that **Molina Healthcare of Michigan** partially addressed the prior year's recommendations. **Molina Healthcare of Michigan** has put forth effort to improve performance for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **Molina Healthcare of Michigan** implemented several member interventions (i.e., provided member education via letter and email, member outreach and assistance with appointment scheduling, UTC postcards) and provider interventions (i.e., updates to the Provider HEDIS manual and provider performance measure education). **Molina Healthcare of Michigan** demonstrated slight improvement for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator, as its rate increased more than 1 percentage point from MY 2018 to MY 2020. However, to continue improving performance for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator, HSAG recommends that **Molina Healthcare of Michigan** continue to evaluate the impact of the interventions currently in place and focus its efforts on providing timely bone mineral density tests or prescriptions to women who suffer a fracture. Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life. Osteoporotic fractures, particularly hip fractures, are associated with

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.[4-3] Although **Molina Healthcare of Michigan** identified several barriers, such as invalid member contact information, lack of provider engagement, and delayed follow-up due to the COVID-19 PHE, HSAG further recommends that **Molina Healthcare of Michigan** consider alternative methods of delivering osteoporosis treatments (e.g., off-site clinics, home delivery and administration, and drive-through administration) to ensure the best possible care for osteoporosis patients during the COVID-19 PHE.[4-4] Regarding HSAG's prior recommendation for MI3.1, **Molina Healthcare of Michigan** has put forth effort to improve the accuracy of critical incident and abuse reporting by updating its programming logic to ensure the appropriate inclusion of members who were eligible during the reporting quarter in data element A. As such, HSAG recommends that **Molina Healthcare of Michigan** continue to monitor and assess the accuracy and validity of reports prior to submission. **Molina Healthcare of Michigan**'s validation process should include validation of a sample of cases against the source data in the system, member-level detail file, and authorization file used for reporting of MI3.1.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Molina Healthcare of Michigan** should prioritize the remediation of the remaining six deficiencies in the Grievance and Appeal Systems standard identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. Specifically, **Molina Healthcare of Michigan** should focus process and document revisions, and training efforts on the following: – When a provider requests an appeal, files a grievance, or requests a SFH on behalf of a member, **Molina Healthcare of Michigan** requires written consent from the member. – Any member grievances filed with a provider are forwarded to Molina Healthcare of Michigan as required in accordance with the three-way contract with the ICO, MDHHS, and CMS. – When a member makes an oral appeal request, Molina Healthcare of Michigan's process includes acknowledging the details of the appeal, and ensuring the details documented are accurately stated by the ICO. Additionally, Molina Healthcare of Michigan's processes ensure members receive appeal rights for services that are denied, reduced, or terminated, and members must go through the ICO's appeal process prior to accessing the SFH process. – For notice of an expedited appeal resolution, **Molina Healthcare of Michigan** makes reasonable efforts to provide the member with oral notice of the decision within 72 hours of the request. – **Molina Healthcare of Michigan** complies with all requirements when it denies a request for an expedited resolution of an appeal. – Accurate and comprehensive information about the grievance and appeal system must be provided to all providers and subcontractors at the time they enter into a contract.

[4-3] National Committee for Quality Assurance. Osteoporosis Management In Women Who Had a Fracture (OMW). Available at: https://www.ncqa.org/hedis/measures/osteoporosis-management-in-women-who-had-a-fracture-omw/. Accessed on: Feb 8, 2022.

[4-4] Yu EW, Tsourdi E, Clarke BL, et al. Osteoporosis Management in the Era of COVID-19. *The American Society for Bone and Mineral Research*. Available at: https://asbmr.onlinelibrary.wiley.com/doi/full/10.1002/jbmr.4049. Accessed on: Jan 25, 2022.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• Further, **Molina Healthcare of Michigan** should prioritize the remediation of the one remaining deficiency in the Coordination and Continuity of Care standard by developing an audit tool component that pertains to IICSP monitoring and member contact requirements based on risk stratification levels.

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

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

- Throughout 2020/2021 Molina conducted an extensive review of policies and procedures to ensure compliance with all standards. The review looked at several areas including member consent, the state fair hearing process, and notification rules as outlined in the contract. Additionally, in June 2021, policies and procedures were updated to clarify requirements related to acknowledging verbal and written grievances and member representation.
- Molina continuously educates new and existing staff members through weekly management meetings and ad-hoc meetings as needed. In September 2019, April 2021, and July 2021 training on policy and procedure updates was completed for all staff. The training also included language requirements for letters.
- Updates were made to the MMP Provider Manual in 2020 and 2021 to ensure they clearly outlined provider responsibility to follow Molina's appeal and grievance process for reporting. During the credentialing process all provides are provided a copy of the Provider Manual which explains the appeal and grievance process.
- Molina is currently finalizing implementation of a new system which will allow for greater visibility and auditing capabilities of the appeals and grievance process. This new system will utilize current templates including those related to state fair hearing and continuation of benefits.

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

- Molina has appeals and grievance standards monitored through monthly key performance indicators (KPI) reports as well as increased quality audits. The ongoing quality audits are completed by a dedicated auditor. Below are the KPI's results for timeliness, which demonstrates remarkable improvement.

	21-Jan	21-Feb	21-Mar	21-Apr	May-21	21-Jun
MMP Medicare, Standard grievance timeliness	100.0%	99%	99.0%	100.0%	100.0%	100.0%
MMP Medicare, Expedited appeals timeliness	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%
MMP Medicare, Standard appeals timeliness	100.0%	100.0%	100.0%	91.0%	100.0%	100.0%
MMP Medicaid, Standard grievances timeliness	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
MMP Medicaid, Standard appeals timeliness	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review						
MMP Medicaid, Expedited appeals timeliness	100.0%	N/A	N/A	N/A	100.0%	100.0%

c. Identify any barriers to implementing initiatives:

- Implementation of the new appeals and grievance system was delayed ensuring that it was fully compliant, and we were able to complete all staff training. Delaying the implementation allowed for a phased-in implementation approach. The phased-in implementation approach allowed additional time for implementing workflows and auditing tools to assist staff and ensure ongoing compliance.

HSAG's Assessment: HSAG determined that **Molina Healthcare of Michigan** partially addressed the prior year's recommendations. The SFY 2021 Compliance Review activity identified continued deficiencies related to appeal acknowledgements. **Molina Healthcare of Michigan** developed and submitted a CAP which was approved by MDHHS/HSAG; therefore, HSAG recommends that **Molina Healthcare of Michigan** fully implement its CAP and the additional recommendations made by HSAG.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

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

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

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

- Molina had no specific recommendations for this process. Molina continues to work to gather correct provider information through provider education and contract manager contacts.

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

- N/A

c. Identify any barriers to implementing initiatives:

- N/A

HSAG's Assessment: HSAG determined that **Molina Healthcare of Michigan** has not addressed the prior year's recommendations to use the case-level analytic data files containing provider deficiencies identified during the survey to address the provider data deficiencies, but HSAG does acknowledge that **Molina Healthcare of Michigan** continues to work to obtain correct provider information through provider education and contract manager contacts. However, with over 57 percent of providers not responding to the most recent survey, not accepting **Molina Healthcare of Michigan**, or not accepting MI Health Link, **Molina Healthcare of Michigan** should develop and implement more concrete efforts to improve the accuracy of all provider contact information accessible by members and ensure that providers understand the MMP that they accept.

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
HSAG recommended the following: • None.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG's Assessment: HSAG did not identify any weaknesses and therefore did not have any recommendations to **Molina Healthcare of Michigan** for the CAHPS activity.

Upper Peninsula Health Plan

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

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
HSAG recommended the following: • As **Upper Peninsula Health Plan** progresses to the second remeasurement, the ICO should revisit the causal/barrier analysis process to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The ICO should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Upper Peninsula Health Plan reviewed the causal/barrier analysis process to ensure that previous identified barriers continue to be barriers and determine if any new barriers exist. No new initiatives were implemented based on this review. A mid-year data analysis also occurred to review opportunities for new initiatives. The mid-year data analysis also occurred to evaluate the effectiveness of interventions. Upper Peninsula Care Coordinator staff received an updated training in regards to outreach following mental health inpatient hospitalizations.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A – no new initiatives implemented. UPHP [Upper Peninsula Health Plan] continues to educate staff on an annual basis and review data with the PIHP on a quarterly basis.
c. Identify any barriers to implementing initiatives: • [None reported by ICO]
HSAG's Assessment: HSAG determined that **Upper Peninsula Health Plan** addressed the prior year's recommendations. The ICO used appropriate QI methods to identify and prioritize its barriers to care and developed intervention efforts to address those barriers. The ICO continued to evaluate the effectiveness of each intervention and used those outcomes to determine each intervention's next steps.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **Upper Peninsula Health Plan** should implement additional validation checks to ensure that accurate initial IICSP and revised IICSP dates are reported for MI2.3.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
• UPHP clinical and IT departments at UPHP met to review the data validation breakdown. After reviewing changes in data and SQL code, it was determined that UPHP IT inadvertently removed logic that skewed the data. It was determined that UPHP needed to reinsert the logic and also needed to add logic that made sure the initial IICSP was categorized as such, and excluded previous eligibility spans that were erroneously being identified with an initial IICSP status. Validation is performed with each quarterly report submission by both UPHP IT and Clinical departments.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • After the sequel code fix, no other data concerns were noted and remedied the data inconsistencies. Data validation occurs with each quarterly submission.
c. Identify any barriers to implementing initiatives: • Staff changeover was identified as the root cause. Validation checks have been put in place with quarterly submissions to continue to monitor.
HSAG's Assessment: HSAG determined that **Upper Peninsula Health Plan** addressed the prior year's recommendations. Although HSAG did not review MI2.3 during the SFY 2021 PMV activity, **Upper Peninsula Health Plan** appears to have addressed HSAG's recommendation by having its clinical and IT departments review and discuss the prior data validation process to determine the appropriate next steps (i.e., revision of programming logic and implementation of quarterly validation checks to help avoid future data inconsistencies).
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Upper Peninsula Health Plan** should prioritize the remediation of the remaining one deficiency identified from the CAP review and discussed through the mandatory technical assistance session with HSAG and MDHHS. **Upper Peninsula Health Plan** should focus on the consideration of performance indicators obtained through the QI plan, UM program, grievance and appeals system, member satisfaction surveys, MRRs, and quality of care and quality of service events during the recredentialing process.
MCE's Response *(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • A new report has been implemented that pulls data from various areas of the company, including but not limited to, grievances, quality of care, care gaps, readmission rates, appeals, and number of members assigned and/or members seen. This report is presented at each Credentialing Committee meeting with data on the providers being presented for reappointment.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Credentialing Committee has grown more familiar with these metrics through asking questions and is becoming comfortable making assessments of this information upon recredentialing decisions.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
c. Identify any barriers to implementing initiatives: • Pulling and compiling information from various databases has proven to be difficult and time consuming. This process is still being developed as we learn the best and most efficient way to present the information.
HSAG's Assessment: HSAG determined that **Upper Peninsula Health Plan** addressed the prior year's recommendations. The SFY 2021 Compliance Review activity confirmed the identified deficiency has been remediated.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Upper Peninsula Health Plan** should use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UPHP worked with Delta Dental, UPHP's dental network contractor, to identify the root cause of the discrepancy and to ensure the discrepancy was corrected for each provider record containing an incorrect or disconnected telephone number. • On an ongoing basis, UPHP Customer Service will route discrepant provider information received from members to UPHP provider relations so the information can be investigated and updated if appropriate; UPHP Provider Relations shares dental provider information with Delta Dental so that they may investigate and update their dental network data if appropriate. • UPHP meets with Delta Dental at least quarterly to ensure any identified issues are resolved.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • All discrepant records have been updated and communication between UPHP and our contracted dental contractor has improved.
c. Identify any barriers to implementing initiatives: • Because UPHP contracts with Delta Dental for dental services/dental network, UPHP must ensure and help support Delta Dental in maintaining the most up to date dental provider information.
HSAG's Assessment: HSAG determined that **Upper Peninsula Health Plan** addressed the prior year's recommendations. **Upper Peninsula Health Plan** worked with its dental network contractor to identify and correct discrepancies in provider data, and built a feedback loop to route member notification of incorrect provider information for correction. **Upper Peninsula Health Plan** should continue to monitor its online provider directory information and update any remaining incorrect data.

5. Prior Year Recommendation from the EQR Technical Report for Consumer Assessment of Healthcare Providers and Systems Analysis
HSAG recommended the following: • None.
MCE's Response ***(Note—The narrative within the ICO's Response section was provided by the ICO and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG's Assessment: HSAG did not identify any weaknesses and therefore did not make any recommendations to **Upper Peninsula Health Plan** for the CAHPS activity.

5. Integrated Care Organization Comparative Information

In addition to performing a comprehensive assessment of each ICO's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each ICO to assess the MI Health Link program. Specifically, HSAG identifies any patterns and commonalities that exist across the seven ICOs and the MI Health Link program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which MDHHS could leverage or modify MDHHS' CQS to promote improvement.

Integrated Care Organization External Quality Review Activity Results

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

Validation of Quality Improvement Projects

For the SFY 2021 validation, the ICOs submitted Remeasurement 2 data for their ongoing state mandated QIP topic: *Follow-up After Hospitalization for Mental Illness*. Table 5-1 below provides a comparison of the validation scores by ICO

Table 5-1—Comparison of Validation by ICO

Overall QIP Validation Status, by ICO		Design, Implementation, and Outcomes Scores		
		Met	Partially Met	Not Met
AET	*Not Met*	*53%*	*42%*	*5%*
AMI	*Not Met*	*95%*	*0%*	*5%*
HAP	*Not Met*	*95%*	*0%*	*5%*
MER	*Met*	*100%*	*0%*	*0%*
MCH*	*Not Met*	*89%*	*5%*	*5%*
MOL	*Met*	*100%*	*0%*	*0%*
UPP*	*Not Met*	*89%*	*5%*	*5%*

* Percentage totals may not equal 100 due to rounding.

The validation statuses for the ICOs that received an overall *Not Met* validation score are related to one or more critical elements not receiving a *Met* score, which impacted the overall validation status. For the SFY 2021 QIP, achieving statistically significant improvement was an MDHHS-approved critical element. Two ICOs, **Meridian Health Plan** and **Molina Healthcare of Michigan**, achieved this high level of performance improvement. However, **AmeriHealth Caritas**, **Michigan Complete Health**, and

Upper Peninsula Health Plan demonstrated non-statistically significant improvement over the baseline rates.

Performance Measure Validation

The SFY 2021 PMV of Core Measure 9.1—*Emergency Department (ED) Behavioral Health Services Utilization*, Core Measure 9.3—*Minimizing Institutional Length of Stay*, MI2.6—*Timely Transmission of Care Transition Record to Health Care Professional*, and MI5.6—*Care for Adults—Medication Review* resulted in six of seven ICOs receiving validation designations of *Reportable (R)* for all measures, indicating the measure data were compliant with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements. **Meridian Health Plan** received a *Do Not Report (DNR)* for one of the four measures, MI2.6—*Timely Transmission of Care Transition Record to Health Care Professional*.

Table 5-2 provides the validation designations for the MI Health Link program PMV of Core Measure 9.1, Core Measure 9.3, MI2.6, and MI5.6.

Table 5-2—Comparison of Overall Validation Designations

ICO	Core Measure 9.1	Core Measure 9.3	MI2.6	MI5.6
AET	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
AMI	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
HAP	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
MER	*REPORTABLE (R)*	*REPORTABLE (R)*	*DO NOT REPORT (DNR)*	*REPORTABLE (R)*
MCH	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
MOL	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
UPP	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*

Performance Measure Rates

Table 5-3 provides an ICO-to-ICO comparison with the statewide average for HEDIS MY 2020 performance data in 10 HEDIS measure domains. Green represents best ICO performance in comparison to the statewide average. Red represents worst ICO performance in comparison to the statewide average. Table 5-3 also provides a comparison of HEDIS MY 2018 and HEDIS MY 2020 statewide averages. Statewide averages in **bold** font and shaded in orange indicate the HEDIS MY 2020 statewide average demonstrated better performance than the HEDIS MY 2018 statewide average. Of note, based on CMS' suspension of all MMP reporting of HEDIS MY 2019 rates due to the COVID-19 PHE, HEDIS MY 2019 statewide averages are not displayed in Table 5-3, as data were not reported for MY 2019.

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

HEDIS Measure	HEDIS MY 2018 Statewide Average (%)	HEDIS MY 2020							
		Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MCH (%)	MOL (%)	UPP (%)
Prevention and Screening									
BCS—Breast Cancer Screening[1]	58.79	56.31	50.55	50.86	57.11	55.29	52.94	58.73	66.26
COL—Colorectal Cancer Screening[1]	50.88	**56.77**	46.23	50.85	60.98	59.21	41.36	63.02	64.72
COA—Care for Older Adults—Advance Care Planning	47.24	42.46	44.28	21.90	55.23	20.92	29.44	42.09	76.16
COA—Care for Older Adults—Medication Review	73.75	66.63	46.23	44.77	62.53	74.94	83.21	70.80	89.78
COA—Care for Older Adults—Functional Status Assessment[1]	64.24	53.52	63.50	52.80	62.53	22.63	40.63	50.61	81.27
COA—Care for Older Adults—Pain Assessment	73.71	67.04	46.72	60.58	78.83	73.24	43.07	71.29	92.21
Respiratory Conditions									
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.46	24.27	20.14	23.88	25.22	26.17	18.00	24.93	31.13
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	70.19	**71.84**	74.11	65.38	69.74	72.25	56.72	71.73	85.00
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	88.90	**90.73**	89.34	96.15	94.74	86.13	80.60	91.96	94.00
Cardiovascular Conditions									
CBP—Controlling High Blood Pressure[2]	—	56.89	51.58	51.82	59.61	62.77	41.12	54.50	78.10
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	92.35	89.59	86.67	100.00	92.86	88.89	60.00	91.43	100.00
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy[1]	78.14	**80.63**	80.76	76.70	84.41	80.09	72.73	80.61	85.27
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%[1]	74.77	**80.11**	74.89	75.95	76.43	81.36	72.92	84.74	86.36
Diabetes									
CDC—Comprehensive Diabetes Care—HbA1c Testing[1]	88.73	84.70	78.10	80.78	87.83	86.37	78.10	87.10	91.48
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**[1]	39.12	44.54	51.82	42.34	47.45	40.63	70.07	41.36	26.03
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)[1]	51.40	47.38	38.69	50.12	45.74	51.34	26.52	50.61	63.26

HEDIS Measure	HEDIS MY 2018 Statewide Average (%)	HEDIS MY 2020							
		Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MCH (%)	MOL (%)	UPP (%)
CDC—Comprehensive Diabetes Care—Eye Exam[1]	64.20	55.61	43.31	53.28	55.47	60.34	37.71	61.56	68.86
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy[1]	93.21	91.69	92.46	91.73	92.46	92.46	89.29	91.24	91.48
CDC—Comprehensive Diabetes Care— Blood Pressure Control <140/90 mm Hg[2]	—	56.67	48.66	51.82	54.99	62.29	39.66	56.69	81.51
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy[1]	72.48	**76.52**	74.02	78.19	80.36	76.95	77.31	76.57	74.40
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%[1]	75.38	**81.68**	75.53	75.79	81.23	83.76	85.63	83.68	86.36
Musculoskeletal Conditions									
ART—Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	70.18	**71.75**	73.33	68.42	72.97	95.65	45.45	66.92	73.33
OMW—Osteoporosis Management in Women Who Had a Fracture[1]	14.94	6.97	0.00	0.00	0.00	33.33	0.00	5.56	9.09
Behavioral Health									
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	61.55	**70.43**	65.67	73.61	71.20	71.57	69.12	71.31	72.88
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	46.28	**55.06**	56.22	59.72	48.80	54.82	61.76	51.81	61.86
FUH—Follow-Up After Hospitalization for Mental Illness–7 Days[1]	24.42	**29.65**	17.52	15.22	14.75	18.60	28.36	40.34	61.11
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days[1]	48.69	**57.00**	44.53	39.13	37.70	59.30	49.25	68.75	81.48
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days[1]	21.02	**31.68**	41.38	22.22	21.13	41.07	19.05	29.59	35.85
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days[1]	41.36	**49.24**	59.48	41.67	38.03	50.00	38.10	50.00	52.83

HEDIS Measure	HEDIS MY 2018 Statewide Average (%)	HEDIS MY 2020							
		Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MCH (%)	MOL (%)	UPP (%)
Medication Management and Care Coordination									
TRC—Transitions of Care–Notification of Inpatient Admission[2]	—	11.77	4.62	11.68	12.17	6.57	2.43	7.06	51.34
TRC—Transitions of Care–Receipt of Discharge Information[2]	—	11.34	3.41	10.46	8.76	10.95	2.92	8.52	44.04
TRC—Transitions of Care–Patient Engagement After Inpatient Discharge[2]	—	75.36	71.53	72.75	73.48	74.70	64.72	77.37	88.56
TRC—Transitions of Care–Medication Reconciliation Post-Discharge[2]	—	30.96	17.52	45.50	35.04	33.82	16.55	21.41	75.67
Overuse/Appropriateness									
*PSA—Non-Recommended PSA-Based Screening of Older Men**	21.68	**21.36**	18.15	18.36	22.44	14.65	23.56	26.40	19.86
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**[1]	42.87	**32.83**	33.60	32.48	28.47	33.33	17.39	34.06	42.98
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**[2]	—	18.05	18.22	10.05	21.04	19.29	6.96	20.33	19.53
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	12.76	**5.37**	5.35	4.78	4.33	7.21	4.99	4.45	7.76
*DAE—Use of High-Risk Medications in Older Adults—Total**	21.68	**21.46**	21.57	13.52	23.64	23.81	10.89	22.82	24.96
Access/Availability of Care									
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	85.00	82.27	78.70	76.66	82.56	84.36	73.37	84.81	88.58
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	94.39	92.90	91.27	90.28	91.82	94.55	87.31	94.96	94.73
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	91.46	89.79	88.14	85.48	88.31	93.43	82.71	91.54	92.80
AAP—Adult' Access to Preventive/Ambulatory Health Services—Total	91.25	89.49	87.38	85.49	88.50	92.07	82.38	91.60	92.81
IET—Initiation of Alcohol and Other Drug Dependence Treatment[2]	—	37.65	41.81	42.33	37.73	50.00	37.50	35.23	18.78

HEDIS Measure	HEDIS MY 2018 Statewide Average (%)	HEDIS MY 2020							
		Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MCH (%)	MOL (%)	UPP (%)
IET—Engagement of Alcohol and Other Drug Dependence Treatment[2]	—	6.59	9.26	9.82	7.27	8.98	6.67	4.10	3.05
Risk-Adjusted Utilization									
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**[2]	—	1.20	1.55	1.09	1.07	1.13	1.07	1.12	1.23
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**[2]	—	1.15	1.25	1.61	1.19	0.84	1.07	1.10	1.23

* Measures for which lower rates indicate better performance.

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

When HEDIS MY 2018 and HEDIS MY 2020 are comparable, statewide averages in **bold** font and shaded in orange indicate the HEDIS MY 2020 statewide average demonstrated better performance than the HEDIS MY 2018 statewide average.

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending in comparison with MY 2018 be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending; therefore, comparisons to MY 2018 rates and benchmarks are not performed for this measure.

NA indicates that data were not available.

Based on the ICOs' performance in the 46 measure rates within the identified domains of care, **Upper Peninsula Health Plan** demonstrated the best overall performance (highest-performing ICO in 29 measure rates), while **Michigan Complete Health** demonstrated the worst overall performance (lowest-performing ICO in 26 measure rates).

Compliance Review

Table 5-4 and Table 5-5 present the results of the current three-year cycle of reviews (SFY 2019–SFY 2021). During SFY 2019, HSAG conducted a full compliance review of all standards, and for the SFY 2020 activity, MDHHS requested that HSAG conduct a comprehensive desk review of the ICOs' completed SFY 2019 CAPs. Table 5-4 presents the combined results of the SFY 2019 and SFY 2020 compliance review results. For the SFY 2021 compliance review activity, HSAG conducted a focused compliance review targeting specific areas of opportunity identified during the SFY 2019 and SFY 2020 reviews. The review consisted exclusively of comprehensive case file and information system reviews for six program areas. Table 5-5 provides a comparison of CAPs required for each ICO within each case file review area. All ICOs required a CAP for two or more program areas. Service authorization denials and member appeals were the weakest program areas as all ICOs were required to submit a CAP for these areas. The strongest program area was related to subcontractor oversight and monitoring as only two ICOs were required to submit a CAP for that area.

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

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

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

Indicates standards in which ICOs did not achieve full compliance.

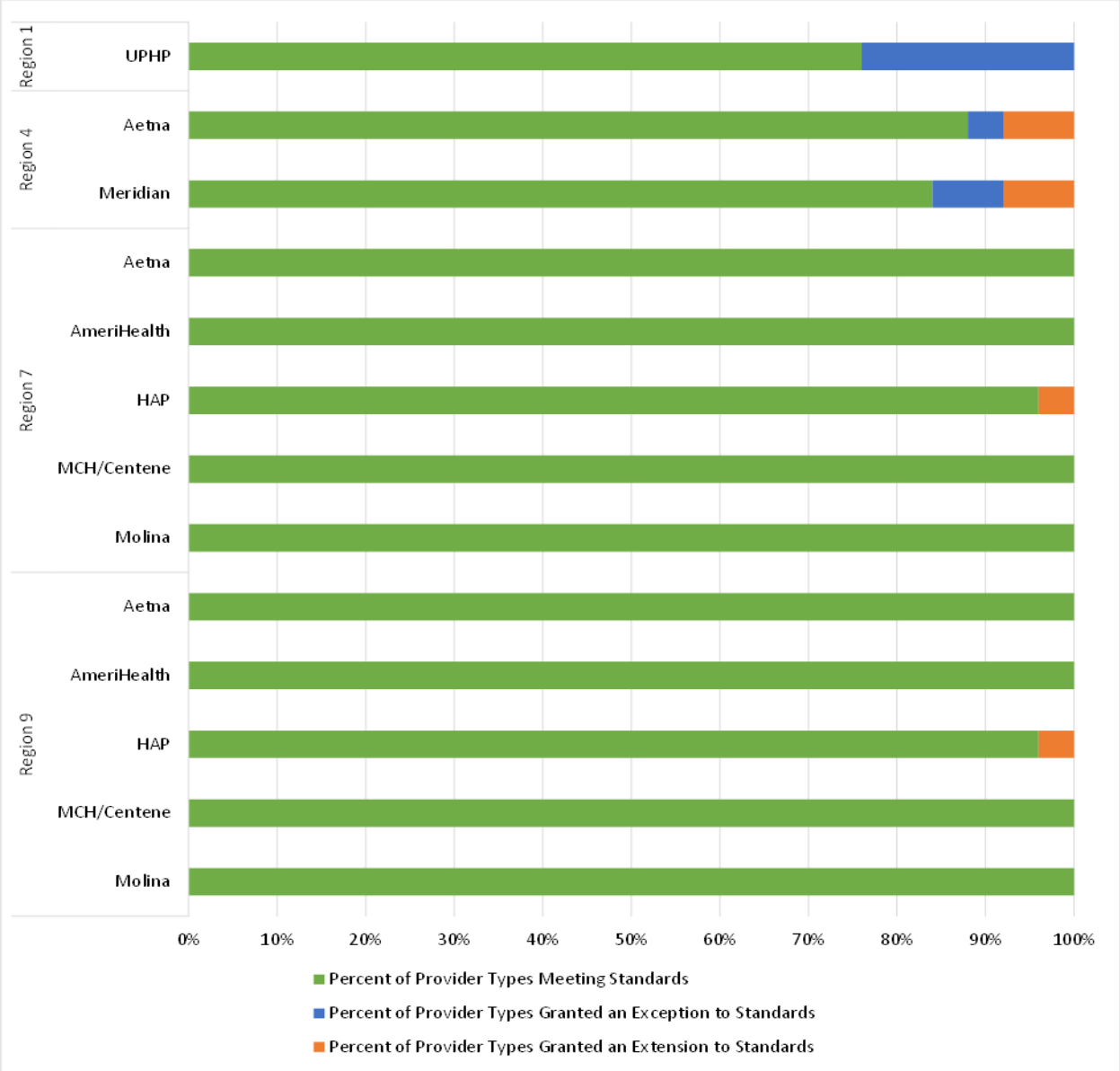
Table 5-5—SFY 2021 ICO Required CAPs

ICO	CAP Required					
	Service Authorization Denials	Individual Practitioner Credentialing	Organizational Credentialing	Member Grievances	Member Appeals	Subcontractors (delegated entities)
AET	✓	✓	✓	✓	✓	
AMI	✓	✓		✓	✓	
HAP	✓	✓	✓	✓	✓	
MHP	✓	✓	✓	✓	✓	✓
MCH	✓				✓	
MOL	✓	✓	✓	✓	✓	
UPP	✓			✓	✓	✓

Network Adequacy Validation

HSAG validated the adequacy of each ICO's provider network according to MI Health Link's minimum network requirements for 25 Medicaid and LTSS provider types. Figure 5-1 presents the ICOs' final region-specific NAV results (i.e., the percentage of the 25 Medicaid and LTSS provider types for which each ICO met the minimum network requirements or received an exception or extension) following all data resubmissions and MDHHS' exception and extension determinations.

Figure 5-1—SFY 2021 Final Network Adequacy Validation Results* by Region and ICO



* All percentages reflect ICOs' region-specific adherence to the minimum time/distance and provider capacity network requirements for 25 Medicaid and LTSS provider types.

Among the four ICOs that failed to meet all minimum network requirements for provider capacity and time/distance, Table 5-6 summarizes MDHHS' exception and extension determinations.

Table 5-6—SFY 2021 Exception and Extension Determinations by ICO and Region

Provider Type	MDHHS Exception or Extension Determination
AET—Region 4	
Adult Day Program	Exception Granted
Hearing Aids	Extension Granted
MIHP Agency	Extension Granted
HAP—Region 7	
Personal Emergency Response System (PERS)	Extension Granted
HAP—Region 9	
PERS	Extension Granted
MER—Region 4	
Adult Day Program	Exception Granted
MIHP Agency	Exception Granted
Hearing Examinations	Extension Granted
Hearing Aids	Extension Granted
UPP—Region 1	
Adult Day Program	Exception Granted
Dental (preventive and restorative)	Exception Granted
Hearing Examinations	Exception Granted
Hearing Aids	Exception Granted
MIHP Agency	Exception Granted
Assistive Technology Van Lifts and Tie Downs	Exception Granted

Secret Shopper Survey

During May and June 2021, HSAG completed a secret shopper telephone survey of PCP offices contracted with one or more ICOs under the MI Health Link program to collect information on the MI Health Link members' access to routine well-checks and nonurgent, problem-focused ("symptomatic") primary care visits. Due to the sampling methodology, HSAG's callers may have contacted the same provider location to attempt to gather survey responses specific to different ICOs within a MI Health Link region. Therefore, survey respondents may have given different information for each ICO- and region-specific sampled provider location (i.e., "case").

Figure 5-2 illustrates the flow of data collection during the survey calls, as well as the total number of cases with each potential survey outcome.

Figure 5-2—Secret Shopper Survey Data Collection Hierarchy and Count of Cases With Each Outcome

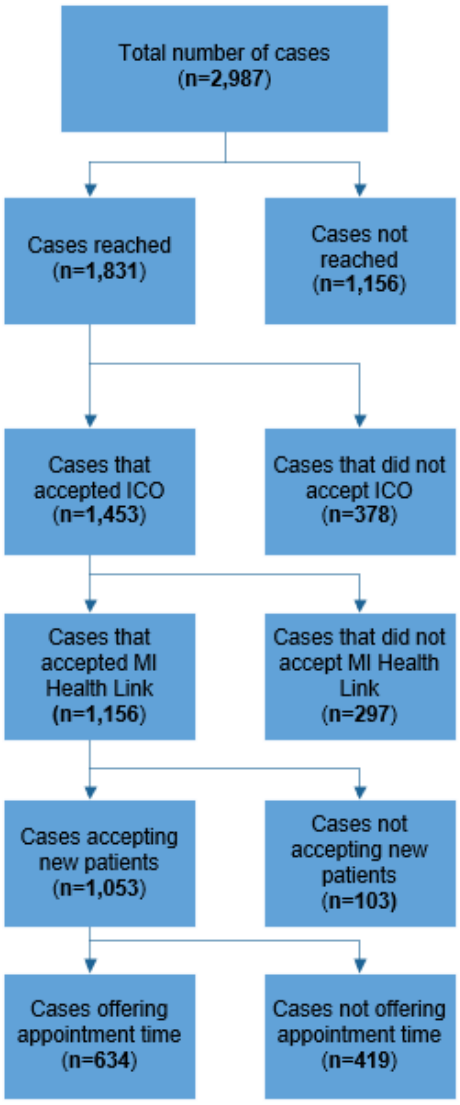


Table 5-7 summarizes the number of survey cases and outcomes by region and ICO.

Table 5-7—Summary of Secret Shopper Survey Case Outcomes, by Region and ICO

ICO	Total Survey Cases[1]	Cases Responding to the Survey[2]	Accepting ICO	Accepting MI Health Link	Accepting New Patients
Region 1					
UPP	125	111	106	104	89
Region 1 Total	**125**	**111**	**106**	**104**	**89**
Region 4					
AET	151	80	67	54	47
MER	113	91	79	60	51
Region 4 Total	**264**	**171**	**146**	**114**	**98**
Region 7					
AET	284	160	139	104	100
AMI	324	199	113	90	85
HAP	365	207	177	145	138
MCH	217	142	109	85	76
MOL	318	173	158	135	116
Region 7 Total	**1,508**	**881**	**696**	**559**	**515**
Region 9					
AET	235	137	118	82	79
AMI	134	96	58	39	39
HAP	308	187	148	114	110
MCH	210	121	83	55	52
MOL	203	127	98	89	71
Region 9 Total	**1,090**	**668**	**505**	**379**	**351**
All ICOs and Regions[1]	**2,987**	**1,831**	**1,453**	**1,156**	**1,053**

[1] Use caution when interpreting results aggregated for All ICOs and Regions, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across ICOs and regions. Survey calls were placed by ICO, region, telephone number, and standardized address; survey responses are unique to the sampled location (i.e., case).

[2] Survey respondents include cases in which any attempts made by HSAG's callers resulted in reaching a PCP's office that was able to answer whether or not the office was contracted with the requested ICO.

Survey cases were stratified by appointment scenario, and survey respondents reported appointment availability for 58.7 percent of all routine well-check cases and 61.8 percent of symptomatic visit cases in which the survey respondent reported that the provider location accepted the ICO and the MI Health Link program, and was accepting new patients.

Table 5-8 and Table 5-9 display the number and percentage of cases in which the survey respondent reported that the provider location offered an appointment date to new MI Health Link patients with the specified ICO for a routine well-check or a symptomatic visit, respectively. Appointments may have been offered with any practitioner at the sampled location.

Table 5-8—New Patient Appointment Wait Time in Calendar Days for Routine Services Among Respondent Cases Accepting the Requested ICO, MI Health Link, and New Patients, by ICO and Region

ICO and Region	Number of Cases Contacted and Accepting New Patients	Cases Offered a Well-Check Appointment		Appointment Wait Time (Days)[3]			
		Number	Rate[1] (%)	Min	Max	Average	Median
All ICOs and Regions[2]	**545**	**320**	**58.7**	**0**	**112**	**13.0**	**7.0**
Region 1							
UPP	41	6	14.6	2	35	11.2	6.5
Region 1 Total	**41**	**6**	**14.6**	**2**	**35**	**11.2**	**6.5**
Region 4							
AET	28	13	46.4	0	42	15.2	4.0
MER	24	17	70.8	0	66	30.5	32.0
Region 4 Total	**52**	**30**	**57.7**	**0**	**66**	**23.8**	**10.5**
Region 7							
AET	63	38	60.3	0	39	6.9	4.5
AMI	47	27	57.4	0	83	13.6	8.0
HAP	68	41	60.3	0	99	11.9	5.0
MCH	31	30	96.8	1	61	11.4	5.0
MOL	61	36	59.0	0	78	13.4	7.0
Region 7 Total	**270**	**172**	**63.7**	**0**	**99**	**11.3**	**5.5**
Region 9							
AET	48	28	58.3	0	52	9.4	5.5
AMI	26	15	57.7	1	33	11.0	7.0
HAP	49	30	61.2	1	112	19.1	8.0
MCH	21	16	76.2	3	31	10.4	8.0
MOL	38	23	60.5	1	39	11.7	7.0

ICO and Region	Number of Cases Contacted and Accepting New Patients	Cases Offered a Well-Check Appointment		Appointment Wait Time (Days)[3]			
		Number	Rate[1] (%)	Min	Max	Average	Median
Region 9 Total	**182**	**112**	**61.5**	**0**	**112**	**12.8**	**7.0**

[1] The denominator includes cases that responded to the survey and indicated that at least one practitioner at the location accepted the requested ICO, the MI Health Link Program, and new patients for a routine visit.

[2] Use caution when interpreting results aggregated for All ICOs and Regions, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across ICOs and regions. Survey calls were placed by ICO, region, telephone number, and standardized address; survey responses are unique to the sampled location (i.e., case).

[3] The appointment wait time summary excludes one case that reported an appointment wait time greater than 140 days.

Table 5-9—New Patient Appointment Wait Time in Calendar Days for Nonurgent Symptomatic Visits Among Respondent Cases Accepting the Requested ICO, MI Health Link, and New Patients, by ICO and Region

ICO and Region	Number of Cases Contacted and Accepting New Patients	Cases Offered a Symptomatic Visit Appointment		Appointment Wait Time (Days)[3]			
		Number	Rate[1] (%)	Min	Max	Average	Median
All ICOs and Regions[2]	**508**	**314**	**61.8**	**0**	**89**	**8.7**	**4.0**
Region 1							
UPP	48	25	52.1	0	23	4.7	2.0
Region 1 Total	**48**	**25**	**52.1**	**0**	**23**	**4.7**	**2.0**
Region 4							
AET	19	13	68.4	0	20	2.8	1.0
MER	27	13	48.1	0	31	6.4	1.0
Region 4 Total	**46**	**26**	**56.5**	**0**	**31**	**4.6**	**1.0**
Region 7							
AET	37	30	81.1	0	56	7.2	3.0
AMI	38	23	60.5	0	89	10.7	4.0
HAP	70	44	62.9	0	55	11.9	7.0
MCH	45	29	64.4	0	76	9.1	1.0
MOL	55	35	63.6	0	27	5.3	3.0
Region 7 Total	**245**	**161**	**65.7**	**0**	**89**	**8.9**	**4.0**

ICO and Region	Number of Cases Contacted and Accepting New Patients	Cases Offered a Symptomatic Visit Appointment		Appointment Wait Time (Days)[3]			
		Number	Rate[1] (%)	Min	Max	Average	Median
Region 9							
AET	31	21	67.7	0	70	8.0	2.0
AMI	13	6	46.2	0	40	10.7	6.5
HAP	61	37	60.7	0	64	11.6	7.0
MCH	31	17	54.8	0	19	5.9	5.0
MOL	33	21	63.6	0	42	14.4	7.0
Region 9 Total	**169**	**102**	**60.4**	**0**	**70**	**10.4**	**6.0**

[1] The denominator includes cases that responded to the survey and indicated that at least one practitioner at the location accepted the requested ICO, the MI Health Link Program, and new patients for a nonurgent symptomatic visit.

[2] Use caution when interpreting results aggregated for All ICOs and Regions, as this group includes the total number of survey cases, including unique telephone numbers and/or addresses associated with multiple locations across ICOs and regions. Survey calls were placed by ICO, region, telephone number, and standardized address; survey responses are unique to the sampled location (i.e., case).

[3] The appointment wait time summary excludes one case that reported an appointment wait time greater than 140 days.

Consumer Assessment of Healthcare Providers and Systems Analysis

HCBS CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in all seven ICOs; however, due to the low number of respondents to the survey, individual plan results are unable to be presented or compared across the ICOs. Table 5-10 presents the 2021 HCBS CAHPS mean scores for the MI Health Link program using a scale from 0 to 100. A higher mean score indicates a positive response (i.e., no unmet need) and a lower mean score indicates a negative response. Higher scores indicate that members reported more positive healthcare experiences.

Table 5-10—Summary of 2021 HCBS CAHPS Mean Scores for the MI Health Link Program

	2020 Mean Score	2021 Mean Score
Global Ratings		
Rating of Personal Assistance and Behavioral Health Staff	95.9	96.3
Rating of Homemaker	95.5*	96.8
Rating of Case Manager	96.1	95.6

	2020 Mean Score	2021 Mean Score
Composite Measures		
Reliable and Helpful Staff	90.0	92.4
Staff Listen and Communicate Well	92.7	92.6
Helpful Case Manager	96.5	94.4
Choosing the Services that Matter to You	93.4	92.4
Transportation to Medical Appointments	87.3	89.2
Personal Safety and Respect	94.7	96.6
Planning Your Time and Activities	73.9	73.8
Recommendation Measures		
Recommend Personal Assistance/Behavioral Health Staff	95.9	96.1
Recommend Homemaker	90.9*	95.3
Recommend Case Manager	92.2	93.8
Unmet Need Measures		
Unmet Need in Dressing/Bathing	S	S
Unmet Need in Meal Preparation/Eating	S	S
Unmet Need in Medication Administration	S	84.2*
Unmet Need in Toileting	100.0*	100.0
Unmet Need with Household Tasks	S	S
Physical Safety Measure		
Hit or Hurt by Staff	100.0	100.0

* Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
"S" indicates that there were fewer than 11 respondents for a measure; therefore, results were suppressed.
▲ Indicates the 2021 score is statistically significantly higher than the 2020 score
▼ Indicates the 2021 score is statistically significantly lower than the 2020 score.
If no statistically significant differences were found, no indicator (▲or ▼) is shown.

6. Program-Wide Conclusions and Recommendations

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

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified areas of strength in the program related to the quality of, timeliness of, and access to care and services.

- **Quality**, **Timeliness**, and **Access**
  - Through the PIP activity, the MI Health Link program is focusing its efforts on improving follow-up visits after a hospitalization for mental illness, which should help members manage their mental health and in turn decrease ED utilization for mental illness. All ICOs demonstrated performance strengths through the QIP activity by using appropriate QI tools to conduct a causal/barrier analysis and prioritizing the identified barriers, meeting the requirements for data analysis and implementation of improvement strategies, designing a methodologically sound improvement project, and/or achieving the goal of statistically significant improvement over the baseline rate for the first and/or second remeasurement periods.
  - While performance in all measures within the Behavioral Health domain remained low, with indicator rates ranging between approximately 30 to 70 percent, the MY 2020 statewide rates for all measures increased compared to the MY 2018 statewide rates. These findings indicate that the MI Health Link program is making progress in improving performance for the *Antidepressant Medication Management*, *Follow-Up After Hospitalization for Mental Illness*, and/or *Follow-Up After Emergency Department Visit for Mental Illness* measures.
- **Quality**
  - Through the compliance review activity, five of the seven ICOs demonstrated appropriate oversight of their delegates, including evidence of periodic formal reviews that included a review of all delegated functions; development of CAPs, when necessary; and regular meetings with the delegates which included performance metric reviews. Robust oversight and monitoring of delegated entities strengthen program integrity efforts. This oversight further assures that the subcontractor is meeting the obligations of the ICO under its contract with MDHHS and/or identifies poor performance which may require remediation.
  - As demonstrated through the PMV activity, six of the seven ICOs received a measure designation of *Reportable (R)* for all measures, signifying that these ICOs reported the measures in compliance with MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. While the remaining ICO received a *Do Not Report (DNR)* designation, three of its four measure rates were *Reportable (R)*.

- **Access**
  - All ICOs serving Region 7 and Region 9 except one met all Medicaid and LTSS minimum network requirements, indicating an adequate network of providers is available to render care and services to members residing in these regions. An adequate provider network is imperative to ensure MI Health Link members have timely access to a wide range of PCPs, specialists, and behavioral health and LTSS providers.

Weaknesses

HSAG's comprehensive assessment of the ICOs and the MI Health Link program also identified areas of focus that represent significant opportunities for improvement within the program related to quality of, timeliness of, and access to care and services.[6-1]

- **Quality**
  - As indicated through the PIP activity, while five ICOs' study indicator rates increased from the baseline rate, four ICOs' rates declined between Remeasurement 1 and Remeasurement 2. Only two of the seven ICOs experienced statistically significant improvement in the SFY 2021 performance rate over the baseline rate and/or Remeasurement 1 rate for the study indicator. None of the three ICOs that had identified a performance goal met the goal, indicating that the implemented interventions were ineffective in increasing or sustaining QI. Two ICOs noted that the COVID-19 pandemic impacted member access to behavioral health providers, and that restrictions on in-person medical care impacted the ability to carry out many interventions. Three ICOs had a relatively small eligible population; therefore, a greater increase in the number of members who are numerator compliant must occur for the ICOs to achieve the desired goal.
  - Five of the seven ICOs did not consistently adhere to the Provider Selection individual practitioner credentialing requirements, and four of the seven ICOs did not consistently adhere to the Provider Selection organizational credentialing requirements under 42 CFR §438.214 and MDHHS-specific requirements, as demonstrated through the compliance review activity. Not conducting all required Medicare and Medicaid exclusion checks and/or not obtaining disclosure of ownership and control interest forms were the primary deficiencies across the ICOs. Adherence to federal and MDHHS individual and organizational credentialing requirements ensures that ICOs maintain a provider network which provides quality care and services to members.

[6-1] The COVID-19 pandemic may have had an impact on performance outcomes due to State mandates or instructions to reduce the use of nonemergent and/or nonessential services to slow the spread of COVID-19. Additionally, the pandemic resulted in the closure of medical offices, and due to fear of contracting the virus, members may have chosen not to access routine care, which may have also impacted performance outcomes in SFY 2021.

- **Quality**, **Timeliness**, and **Access**
  - Through the compliance review activity, all seven ICOs demonstrated deficiencies related to Coverage and Authorization of Services, specifically related to the content of the IDN. Strict adherence to authorization of services protocols is necessary to ensure members receive timely notification of a denied service in easily understood language and have access to their appeal and SFH rights. Additionally, none of the seven ICOs consistently adhered to the Appeal Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring that appeals are reviewed and resolved adequately and in a timely manner is essential to maintain access to high-quality care and services. Additionally, the notice to the member about an appeal should be written at the appropriate reading grade level in order for members to understand the action and their rights.
  - As identified through the secret shopper survey, a moderate to large percentage of sampled providers (16 to 71 percent) were unable to be reached, did not accept the ICO, or did not accept and/or recognize the MI Health Link program, which suggests that inaccuracies in the ICOs' provider data are creating barriers for members in accessing needed care. Additionally, of those providers reached, a limited number of providers offered appointment dates and times to the callers, indicating additional barriers to receiving timely care.
- **Quality** and **Access**
  - The statewide averages within the Prevention and Screening domain ranged between approximately 56 and 67 percent, indicating many MI Health Link adult members did not receive a breast cancer screening or colorectal cancer screening; and older adults did not receive advance care planning, a medication review, a functional status assessment, or a pain assessment. Further, the statewide average rate for MY 2020 for the *Breast Cancer Screening* measure and for all *Care for Older Adults* measures decreased from the MY 2018 statewide averages.
  - Within the Diabetes domain, five of the seven MY 2020 statewide averages demonstrated declines in performance compared to the reported MY 2018 statewide averages. These findings indicate that less MI Health Link adult members diagnosed with diabetes had HbA1c testing, HbA1c control, retinal eye exams, and medical attention for nephropathy; and more MI Health Link adult members had poor HbA1c control.
- **Quality** and **Timeliness**
  - As demonstrated through the results of the compliance review activity, six of the seven ICOs did not consistently adhere to the Grievance Systems requirements under 42 CFR §438.228 and MDHHS-specific requirements. Ensuring grievances are reviewed and resolved by the appropriate entity (i.e., the ICO or its delegates) in a timely manner is essential to maintain high-quality care and services and to ensure member retention.
- **Access**
  - While the MY 2020 statewide averages remained relatively high, with indicator rates ranging from approximately 82 to 93 percent, all four MY 2020 statewide averages for the *Adults' Access to Preventive/Ambulatory Health Services* within the Access/Availability of Care domain decreased slightly from the MY 2018 statewide averages, indicating fewer MI Health Link members 20 years of age and older had an ambulatory or preventive care visit with their physician.

Quality Strategy Recommendations for the MI Health Link Program

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

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

In consideration of the goals of the CQS and the comparative review of findings for all activities related to quality, timely, and accessible care and services, HSAG recommends the following QI initiatives, which target the identified, specific goals within MDHHS' CQS.[6-2]

- **Goal 1:** Ensure high-quality and high levels of access to care.
  - **Objective 1.2**: Assess and reduce identified racial disparities.
- **Goal 3:** Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external).
  - **Objective 3.1**: Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
- **Goal 4:** Reduce racial and ethnic disparities in healthcare and health outcomes.
  - **Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.
  - **Objective 4.5**: Expand and share promising practices for reducing racial disparities.
- **Goal 5:** Improve quality outcomes and disparity reduction through value-based initiatives and payment reform.
  - **Objective 5.2**: Align value-based goals and objectives across programs.

[6-2] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy: 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Feb 24, 2022.

To improve program-wide performance in support of the objectives under **Goal 1**, **Goal 3**, **Goal 4**, and **Goal 5**, and to enhance monitoring efforts, improve all members' access to timely care and services, and align value-based goals and objectives across programs, HSAG recommends the following:

- **SFY 2022 PIP**—For SFY 2022, the ICOs will be initiating a QIP topic on racial and ethnic disparities with a focus on reducing existing disparities in access to healthcare or health outcomes. The ICOs should evaluate their performance measure outcomes and target efforts in areas with more prevalent opportunities for improvement (e.g., Diabetes, Prevention and Screening). As part of the PIP process, specifically when the ICOs are in the process of developing PIP interventions, MDHHS should consider the following:
  - To ensure interventions are actionable and will support performance improvement, MDHHS should review the ICOs' planned interventions prior to ICO implementation and provide feedback and/or approval on any planned interventions. MDHHS could also consider whether a state-required intervention would be appropriate for the ICOs to implement. MDHHS could consult with HSAG through these processes.
  - Once interventions have been developed and implemented, MDHHS could consider assessing the ICOs' processes to continuously measure and analyze intervention effectiveness through required quarterly status updates. These updates could include a summary of the ICOs' intervention effectiveness, including any noted barriers, steps to mitigate those barriers, and any revisions that have been made to the interventions to support improvement. This is especially important through the COVID-19 pandemic as ICOs have reported the pandemic as a barrier to successfully improving performance. MDHHS could leverage the HSAG-developed Intervention Progress Form to obtain feedback; however, this recommendation is specifically for MDHHS as MDHHS could provide valuable feedback to the ICOs through its knowledge of the environment in Michigan.
  - MDHHS could also consider having the ICOs share promising practices (e.g., effective interventions) through a dedicated workgroup session to reduce racial disparities and improve performance specifically through the PIP activity. This session could also be used to discuss how COVID-19 was considered when developing interventions that could be successful even through a pandemic.
- **Provider Directory Validation**—Ensuring that members have access to current, accurate provider data is important to streamline access to care and maintain member satisfaction. However, as demonstrated through the secret shopper surveys, inaccuracies were identified in the ICOs' provider data. MDHHS could consider implementing a statewide initiative to improve the accuracy of provider information that is available to members through the provider directories. As part of this initiative, MDHHS could require ICOs to conduct the following:
  - To supplement the NAV activities conducted by HSAG, the ICOs could conduct quarterly secret shopper surveys of rotating provider types to identify provider data inaccuracies. The results of the survey, including the assessed provider types, number of providers surveyed, response rates, and outcomes, should be provided to MDHHS in a report format and include the ICOs' remediation plans for improving provider data.
  - The ICOs could provide MDHHS with an annual provider directory improvement plan that dictates its process to obtain complete and accurate provider data. As part of the improvement

plan, MDHHS could require periodic outreach to providers to validate provider directory information. The improvement plan should include the schedule for outreach and describe the mode of communication to providers, the data elements being confirmed, and the process for providers to confirm/update provider data.

- **MDHHS Collaborative—**MDHHS is responsible for several separate Medicaid managed care programs. These programs are managed separately by multiple teams within MDHHS with minimal program alignment. To support the sharing of best practices and potentially reduce duplicative efforts, HSAG recommends the following:
  - MDHHS should establish a collaborative workgroup whose membership consists of representation from all Medicaid managed care programs. As part of this workgroup, MDHHS should implement a communication channel and protocol for ongoing collaboration between the managed care programs. Through the workgroup, MDHHS could:
    - Determine processes within the programs that could be streamlined to reduce efforts.
    - Designate team members from each program area to report regularly on program-level activities, including successes and challenges, and solicit feedback from other program team members, when necessary, to identify potential opportunities for improvement and program enhancements.

  HSAG is making this recommendation for all Medicaid managed care programs in Michigan.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Quality Improvement Projects[A-1]

Activity Objectives

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

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve QI.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

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

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

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

[A-1] MCEs that participate in Medicare and/or Medicaid are required by regulation to develop and implement quality/performance improvement projects. Medicare plans are required to conduct and report on quality improvement projects (QIPs), and Medicaid plans are required to conduct and report on performance improvement projects (PIPs). Because both Medicare and Medicaid plans are referenced in this report, QIPs and PIPs will be referenced throughout the report.

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

MDHHS requires that each ICO conduct one QIP that is validated by HSAG. For this year's SFY 2021 validation, ICOs submitted Remeasurement 2 data for the state-mandated QIP topic, *Follow-Up After Hospitalization for Mental Illness*. The selected QIP topic uses the NCQA HEDIS *Follow-Up After Hospitalization for Mental Illness (FUH)* methodology. The state-mandated QIP topic addresses follow-up visits with a mental health practitioner following a hospitalization for mental illness. The goal of this QIP is to improve the percentage of discharges for which the member received a follow-up visit within 30 days after discharge. This QIP topic has the potential to improve the health of members with mental illness and reduce readmissions through increasing appropriate follow-up care.

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

Technical Methods of Data Collection and Analysis

Since these QIPs were initiated in SFY 2019, the methodology used to validate QIPs was based on CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-2] When the ICOs implement new QIPs, HSAG will use the CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[A-3]

Using this protocol, HSAG, in collaboration with MDHHS, developed the QIP Submission Form, which each ICO completed and submitted to HSAG for review and evaluation. The QIP Submission Form standardized the process for submitting information regarding QIPs and ensured all CMS EQR Protocol requirements were addressed.

HSAG, with MDHHS' input and approval, developed a QIP Validation Tool to ensure uniform validation of QIPs. Using this tool, HSAG evaluated each of the QIPs according to the CMS EQR Protocol. The HSAG QIP review team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in QI processes. The CMS EQR Protocol identifies 10 steps that should be validated for each QIP. For the SFY 2021 submissions, the ICOs reported Remeasurement 2 data and were validated for Step I through Step X in the QIP Validation Tool.

A-2 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Mar 7, 2022.

A-3 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 7, 2022.

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

Step I. Appropriate Study Topic
Step II. Clearly Defined, Answerable Study Question(s)
Step III. Correctly Identified Study Population
Step IV. Clearly Defined Study Indicator(s)
Step V. Valid Sampling Techniques (if sampling was used)
Step VI. Accurate/Complete Data Collection
Step VII. Sufficient Data Analysis and Interpretation
Step VIII. Appropriate Improvement Strategies
Step IX. Real Improvement Achieved
Step X. Sustained Improvement Achieved

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

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

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

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

- *Met*: High confidence/confidence in reported QIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported QIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Partially Met*.

- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Not Met*.

The ICOs had the opportunity to receive initial QIP validation scores, request additional technical assistance from HSAG, make any necessary corrections, and resubmit the QIP for final validation. HSAG conducted a final validation for any resubmitted QIPs and documented the findings and recommendations for each QIP. Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each ICO. These reports, which complied with 42 CFR §438.364, were provided to MDHHS and the ICOs.

Description of Data Obtained and Related Time Period

For SFY 2021, the ICOs submitted the QIP Remeasurement 2 data (Steps I through VIII) for their QIP topic. The ICOs used the HEDIS measure specifications for the *Follow-Up After Hospitalization for Mental Illness* study indicator. HSAG obtained the data needed to conduct the QIP validation from the ICOs' QIP Summary Forms. These forms provided data and detailed information about each of the QIPs and the activities completed. The ICOs submitted each QIP Summary Form according to the approved timeline. After initial validation, the ICOs received HSAG's feedback and technical assistance, and resubmitted the QIP Summary Forms for final validation. The study indicator measurement period dates for the QIP are listed in Table A-1.

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

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

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each ICO provided to members, HSAG validated the QIPs to ensure they used a sound methodology in their design, implementation, analysis, and reporting of the study's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *Met*, *Partially Met*, or *Not Met*. HSAG further analyzed the quantitative results (e.g., study indicator results compared to baseline, prior remeasurement period results, and study goal, as applicable) and qualitative results (e.g., technical design of the QIP, data analysis, and implementation of improvement strategies) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to ICO Medicaid members.

Performance Measure Validation

Activity Objectives

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

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

HSAG validated a set of performance measures that were selected by MDHHS for validation. Table A-2 lists the performance measures calculated by the ICOs for CY 2020 (i.e., January 1, 2020 through December 31, 2020), along with the performance measure number. The performance measures are numbered as they appear in the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements* [A-4] and the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements: Michigan-Specific Reporting Requirements*[A-5] technical specification manuals.

Table A-2—Performance Measures for Validation

Performance Measure	Description
Core Measure 9.1	*Emergency Department (ED) Behavioral Health Services Utilization*
Core Measure 9.3	*Minimizing Institutional Length of Stay*
MI2.6	*Timely Transmission of Care Transition Record to Health Care Professional*
MI5.6	*Care for Adults—Medication Review*

[A-4] The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements*. Available at: https://www.cms.gov/files/document/corereportingreqscy2021.pdf. Accessed on: Mar 9, 2022.

[A-5] The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements: Michigan-Specific Reporting Requirements.* Available at: https://www.cms.gov/files/document/mireportingrequirements02262021.pdf. Accessed on: Mar 9, 2022.

Technical Methods of Data Collection and Analysis

HSAG developed the PMV protocol for ICOs in accordance with the *CMS External Quality Review (EQR) Protocols, October 2019.*[A-6] The CMS Core Reporting Requirements (issued November 2, 2020, and effective as of January 1, 2021) and Michigan-Specific Reporting Requirements (issued February 26, 2021) documents provide the reporting specifications that ICOs were required to follow.

The CMS EQR Protocol 2 identifies key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of the data:

- **ISCAT**—The ICOs were required to submit a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure reporting. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures**—ICOs that reported the performance measures using computer programming language were required to submit source code for each performance measure being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the state-defined performance measure specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). ICOs that did not use computer programming language to report the performance measures were required to submit documentation describing the actions taken to report each measure.
- **Medical record documentation—**As applicable, the ICOs submitted the following documentation for review: medical record hybrid tools, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from the hybrid sample to ensure the accuracy of the hybrid data being abstracted by the ICOs. HSAG followed CMS EQR Protocol 2 and NCQA guidelines to validate the integrity of the ICOs' medical record review validation (MRRV) processes and used the MRRV results to determine if the findings impacted the performance measure rates' audit results.
- **Performance measure reports**—HSAG also reviewed the ICOs' SFY 2020 performance measure reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The ICOs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG

[A-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2022.

reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each measure for data verification.

Performance Measure Activities

HSAG conducted PMV virtually with each ICO. HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key ICO staff members involved in the PMV activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and report the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether denominators were identified correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key ICO staff members familiar with the processing, monitoring, and reporting of the performance measures. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance measures was generated. HSAG performed PSV to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **PSV**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each ICO provided HSAG with measure-level detail files which included the data the ICOs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the ICOs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and virtual review, these data were also reviewed for verification, both live and using screen shots in the ICOs' systems, which provided the ICOs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final measure reporting. Instances could exist in which a sample case is acceptable based on clarification during the virtual review and follow-up documentation provided by the ICOs. Using this technique, HSAG assessed the ICOs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the ICOs have system documentation which supports that the measures appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it

is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the virtual meeting and reviewed the documentation requirements for any post-virtual review activities.

Virtual Review Activities

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

Final Validation Results

Based on the validation activities described above, HSAG provided each ICO a validation designation for Core Measure 9.1, Core Measure 9.3, MI2.6, and MI5.6. The ICO received a validation designation of either *Reportable (R)*, *Do Not Report (DNR)*, *Not Applicable (NA)*, or *Not Reported (NR)* for each performance measure. Table A-3 includes a definition of each validation designation.

Table A-3—Measure-Specific Validation Designations

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

According to the protocol, the validation designation for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measure by more

than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of *R*.

Description of Data Obtained and Related Time Period

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

Table A-4—Reporting Periods

Performance Measure	Reporting Period
Core Measure 9.1	Quarter 1: January 1, 2020–March 31, 2020 Quarter 2: April 1, 2020–June 30, 2020 Quarter 3: July 1, 2020–September 30, 2020 Quarter 4: September 1, 2020–December 31, 2020
Core Measure 9.3	CY 2020
MI2.6	CY 2020
MI5.6	CY 2020

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each ICO provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. HSAG further analyzed the qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to ICO Medicaid members.

Performance Measure Rates

Activity Objectives

HSAG completed a review of each ICO's performance measure data that was audited by an organization licensed to conduct NCQA HEDIS Compliance Audits™,[A-7] for 2020, as provided by MDHHS, for the SFY 2021 EQR.

[A-7] HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Technical Methods of Data Collection and Analysis

MDHHS and CMS required each ICO to contract with an organization licensed by NCQA to conduct HEDIS Compliance Audits and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS MY 2020 performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR.

Description of Data Obtained and Related Time Period

In accordance with the three-way contract between CMS, MDHHS, and each ICO, HEDIS data must be reported consistent with Medicare requirements. The ICOs are required to report a combined set of core measures annually. For this EQR, HSAG reviewed HEDIS MY 2020 reported data.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each ICO provided to members, HSAG evaluated the results for each performance measure that was assigned an audit finding of *Reportable*, *Small Denominator*, *No Benefit*, *Not Reportable*, *Not Required*, *Biased Rate*, or *Un-Audited*. HSAG further analyzed the results of the ICO's HEDIS MY 2020 performance measure rates and 2020 performance levels based on comparisons to HEDIS MY 2018 performance levels and MY 2020 statewide averages to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of, timeliness of, and access to care and services furnished to ICO Medicaid members.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the ICOs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the seven ICOs contracted with MDHHS to deliver services to MI Health Link members.

The current cycle of compliance reviews for the ICOs is outlined in Table A-5. MDHHS elected to conduct a full compliance review in Year One (SFY 2019) and a CAP review in Year Two (SFY 2020).

SFY 2021 marks the third year of the three-year cycle, and MDHHS requested that HSAG conduct a focused compliance review targeting specific areas of opportunity identified during the SFY 2019 and SFY 2020 reviews.

Table A-5—Current Three-Year Cycle (SFY 2019–SFY 2021)

Year One (SFY 2019)		Year Two (SFY 2020)	Year Three (SFY 2021)
Full Compliance Review	**Associated Federal Citation**	**CAP Review**	**Focused Compliance Review**
Standard I—Availability of Services	§438.206	Review of standards/elements that received a *Not Met* score during the SFY 2019 review. The standards/elements reviewed varied between each ICO.	Review of focus areas identified during the SFY 2019 and SFY 2020 reviews consisting of a thorough review of case files in select program areas.
Standard II—Assurance of Adequate Capacity and Services	§438.207		
Standard III—Coordination and Continuity of Care	§438.208		
Standard IV—Coverage and Authorization of Services	§438.210		
Standard V—Provider Selection	§438.214		
Standard VI—Confidentiality	§438.224		
Standard VII—Grievance and Appeal Systems	§438.228 and Subpart F		
Standard VIII—Subcontractual Relationships and Delegation	§438.230		
Standard IX—Practice Guidelines	§438.236		
Standard X—Health Information Systems[1]	§438.242		
Standard XI—Quality Assessment and Performance Improvement	§438.330		

[1] The Health Information Systems standard includes an assessment of each ICO's information systems capabilities.

The SFY 2021 focused compliance review consisted of a case file review, including an information systems review, in specific program areas. The case file reviews and their associated standards are displayed in Table A-6.

Table A-6—Case File Reviews and Associated Standards

Case File Reviews	Associated Standard
Service Authorization Denials	Standard IV—Coverage and Authorization of Services
Individual Practitioner Credentialing Organizational Credentialing	Standard V—Provider Selection
Member Grievances Member Appeals	Standard VII—Grievance and Appeal Systems
Subcontractors	Standard VIII—Subcontractual Relationships and Delegation

HSAG conducted a comprehensive desk review of the case files submitted by the ICOs. After the desk review, HSAG conducted a virtual interview session with each ICO. ICOs were required to present case files, provide information system demonstrations, and answer questions posed by the HSAG review team. The goal of this focused compliance review was to assess each ICO's compliance with the implementation of federal and State contract requirements in select program areas.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance reviews of the ICOs, HSAG developed standardized case file review tools for use in the focused compliance reviews. The content of the tools was based on applicable federal regulations; applicable accreditation standards; and the requirements set forth in the three-way contract agreement among CMS, the State of Michigan, and the ICOs. The review processes and scoring methodology used by HSAG in evaluating the ICOs' compliance were consistent with the CMS publication, *Protocol 3. Review of Compliance With Medicaid and Chip Managed Care Regulations*: *A Mandatory EQR-Related Activity*, October 2019.[A-8]

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

Pre-Virtual Review Activities:

- Collaborated with MDHHS to develop the focused compliance review methodology and case file review tools.
- Prepared and forwarded to each ICO a detailed timeline and description of the focused compliance review process.
- Generated a sample of cases for service authorization denials, individual practitioner credentialing, organizational credentialing, member grievances, member appeals, and subcontractors.
- Conducted a desk review of supporting documentation the ICOs submitted to HSAG.
- Followed up with the ICOs, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual interview sessions and provided the agenda to the ICOs to facilitate preparation for HSAG's review.

Virtual Review Activities:

- Conducted an opening conference, with introductions and a review of the virtual case file review agenda and logistics.
- Conducted a review of service authorization denials, credentialing, grievances, appeals, and subcontractor case files.

[A-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid And Chip Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 7, 2022.

- Conducted a review of the data systems that the ICO used in its operation, applicable to the program areas under review.
- Interviewed ICO key program staff members.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

For the case files reviewed and through the interview process with the ICO, HSAG identified program areas that did not demonstrate compliance with State or federal requirements. The ICOs were required to develop a CAP to remediate any noncompliant program areas.

Description of Data Obtained and Related Time Period

To assess the ICO's compliance with federal regulations and contract requirements, HSAG reviewed supporting documentation for each case file and considered interview responses from key ICO staff members, when applicable.

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

Table A-7—Description of Data Sources and Time Periods

Data Obtained	Time Period to Which the Data Applied
Service authorization denial case files	Case closed (or the review process was completed) between October 1, 2020–February 12, 2021
Individual practitioner credentialing case files	
Organization credentialing case files	
Member grievance case files	
Member appeal case files	
Subcontractor written contracts, and oversight and monitoring documentation	Subcontractors serving the MI Health Link program as of the initiation of the focused compliance review activity
Interviews with ICO key staff members	April 5–9, 2021

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each ICO individually, HSAG used the results of the comprehensive case file reviews for six program areas. For any program area that was determined to be out of compliance, the ICOs were required to submit a CAP.

HSAG determined each ICO's substantial strengths and weaknesses as follows:

- Strength—Any program area that did not require a CAP
- Weakness—Any program area that required a CAP

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality and timeliness of, and access to care and services that the ICO provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the ICO's Medicaid members.

Network Adequacy Validation

Activity Objectives

HSAG's SFY 2021 NAV validated the ICOs' Medicaid and LTSS networks applicable to the fiscal year from October 1, 2020, through September 30, 2021, using time/distance and provider capacity analyses for the 25 Medicaid and LTSS provider types listed below. All provider types were evaluated for capacity network requirements,[A-9] and provider types identified with an asterisk (*) were also evaluated for time and distance network requirements.

- Adaptive Medical Equipment and Supplies
- Adult Day Program*
- Assistive Technology Devices
- Assistive Technology Van Lifts and Tie Downs
- Chore Services
- Community Transition Services
- Dental (preventive and restorative)*
- Environmental Modifications
- Expanded Community Living Supports
- Eye Examinations (provided by optometrists)*
- Eye Wear (providers dispensing eyeglasses and contact lenses)*
- Fiscal Intermediary
- Hearing Aids*
- Hearing Examinations*
- Home-Delivered Meals
- Maternal Infant Health Program (MIHP) Agency*
- Medical Supplies (e.g., incontinence supplies)
- Non-Emergency Medical Transportation

[A-9] Facilities with multiple practitioners at one physical address were counted as multiple provider choices available for the ICO's enrollees in the region.

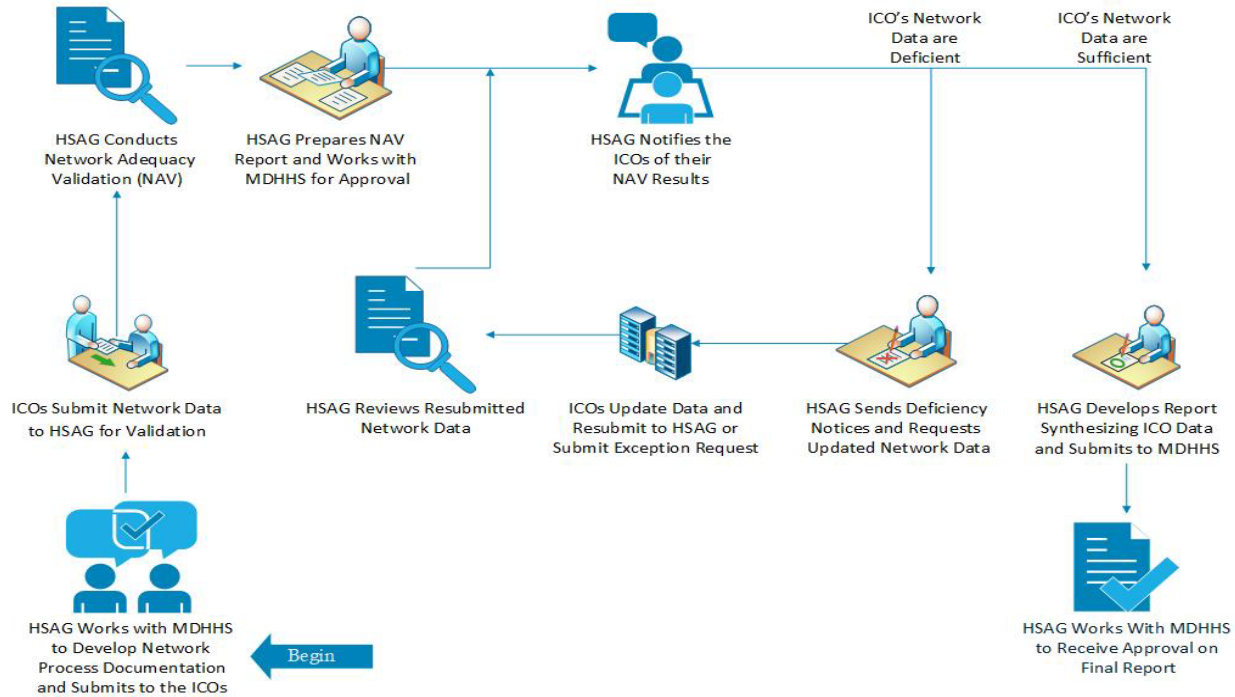
- Non-Medical Transportation (waiver service only)
- Personal Care Services
- Personal Emergency Response System
- Preventive Nursing (non-agency and agency)
- Private Duty Nursing (non-agency and agency)
- Respite
- Skilled Nursing Home

Technical Methods of Data Collection

Using an MDHHS-approved ICO Document Request and MI Health Link NAV Microsoft Excel Template, each ICO submitted a region-specific electronic listing to HSAG and MDHHS of all providers and facilities that had a signed contract with the ICO to participate in MI Health Link. Each ICO also submitted an electronic listing of all members assigned to the ICO for the specified MI Health Link region.

Beginning in the lower-left corner, Figure A-1 summarizes HSAG's SFY 2021 NAV process.

Figure A-1—SFY 2021 NAV Process



Each ICO submitted member and network provider data files to HSAG during an October 2020 pilot phase. Based on data-related findings during the pilot phase, HSAG and MDHHS updated the data submission instructions and template in January 2021, requesting that the ICOs resubmit member and provider data during the February 2021 initial validation phase. During February 2021, ICOs also submitted provider network data for seven additional provider types for MDHHS' informational use only; these data were not included in time/distance or provider capacity calculations.

Following HSAG's initial NAV analyses using the February 2021 data, HSAG and MDHHS asked applicable ICOs to supply additional data files to HSAG during April and May 2021 to address network deficiencies.

After each data submission, HSAG validated that the ICOs' data files reflected a provider network that met the MI Health Link minimum network requirements for each Medicaid and LTSS provider type:

- For the seven provider types that typically require members to travel to receive services at a provider's location (i.e., provider types with travel time and distance requirements), HSAG assessed whether or not each ICO's region-specific network offered a choice of at least two providers for each provider type with sufficient capacity to accept members and coverage that required the ICO member to not travel more than a 30-mile radius or for no more than 30 minutes based on driving under normal traffic conditions.[A-10]
  - An ICO's region-specific results failed to meet the minimum network requirements for instances in which fewer than 90 percent of the ICO's members residing in the region were within 30 miles of driving distance from the nearest two providers, or when fewer than two providers within 30 miles of driving distance were contracted with the ICO to serve MI Health Link members residing in the region (i.e., zero providers or one provider).
  - HSAG supplied travel time results for MDHHS' information only.
- For the 18 provider types that rendered services in the member's home or for services that originated at the member's home, HSAG assessed whether or not each ICO's region-specific network ensured a choice of at least two providers.

Following each data submission phase, HSAG calculated region-specific time/distance results and capacity results for each provider type and ICO. HSAG then compared these analytic results to MDHHS' minimum network standards and identified the ICOs that failed to meet the minimum network requirements. HSAG reviewed the NAV results with MDHHS, then worked with MDHHS to assemble and finalize ICO-specific notices that included the ICO's region-specific NAV results and a notice of deficiencies or no deficiencies.

[A-10] If a region did not contain an adequate number of providers to meet the travel time and distance requirement, MDHHS required the ICO to submit an exception request to HSAG. Historically, this situation is not unusual for Adult Day Program and MIHP Agency provider types. MDHHS directed HSAG to deem the ICO compliant with the travel time and distance requirement if the ICO's exemption request indicates that the ICO attempted to contract or hold contracts with all available providers in the region.

Upon receiving a deficiency notice, MDHHS expected the ICOs to work to come into compliance for any region-specific NAV finding for which a provider type failed to meet the minimum network requirement. For provider types that failed to meet the minimum network requirements, the ICOs were allowed one additional opportunity to submit revised provider data to demonstrate compliance with network standards.

If an ICO was deficient based on the February 2021 data, the ICO was allowed to request an exception or extension to the network standard from MDHHS. MDHHS anticipated exception requests for instances in which an adequate number of providers were not available in the region.

Description of Data Obtained and Related Time Period

During February 2021 (i.e., the initial NAV phase), ICOs supplied HSAG and MDHHS with the following data:

- Member data reflecting all members assigned to the ICO as of February 1, 2021
- Provider data reflecting the 25 Medicaid and LTSS provider types for all providers and facilities that had a signed contract with the ICO to participate in the MI Health Link program as of February 1, 2021

Each ICO also submitted data for the following seven additional provider types for MDHHS' informational use only, and these data were not included in NAV analyses:

- Adult Foster Care
- Homes for the Aged
- Individual providers affiliated with each provider group/agency for the following services that may be rendered by agencies and/or individual providers:[A-11]
  - Expanded Community Living Supports
  - Personal Care Services
  - Preventive Nursing
  - Private Duty Nursing
  - Respite

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each ICO provided to members, HSAG calculated region-specific time/distance results and capacity results for each provider type and ICO. HSAG then compared these analytic results to MDHHS' minimum network standards and identified the ICOs that failed to meet the minimum network requirements. HSAG

[A-11] All agency-level data for *Expanded Community Living Supports*, *Personal Care Services*, *Preventive Nursing Services*, *Private Duty Nursing*, and *Respite* were included in HSAG's NAV and underwent processing identical to provider and enrollee data file processing.

determined each ICO's substantial strengths and weaknesses by considering the degree to which the ICO met minimum network requirements for its regional geographical area(s) and the exceptions or extensions determined by MDHHS.

Secret Shopper Survey

Activity Objectives

The primary purpose of the SFY 2021 secret shopper survey was to collect appointment availability information for routine well-checks or nonurgent symptomatic primary care visits among new patients enrolled with an ICO under the MI Health Link program. As a secondary survey objective, HSAG evaluated the accuracy of selected provider data elements related to members' access to primary care. Specific survey objectives included the following:

- Determine whether PCP service locations accepted patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligned with the ICOs' provider data.
- Determine whether PCP service locations accepted new MI Health Link patients for the requested ICO and the degree to which new patient acceptance aligned with the ICOs' provider data.
- Determine appointment availability with the sampled PCP service locations for routine well-checks and nonurgent symptomatic visits.

Technical Methods of Data Collection and Analysis

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

Each ICO submitted PCP data to HSAG, reflecting individual practitioners[A-12] actively enrolled with the ICO to serve members in the MI Health Link program as of March 15, 2021, and specializing in family practice, general practice, geriatric medicine, internal medicine, or obstetrics/gynecology (OB/GYN).[A-13] Out-of-state PCPs located in Indiana, Ohio, or Wisconsin and within a reasonable distance from the

[A-12] Following HSAG's review of the ICOs' provider data, MDHHS opted to exclude individual practitioners with specialties other than physical health primary care and/or women's health, even if the ICO indicated that the individual provider functions as a PCP for selected MI Health Link enrollees.

[A-13] In the MI Health Link Program, PCPs may also include individual practitioners with other physical health sub-specialties who also perform primary care functions in a federally qualified health center (FQHC), rural health clinic (RHC), public health department, or other community clinic. Because the secret shopper survey was conducted by service location, rather than asking about individual practitioners, FQHCs, RHCs, and other community clinics appeared in the sample frame due to the presence of PCP records for individual practitioners affiliated with these locations.

Michigan State border were included in the study. HSAG randomly selected survey cases by ICO from a de-duplicated list of unique provider locations.[A-14]

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

Several limitations and analytic considerations must be noted when reviewing secret shopper telephone survey results:

1. Survey calls were conducted at least four weeks following HSAG's April 2021 receipt of each ICO's provider data, resulting in the possibility that provider locations updated their contact information with the ICO prior to HSAG's survey calls.
2. The COVID-19 PHE and subsequent healthcare service disruptions continued through 2021. Providers' offices may have required longer time periods between requests and potential appointments due to a variety of reasons related to the PHE that may include, but are not limited to, staffing shortages, fewer appointments for new patients to accommodate a backlog of appointments for existing patients, or the ability to offer fewer appointments to allow for enhanced office cleaning procedures.
3. The number of calendar days until the soonest available appointment is based on appointments requested with the sampled provider location. Cases were counted as being unable to offer an appointment if the survey respondent offered an appointment at a different location from the address on the sampled provider location. As such, survey results may underrepresent timely appointments for situations in which MI Health Link enrollees are willing to travel to an alternate location.
4. Survey findings were compiled from self-reported responses supplied to HSAG's callers by providers' office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication (e.g., the ICO's online provider directory or web-based appointment scheduling portals for individual provider locations).
5. To maintain the secret nature of the survey, callers posed as ICOs' MI Health Link enrollees who were not existing patients at the sampled provider locations and did not have specific health conditions or comorbidities that may have justified shorter appointment wait times. As such, survey results may not represent appointment timeliness among ICOs' MI Health Link enrollees who are existing patients with these provider locations and/or have chronic health conditions that warrant appointments within a limited time period.
6. Due to the nature of the secret shopper survey, callers were not permitted to supply personal information or details that may have been required by providers' offices to access appointment scheduling systems.
7. ICOs are responsible for ensuring that MI Health Link enrollees have access to a provider location within MDHHS' minimum appointment timeliness requirements, rather than requiring that each

[A-14] HSAG identified unique provider locations within each ICO and region using the telephone number and United States Postal Service (USPS) standardized address. The number of individual providers associated with each unique provider location varied.

individual provider or location offer appointments within specified time frames. As such, extended appointment wait times from individual provider locations should be considered in the context of the ICO's processes for assisting MI Health Link enrollees who require timely appointments.

MDHHS CAP Requirements—The ICOs were required to review the survey findings to identify the cases that require development and implementation of a CAP. At a minimum, the remediation plan was expected to include the following:

- In cases in which HSAG was unable to reach the provider, the ICO must have addressed provider data deficiencies identified during the survey (e.g., incorrect or disconnected telephone number, fax/busy signal, nonmedical facility, location does not exist, location permanently closed, location unavailable). The ICOs were required to use a variety of strategies to improve the accuracy of their PCP provider data, including but not limited to outreach among contracted providers, reconciliation of internal provider data against the SFY 2021 Secret Shopper Survey results, and review of provider data oversight processes and reports.
- In cases in which the provided data were inaccurate and HSAG obtained corrected phone numbers, the ICOs were required to validate the information and update their data and member directory accordingly.
- In cases in which the location did not accept the ICO or did not accept MI Health Link, to ensure providers' awareness of the ICO and MI Health Link Program, the ICOs were required to provide MDHHS with evidence of training offered to providers' offices regarding the ICO and MI Health Link Program.
- In cases in which it was indicated that the location did not accept new patients, the ICOs were required to validate the finding and update their data and member directory accordingly.
- In some cases in which HSAG was able to reach the provider and an appointment was offered at an excessively far out date, the ICOs were required to evaluate and address the expectations with the provider for the new patient wait time to assure timely access to services.

The CAP implementation and reporting consisted of the following two steps:

1. Remediation Report—In this step, the ICOs were to complete the Remediation Steps and Responsible Party sections of the CAP template.
2. Final Completion Report—In this step, the ICOs were to complete the Date Completed and Evidence sections of the CAP template. The ICOs were required to provide evidence that remediations were completed.

The ICOs were also expected to extend any training and oversight activities implemented for the CAP to providers not included in the survey sample.

Description of Data Obtained and Related Time Period

HSAG completed the survey calls during May and June 2021. Prior to analyzing the results, HSAG reviewed the responses to ensure complete and accurate data entry.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each ICO provided to members, HSAG analyzed the results of the activity to determine each ICO's substantial strengths and weaknesses by assessing (1) which PCP service locations accepted patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligned with the ICOs' provider data, (2) whether PCP service locations accepting MI Health Link for the requested ICO accepted new patients and the degree to which new patient acceptance aligned with the ICOs' provider data, and (3) appointment availability with the sampled PCP service locations for routine well-checks and nonurgent symptomatic visits.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

The goal of the HCBS CAHPS Survey is to gather direct feedback from Medicaid members receiving HCBS about their experiences and the quality of the LTSS they receive. The survey provides state Medicaid agencies with standard individual experience metrics for HCBS programs that are applicable to all populations served by these programs, including frail elderly and people with one or more disabilities, such as physical disabilities, cognitive disabilities, intellectual impairments, or disabilities due to mental illness.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the HCBS CAHPS Survey. The method of data collection for the surveys was via computer assisted telephone interviewing, known as CATI. Members could complete the survey over the telephone in either English or Spanish. Prior to survey administration, a pre-notification letter was sent out to members alerting them to expect a telephone call to complete the survey, and assured members that the survey was sponsored by the federal government and endorsed by MDHHS. For the HCBS CAHPS Survey, adult members included as eligible for the survey were 21 years of age or older as of February 28, 2021, and were continuously enrolled in a plan during the three-month measurement period (December 1, 2021, to February 28, 2021), with no gaps in enrollment. They also must have had received at least one qualifying personal care service **or** were currently enrolled in the MI Health Link HCBS waiver and received respite care at home, chore services, or expanded community living supports.

The survey questions were categorized into various measures of member experience. The survey included 96 core questions that yielded 19 measures. These measures included three global ratings, seven composite measures, three recommendation measures, five unmet need measures, and one physical safety

measure. The global ratings reflect overall member experience with the personal assistance and behavioral health staff, homemaker, and case manager. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Helpful Case Manager* or *Personal Safety and Respect*). The recommendation measures evaluate whether a member would recommend their personal assistance and behavioral health staff, homemaker, or case manager to family and friends. The unmet need measures assess whether certain needs are not being met due to lack of staff. The physical safety measure evaluates whether any staff hit or hurt the member.

Description of Data Obtained and Related Time Period

The survey was administered to eligible adult members in the MI Health Link ICOs from May to July 2021.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each ICO provided to members, HSAG calculated mean scores for each measure. Mean scores were transformed to a 0 to 100 scale for each measure and then compared to scores from 2020 to review and evaluate any statistically significant differences. A higher mean score indicates a positive response (i.e., no unmet need), and a lower mean score indicates a negative response.