State Fiscal Year 2022 External Quality Review Technical Report

for Integrated Care Organizations

April 2023

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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 Behavioral and Physical Health and Aging Services Administration (BPHASA)[1-1] within MDHHS administers and oversees the Michigan Medicaid managed care program, including the MI Health Link program, which contracts with six 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) 2022 are displayed in Table 1-1.

Table 1-1—ICOs in Michigan

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

[1-1] MDHHS announced the creation of BPHASA effective March 21, 2022. The BPHASA combined Michigan's Medicaid office, services for aging adults and community-based services for adults with intellectual and developmental disabilities, serious mental illness, and substance use disorders under one umbrella within MDHHS. For more information refer to: https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/behavioral-and-physical-health-and-aging-services.

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).[1-2] 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 the quality, timeliness, and accessibility of 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 2022 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, timeliness, and accessibility of 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)[1-3]	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	Protocol 4. Validation of Network Adequacy*

[1-2] 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: Feb 24, 2023.

[1-3] 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
	in coverage areas to deliver healthcare services to its managed care members.	
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-4] 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 Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2022 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 conclusions and actionable, state-specific recommendations, when applicable, for MDHHS to drive progress toward achieving the goals of Michigan's Comprehensive Quality Strategy (CQS)[1-5] and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members.

Table 1-3—MI Health Link Program Substantive Findings

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1—Ensure high quality and high levels of access to care	**Conclusions:** The results of the PMV activity confirmed that MDHHS and the MI Health Link program are making improvement in achieving Goal #1 of the CQS in the following areas: • Preventive and Screening domain: – Three of the four indicator rates for the *COA—Care for Older Adults* measure demonstrated an improvement in performance from the previous year. The indicator rates improved between 4.9 and 8.22 percentage points. • Cardiovascular Conditions domain: – All four indicator rates for the *CBP—Controlling High Blood Pressure*, *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*, and *SPC—Statin Therapy for Patients With Cardiovascular Disease* measures demonstrated an	☒ Quality ☒ Timeliness ☒ Access

[1-4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-5] 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, 2023.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	improvement in performance from the previous year. The indicator rates improved between 1.37 and 5.66 percentage points. • Diabetes domain: – Five of the six indicator rates for the *CDC—Comprehensive Diabetes Care* measure demonstrated an improvement in performance from the prior year. The indicator rates improved between 1.01[1-6] and 4.15 percentage points. – Both indicator rates for the *SPD—Statin Therapy for Patients With Diabetes* measure demonstrated a slight improvement in performance from the previous year. The indicator rates improved between 0.31 and 0.78 percentage points. • Musculoskeletal domain: – The indicator rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure demonstrated an improvement in performance from the previous year. The indicator rate improved by 9.15 percentage points. • Behavioral Health domain: – Both indicator rates for the *AMM—Antidepressant Medication Management* measure demonstrated an improvement in performance from the previous year. The indicator rates improved between 4.63 and 5.69 percentage points. – Both indicator rates for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness* measure demonstrated an improvement in performance from the previous year. The indicator rates improved between 2.19 and 2.47 percentage points. • Access/Availability of Care domain: – All four indicator rates for the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure demonstrated an improvement in performance from the previous year. The indicator rates improved between 0.59 and 2 percentage points. – The indicator rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure demonstrated an improvement in performance from the previous year. The indicator rate improved by 10.94 percentage points. Additionally, the network requirements analysis of the NAV activity demonstrated that, overall, the MI Health Link program had a	

[1-6] The indicator rate for the *CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)* measure decreased by 1.01 percentage points, which demonstrates better performance.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	sufficient network of long-term services and supports (LTSS) providers, with most MDHHS-established minimum network requirements being met. However, the results of the analysis also suggest some members may not have reasonable access to some provider types as three ICOs failed to meet all minimum network requirements for provider capacity and time/distance. These provider types included Adult Day Program, Assistive Technology—Van Lifts and Tie Downs, Dental, Hearing Aids, Hearing Examinations, Maternal Infant Health Program (MIHP) Agency, and Non-Emergency Medical Transportation (NEMT). While, in most cases, the ICOs contracted with all available providers in their region(s), the lack of available providers may prevent members from accessing care and services. The results of the secret shopper survey also suggested that members may be experiencing barriers in accessing dental services. Overall, a high volume of dental providers reported not accepting an ICO, the MI Health Link program, and/or new patients. Many of the ICOs delegate the delivery of dental services to a dental subcontractor, which is likely a contributing factor to why dental providers reported they are not accepting the ICO or the MI Health Link program. Additionally, of the dental providers who reported accepting an ICO, the MI Health Link program, and new patients, only 60.4 percent of callers were offered an appointment. Considering all surveyed providers, only 16.7 percent resulted in an offered appointment. While the average appointment wait time was 37 days, in many instances, the maximum wait time was significantly above MDHHS' appointment time standard of eight weeks for initial dental appointments. These results indicate opportunities to mitigate barriers to ensure dental services are accessible and available. However, MDHHS required all ICOs to implement a corrective action plan (CAP) to remediate the deficiencies identified through the survey. Further, the PMV activity results also demonstrated continued opportunities to enhance access to quality care as several Healthcare Effectiveness Data and Information Set (HEDIS®)[1-7] measures declined in performance from the previous year. Within the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, and Access/Availability of Care domains, 10 indicator rates declined in performance from the previous year. The measures with the greatest percentage point decline (i.e., greater than 3 percentage points) included *BCS—Breast Cancer Screening*, *PCE—Pharmacotherapy*	

[1-7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Management of COPD [Chronic Obstructive Pulmonary Disease] *Exacerbation—Systemic Corticosteroid*, and *FUH—Follow-Up After Hospitalization for Mental Illness*. **Recommendations:** The current secret shopper survey activity reports on the minimum, maximum, average, and median appointment wait times. However, MDHHS' contract with the ICOs has defined appointment wait time standards according to the type of requested services or care (e.g., urgent, routine, specialty). In future secret shopper activities, MDHHS could consider including in the methodology an evaluation of each ICO's compliance in adherence to the corresponding appointment time standard. Additionally, MDHHS required each ICO to develop a CAP to address the findings of the dental provider secret shopper survey activity. As MDHHS has elected to conduct another dental provider secret shopper survey activity in SFY 2023, MDHHS could consider additional penalties if improvement in performance is not realized. Further**,** HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #1.	
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** MDHHS requires the ICOs to develop person-centered care plans referred to as Individual Integrated Care and Supports Plans (IICSPs). The IICSP must be developed by the member, the member's ICO care coordinator, and the member's Integrated Care Team (ICT) and incorporate the following elements: assessment results; summary of the member's health; the member's preferences for care, supports, and services; the member's prioritized list of concerns, goals and objectives, and strengths; specific services including amount, scope and duration, providers, and benefits; the plan for addressing concerns or goals; the person(s) responsible for specific interventions, monitoring, and reassessment; and the due date for the intervention and reassessment. The ICOs' adherence to IICSP requirements and the person-centered planning process was evaluated through the compliance review activity. However, all ICOs were cited for deficiencies for not developing IICSPs that captured all required components. IICSPs must be developed through the person-centered planning process and include the necessary information to assist the member in achieving personally defined outcomes in the most integrated settings, ensure delivery of services in a manner that reflects	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	personal preferences and choices, and contribute to the assurance of health and welfare.[1-8] Additionally, MDHHS requested that the CAHPS Home and Community-Based Services (HCBS CAHPS Survey) be conducted, which gathers direct feedback from members receiving HCBS about their experiences and the quality of LTSS they receive. Eleven of the 15 reportable measures had median scores above 90 (using a scale of 0 to 100), with three of those measures above 95, indicating many members reported having positive experiences. The measures with the highest scores included *Rating of Personal Assistance and Behavioral Health Staff*, *Rating of Case Manager*, and *Not Hit or Hurt by Staff*. However, the *Reliable and Helpful Staff* measure experienced a statistically significant decline in the median score compared to the previous year's results. Further, the lowest performing measure was *Planning Your Time and Activities* with a score of 73.5, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. **Recommendations:** While HCBS CAHPS Survey scores could be reported for the MI Health Link program, ICO-specific scores were unable to be presented due to the low number of respondents to the survey. MDHHS should continue to work with HSAG to develop innovative approaches to increase the number of members participating in the survey during the 2023 HCBS CAHPS Survey activity. Additionally, while MDHHS requires IICSPs include the member's preferences in social activities, in an effort to increase positive member experiences in *Planning Your Time and Activities*, MDHHS could consider adding more specificity in its contract with the ICOs detailing the information that should be included in the IICSP related to social activities and community inclusion. The person-centered planning process could also include the development of a calendar, when appropriate, that outlines routines, activities of daily living, and social activities chosen by the member to be used as tool for the member and care manager to identify opportunities to increase	

[1-8] Centers for Medicare & Medicaid Services. System-Wide Person Centered Planning. Available at: https://www.medicaid.gov/sites/default/files/2019-12/system-wide-person-centered-planning.pdf. Accessed on: Feb 24, 2023.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	engagement in meaningful activities of daily living, including social activities. Further, the compliance review activity identified continued opportunities for improvement in the development of IICSPs during the current three-year cycle and the previous three-year cycle of reviews. Given this continued trend, MDHHS could consider developing a standard IICSP template in which all ICOs are required to use. This template could be developed in partnership with the ICOs with the intent to increase adherence to MDHHS' IICSP content requirements. Lastly, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #2.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)	**Conclusions:** MDHHS requires each ICO to employ a care coordination platform supported by web-based technology that manages communication and information flow regarding referrals, care transitions, and care delivery; facilitates timely and thorough coordination and communication among the member, ICO, prepaid inpatient health plan (PIHP), primary care provider (PCP), LTSS supports coordinators, and other providers; provides prior authorization information for services; and houses the Integrated Care Bridge Record (individualized member health record). The care coordination platform also allows ICO care coordinators, supports coordinators, and providers to post key updates and notify ICT members. Each ICO must also have a mechanism to alert ICT members of emergency department (ED) use or inpatient admissions using the electronic care coordination platform or other methods such as telephonic notification. Effective care coordination and communication among managed care programs, members, and providers should positively impact the health outcomes for all Medicaid populations, including MI Health Link members. Additionally, MDHHS is able to monitor care coordination and communication of care through the PMV and compliance review activities. For example, one performance indicator included as part of the PMV activity measured the number of members for whom a transition record was transmitted timely to a PCP or other sites of care when a member was discharged from an inpatient facility. Another performance indicator measured the number of members who had a medication review conducted by a prescribing practitioner or a clinical pharmacist. All ICOs were compliant with State and federal specifications when reporting data for these measures. Further, transition from an inpatient setting back to home often results in poor care coordination, including communication lapses	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication, and follow-up needs.[1-9] However, the results of the PMV activity confirm several opportunities to improve transition of care processes. While three measure indicator rates, *TRC—Transitions of Care—Notification of Inpatient Admission*, *TRC—Transitions of Care—Receipt of Discharge Information*, and *TRC—Transitions of Care—Medication Reconciliation Post-Discharge*, improved in performance from the previous year, the rates remained relatively low (13.11, 12.77, and 43.96, respectively). Additionally, while the indicator rate for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure declined slightly in performance from the previous year, it had the highest rate (74.60) among the indicator rates for the *TRC—Transitions of Care* measure. Lastly, through the compliance review, MDHHS is able to monitor whether the ICOs have processes to ensure care coordinators have access to and are informed of all adverse benefit determinations (ABDs) to service authorization requests. However, four ICOs did not have mechanisms in place to ensure care coordinators received communication of ABDs rendered by a delegate. Communication of timely service authorization denials is necessary for care coordinators to effectively coordinate care and ensure a member's service needs are being met. **Recommendations:** Currently, ICOs contract with PIHPs to deliver Medicare behavioral health services; however, Medicaid-covered behavioral health services are carved out of the ICO benefit package and instead are delivered by the PIHPs through contracts directly with MDHHS. As such, the service delivery of the MI Health Link program is not fully integrated, and ICOs may not be fully aware of their members' service utilization. MDHHS could consider possible options to fully integrate all behavioral health services under the ICO benefit package or develop standardized mechanisms to ensure Medicaid behavioral health service utilization is communicated to the ICOs to assist in coordinating care and services for members. Additionally, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #3.	

[1-9] National Committee for Quality Assurance. Transitions of Care (TRC). Available at: https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed on: Feb 24, 2023.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** For SFY 2022, the ICOs were responsible for initiating a new QIP to address healthcare disparities within their population. While MDHHS did not mandate a statewide topic, the ICOs were instructed to identify existing racial or ethnic disparities within the regions and populations served and determine plan-specific topics and performance indicators. Four of the six ICOs received an overall validation of *Met*, indicating those ICOs designed methodologically sound QIPs. The remaining two ICOs had opportunities for improvement related to their sampling method and/or conducting accurate statistical testing for comparison between the two population subgroups. Through the QIP activity, the ICOs' implemented interventions are aimed at eliminating those racial and ethnic disparities. Additionally, MDHHS requires each ICO's quality program to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. Each ICO's QIP and other activities or initiatives targeting populations experiencing health disparities should be reported through the annual quality program evaluation. The ICOs' quality programs will be reviewed during the future SFY 2023 compliance review activity. Further, MDHHS has partnered with the Michigan Public Health Institute (MPHI) to develop an annual Expanding Equity in MI Health Link report. The ICOs submitted performance data on a select list of measures and the aggregated statewide rates are presented for all racial/ethnic populations enrolled in the MI Health Link program. The goal of the project is to continue to improve quality in the MI Health Link program while decreasing overall disparities that may be present. **Recommendations:** MDHHS has required QIPs to support the reduction in racial and ethnic disparities. As the QIPs progress and the ICOs identify or change interventions, MDHHS should continue to review the planned interventions to confirm that these interventions specifically target the disparate populations and have the likelihood of removing the barriers that prevent members' access to needed services. Additionally, MDHHS could consider how EQR activity results could be stratified by race/ethnicity. For example, stratifying the results of the NAV activity to determine if members with different races/ethnicities have equal access to Medicaid providers. Further, MDHHS should continue to leverage the information gleaned from the annual Expanding Equity in MI Health Link report	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	to implement statewide initiatives focused on national and Michigan-specific priorities. Lastly, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #4.	
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** MDHHS has implemented a quality withhold policy in which CMS and MDHHS withhold a percentage of their respective components of the capitations payment. The withheld amounts are then repaid subject to each ICO's performance consistent with the established quality thresholds. MDHHS' contract with the ICOs identify the quality withhold measures for each year of the demonstration and include a combination of CMS/state-defined measures, HEDIS, CAHPS, and CMS data. In SFY 2022, which relied on measurement year (MY) 2021 data, all ICOs received a portion of their withheld funds. **Aetna**, **HAP**, **Molina**, and **UPHP** received 75 percent of withheld funds, while **AmeriHealth** and **Meridian** received 50 percent. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #5, which may include the quality withhold measures and benchmarks.	☒ Quality ☐ Timeliness ☐ Access

2. Overview of the Integrated Care Organizations

Managed Care in Michigan

BPHASA within MDHHS administers and oversees the Michigan Medicaid managed care programs. Effective in March 2021, BPHASA combined Michigan's Medicaid office, services for aging adults and community-based services for adults with intellectual and developmental disabilities, serious mental illness, and substance use disorders under one umbrella within MDHHS. BPHASA is also the designated State Unit on Aging. Prior to March 2021, the Michigan Medicaid managed care programs were administered by separate divisions within MDHHS. The creation of BPHASA integrates MDHHS teams that focus on aging and long-term care issues and allows BPHASA to develop innovative policies that benefit Michigan and its residents. The restructure also builds on the administration's existing efforts to deliver services to adults with mild to moderate mental illness. Table 2-1 displays the Michigan managed care programs and the MCE(s) responsible for providing services to members.

Table 2-1—Medicaid Managed Care Programs in Michigan

Medicaid Managed Care Program	MCEs
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)
Managed Long-Term Services and Supports (MLTSS), including: • MI Health Link Demonstration • MI Choice Waiver Program • Program of All-Inclusive Care for the Elderly (PACE)	ICOs Prepaid Ambulatory Health Plans (PAHPs, also referred to as waiver agencies) PACE organizations
Dental Managed Care Programs, including: • Healthy Kids Dental • Pregnant Women Dental • HMP Dental	Dental PAHPs
Behavioral Health Managed Care	PIHPs

MI Health Link Program

The MI Health Link program was developed in 2014 in response to the CMS Financial Alignment Initiative (FAI) 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 2022 review period, MDHHS contracted with six 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

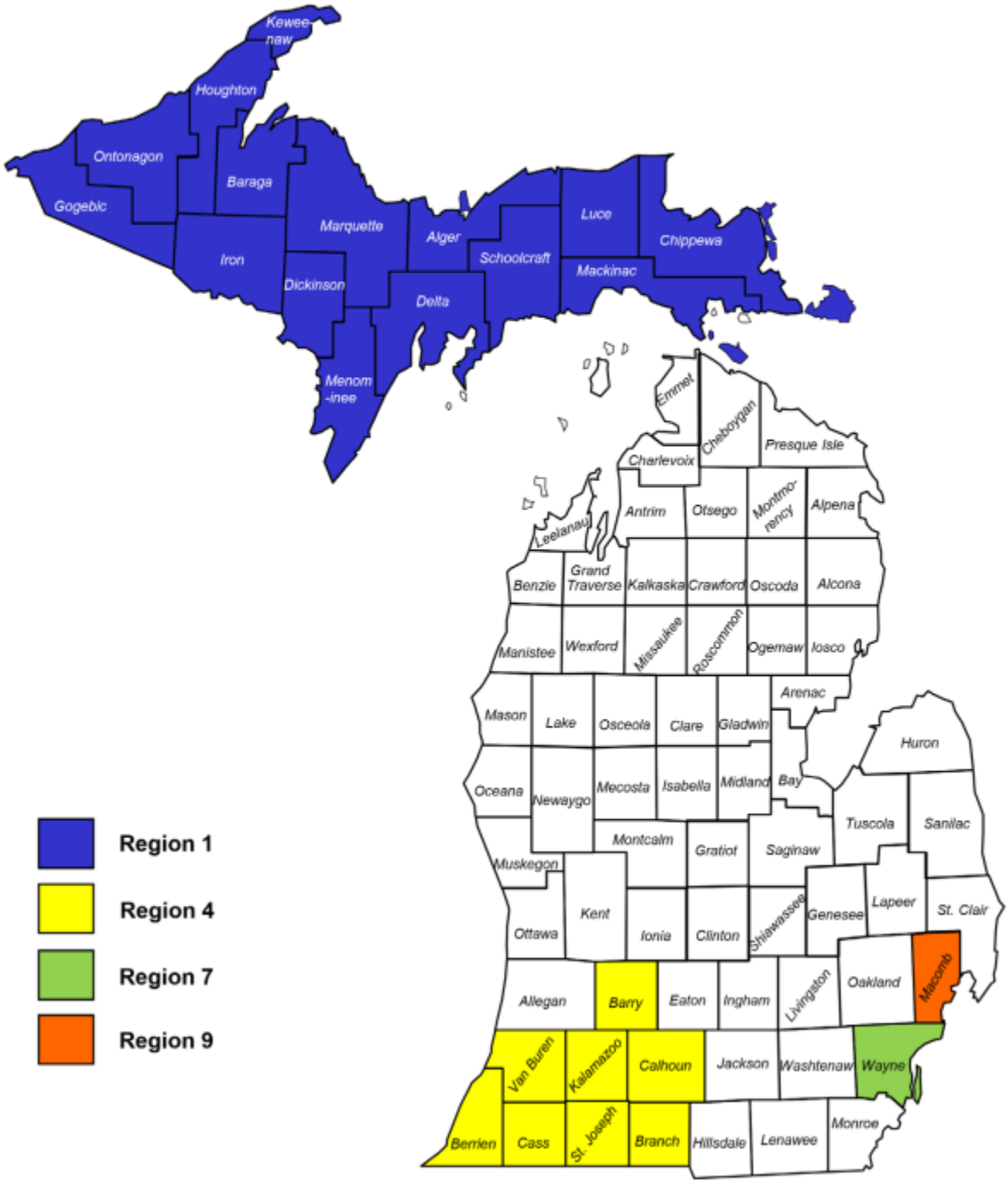
ICO	Covered Services[2-1]	Service Area/Regions Served[2-2]	Member Enrollment[2-3]
AET	MI Health Link benefits include: • No co-pays for in-network services, including medications • No deductibles for in-network services • Medications • Care coordination • Behavioral healthcare • Dental care • Hearing 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	9,509
AMI		Regions 7 and 9	3,374
HAP		Regions 7 and 9	4,835
MER		Regions 4, 7, and 9	9,282
MOL		Regions 7 and 9	12,483
UPHP		Region 1	4,901

2-1 Michigan Department of Health and Human Services. *MI Health Link*. Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html. Accessed on: Feb 24, 2023.

2-2 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: Feb 24, 2023.

2-3 December 2022 enrollment data were provided by MDHHS.

Figure 2-1—ICO Regions[2-4]



[2-4] Michigan Department of Community Health. *MI Health Link Regions*. Available at: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder93/Folder1/Folder193/MI_Health_Link_Counties.pdf?rev=e625ee0535d44526aa94b885636b3e47&hash=3305162FEE2BB48400F71D25B885FB68. Accessed on: Feb 24, 2023.

Quality Strategy

The 2020–2023 MDHHS CQS provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including CHCP, LTSS, dental programs, and behavioral health managed care. 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.

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

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

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

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

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

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

Quality Initiatives and Interventions

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

- **Accreditation**—MCEs, including all MHPs and ICOs and some 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 2022 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 2022 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 2022 QIP validation activity, the ICOs initiated new QIP topics that focused on disparities within their populations, as applicable, and reported baseline data for each specified performance indicator. HSAG conducted validation on the QIP Design (Steps 1 through 6) and Implementation (Steps 7 and 8) stages of the selected QIP topic for each ICO in accordance with CMS' EQR protocol for the validation of QIPs (CMS EQR Protocol 1). Table 3-1 outlines the selected QIP topics and performance indicators as defined by each ICO.

Table 3-1—QIP Topics and Performance Indicators

ICO	QIP Topic	Performance Indicators
AET	*Comprehensive Diabetes Care—HbA1c* [Hemoglobin A1c] *Test: Decreasing the Disparity Between White and African American Members*	1. Comprehensive Diabetes Care—HbA1c Test: Black or African American (Non-Hispanic or Latino).
		2. Comprehensive Diabetes Care—HbA1c Test: White (Non-Hispanic or Latino).
AMI	*Transitions of Care, Medication Reconciliation Post-Discharge*	1. Medication Reconciliation Post-Discharge for Disparate Group: Members Identified as Black/African American.
		2. Medication Reconciliation Post-Discharge for Comparison Group: Members Identified as White.
HAP	*Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members*	1. The percentage of African American members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
		2. The percentage of Caucasian members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
MER	*Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes*	1. HEDIS statin therapy for patients with diabetes adherence performance—African American/Black population—all regions.
		2. HEDIS SPD adherence performance—White population—all regions.
MOL	*Addressing Disparities in Controlling Blood Pressure*	1. Controlling high blood pressure—Black.
		2. Controlling high blood pressure—White.
UPHP	*Annual Dental Care*	1. Annual dental visit for UPHP American Indian/Alaskan Native MI Health Link (MHL) members.
		2. Annual dental visit for UPHP White MHL members.

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 the *Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements* (Medicare-Medicaid Plan [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 2022 PMV, the ICOs[3-3] were required to submit a completed Information Systems Capabilities Assessment Tool (ISCAT) that provided information on their information systems (IS); processes used for collecting, storing, and processing data; and processes used for performance measure reporting. HSAG subsequently validated 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) 2021 (i.e., January 1, 2021, through December 31, 2021), along with the performance measure number. The performance measures are numbered as they appear in the MMP Core 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*

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, 2023.

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/mireportingrequirements02282022.pdf-0. Accessed on: Feb 24, 2023.

3-3 While Michigan Complete Health calculated and reported all performance measures for CY 2021, Michigan Complete Health merged with Meridian effective January 1, 2022. Therefore, results for Michigan Complete Health are not included within the SFY 2022 EQR technical report.

Performance Measure Rates

MDHHS and CMS also required each ICO to contract with an NCQA-certified HEDIS vendor and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS MY 2021 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
Respiratory Conditions
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator
Cardiovascular Conditions
CBP—Controlling High Blood Pressure
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%
Diabetes
CDC—Comprehensive Diabetes Care—Hemoglobin A1c 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%

HEDIS Measure
Musculoskeletal Conditions
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
*PSA—Non-Recommended PSA-Based Screening of Older Men**
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**
*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 2022 commenced a new three-year cycle of compliance reviews. The compliance reviews for the MDHHS-contracted ICOs comprise 14 program areas, referred to as standards, that correlate to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also include applicable state-specific contract requirements and areas of focus identified by MDHHS. HSAG conducted a review of the first seven standards in Year One (SFY 2022). For SFY 2023, the remaining seven standards will be reviewed (Year Two of the cycle). In Year Three (SFY 2024), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2022 and SFY 2023 compliance reviews. Table 3-4 outlines the standards reviewed over the three-year compliance review cycle. The compliance review activity was conducted in accordance with CMS' EQR protocol for the review of compliance with Medicaid and CHIP managed care regulations (CMS EQR Protocol 3).

Table 3-4—Current Three-Year Compliance Review Cycle (SFY 2022–SFY 2024)

Standard	Associated Federal Citations[1]	Year One (SFY 2022)	Year Two (SFY 2023)	Year Three (SFY 2024)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of ICOs' implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal systems standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

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 2022 activities assessing different aspects of the ICOs' network adequacy:

1. A NAV analysis of the ICOs' alignment with minimum time/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 dental providers contracted with one or more ICOs to serve individuals enrolled in the MI Health Link program (i.e., the secret shopper survey).

Time/Distance and Provider Capacity Analysis

To initiate the NAV activity, each ICO submitted member and network provider data files and exception requests to HSAG in September 2022, followed by an initial data file review. Following the initial data file review, HSAG requested that applicable ICOs submit updated data files and/or exception[3-4] requests during October 2022 to address potential data quality and validity concerns prior to completing the NAV analyses. Based on the NAV findings, MDHHS requested an additional data resubmission of the network data files and exception requests from both **Aetna** and **Meridian** in December 2022. The provider types included in the validation are displayed in Table 3-5.

Table 3-5—MI Health Link Provider Types

Provider Type
Provider Types With Travel Time/Distance Network 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
MIHP Agency
Provider Types With Capacity-Based Network Requirements
Adaptive Medical Equipment and Supplies

[3-4] MDHHS allowed ICOs to request exceptions to the minimum network requirements for any provider types for which there are known network access gaps. 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.

Provider Type
Assistive Technology—Devices
Assistive Technology—Van Lifts and Tie Downs
Chore Services
Community Transition Services
Environmental Modifications
Expanded Community Living Supports (ECLS)
Fiscal Intermediary
Home Delivered Meals
Medical Supplies
NEMT
Non-Medical Transportation (waiver service only)
Personal Care Services
Personal Emergency Response System
Preventive Nursing Services
Private Duty Nursing
Respite
Skilled Nursing Home

Secret Shopper Survey

During March and April 2022, HSAG completed a secret shopper telephone survey of dental offices contracted with one or more ICOs under the MI Health Link program to collect appointment availability information for preventive dental care visits for the 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 dental service locations accept patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligns with the ICOs' provider data.
2. Determine whether dental service locations accepting MI Health Link for the requested ICO accept new patients and the degree to which new patient acceptance aligns with the ICOs' provider data.
3. Determine appointment availability with the sampled dental service locations for preventive dental care.

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

For SFY 2022, HSAG administered the 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 2022 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 Premier Plan

Validation of Quality Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Aetna**'s QIP (i.e., the QIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-6 displays the overall validation status and the baseline results for the performance indicators. The QIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-6—Overall Validation Rating for AET

QIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Comprehensive Diabetes Care—HbA1c Test: Decreasing the Disparity Between White and African American Members	*Partially Met*	Comprehensive Diabetes Care—HbA1c Test: Black or African American (Non-Hispanic or Latino).	77.6%			Yes
		Comprehensive Diabetes Care—HbA1c Test: White (Non-Hispanic or Latino).	90.4%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Aetna**'s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black or African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-7 displays the interventions, as available, initiated by the ICO to support achievement of the QIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-7—Baseline Interventions for AET

Intervention Descriptions	
Directed a member outreach call campaign targeting members with no PCP visit in the last year and a diagnosis of diabetes.	Conducted outreach to PCPs who have treated members who do not have a completed HbA1c test for the year. Also reminded providers of those with a gap in care for an HbA1c test.

Intervention Descriptions	
Care management associate attempted to contact unable-to-reach members following multiple outreach attempts. Outreach includes alternative methods such as mailed letters, text messaging, and phone calls. Research for additional contact information was done through provider and downstream entity outreach.	

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 QIP 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's Aim statement set the focus of the project and the performance indicators were well defined. [**Quality**]

Strength #2: Aetna used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers, and interventions were implemented in a timely manner. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Aetna received a *Met* score for only 75 percent of the requirements in the Design stage of the project, indicating gaps in the ICO's documentation which led to the overall validation rating of *Partially Met*. [**Quality**]

Why the weakness exists: Aetna had opportunities for improvement within the analysis and reporting of plan-specific data used to select the QIP topic and the reporting of the sampling method used in the generation of the performance indicators. Specifically, **Aetna** did not conduct or report statistical testing between the subpopulations to confirm an existing disparity and did not report an accurate eligible population size. Additionally, without an accurate eligible population size, the margin of error and whether the sample was generalizable to the eligible population could not be verified.

Recommendation: HSAG recommends that **Aetna** review the QIP Completion Instructions to ensure that all requirements for each completed evaluation element have been addressed. **Aetna** should seek technical assistance from HSAG throughout the QIP process to address any questions or concerns.

Performance Measure Validation

Performance Results

HSAG evaluated **Aetna**'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 (i.e., claims and encounters), care coordination system (i.e., tracking and management of care transition record transmissions), medication review system (i.e., tracking and management of medication reviews), hybrid data collection and review, or data integration.

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

Table 3-8—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 3-9 shows each of **Aetna**'s audited HEDIS measures, rates for HEDIS MY 2020 and HEDIS MY 2021 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2021 with HEDIS MY 2020, and the HEDIS MY 2021 MI Health Link statewide average performance rates. HEDIS MY 2021 measure rates performing better than the statewide average are notated by green font.

Table 3-9—Measure-Specific Percentage Rates for AET

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening	50.55	47.16	−3.39	52.74
COL—Colorectal Cancer Screening	46.23	50.12	+3.89	56.03
COA—Care for Older Adults—Advance Care Planning	44.28	29.93	−14.35	41.07
COA—Care for Older Adults—Medication Review	46.23	58.64	+12.41	74.85
COA—Care for Older Adults—Functional Status Assessment	63.50	78.10	+14.60	58.42
COA—Care for Older Adults—Pain Assessment	46.72	81.75	+35.03	75.25
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	20.14	21.37	+1.23	22.93
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	74.11	78.43	+4.32	68.65
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	89.34	88.73	−0.61	89.67
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure	51.58	54.99	+3.41	60.52
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	86.67	100	+13.33	95.25
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	80.76	78.85	−1.91	82.00
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	74.89	76.02	+1.13	84.22
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing	78.10	84.43	+6.33	87.50
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**	51.82	44.77	−7.05	43.53
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	38.69	48.42	+9.73	49.06
CDC—Comprehensive Diabetes Care—Eye Exam	43.31	52.80	+9.49	57.33
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	92.46	88.56	−3.90	90.01
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	48.66	52.80	+4.14	60.82
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	74.02	74.37	+0.35	76.83
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	75.53	75.89	+0.36	82.46

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Musculoskeletal Conditions				
OMW—Osteoporosis Management in Women Who Had a Fracture	0.00	5.88	+5.88	16.12
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	65.67	69.19	+3.52	75.06
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	56.22	52.53	−3.69	60.75
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	17.52	20.95	+3.43	26.13
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	44.53	47.97	+3.44	50.22
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	41.38	43.93	+2.55	33.87
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	59.48	58.88	−0.60	51.71
Medication Management and Care Coordination				
TRC—Transitions of Care—Notification of Inpatient Admission	4.62	0.49	−4.13	13.11
TRC—Transitions of Care—Receipt of Discharge Information	3.41	2.19	−1.22	12.77
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	71.53	74.70	+3.17	74.60
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	17.52	38.69	+21.17	43.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	18.15	18.27	+0.12	24.68
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**	33.60	34.83	+1.23	31.94
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**	18.22	17.05	−1.17	17.81
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	5.35	5.93	+0.58	5.50
*DAE—Use of High-Risk Medications in Older Adults—Total**	21.57	21.39	−0.18	21.56
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	78.70	81.40	+2.70	84.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	91.27	92.50	+1.23	93.49
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	88.14	90.19	+2.05	91.45

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	87.38	89.13	+1.75	90.77
IET—Initiation of Alcohol and Other Drug Dependence Treatment	41.81	34.72	−7.09	48.59
IET—Engagement of Alcohol and Other Drug Dependence Treatment	9.26	6.94	−2.32	6.53
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	1.55	1.24	−0.31	1.17
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	1.25	1.40	+0.15	1.20

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

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: In alignment with HSAG's recommendation from the SFY 2021 PMV, **Aetna** worked with its certified HEDIS software vendor to program MI5.6 sample logic into its annual hybrid sample process, which was already in place for **Aetna**'s HEDIS reporting. **Aetna** therefore improved the accuracy of its sampling process by removing the manual sorting step which caused an error in the SFY 2021 PMV. [**Quality**]

Strength #2: Aetna demonstrated continued strength thorough its claims completeness factor calculation process, providing assurances that **Aetna**'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** 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), ensuring the accuracy of data element B. [**Quality** and **Timeliness**]

Strength #3: In the Prevention and Screening domain, **Aetna**'s rates for the *COA—Care for Older Adults—Pain Assessment* and *Functional Status Assessment* measure indicators increased by more than 14 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI

Health Link statewide average, suggesting strength and improvement in adult members 66 years and older having pain and functional status assessments conducted during the measurement year. As the population ages, physical and cognitive function can decline, and pain becomes more prevalent. Screening of elderly patients is effective in identifying functional decline.[3-5] [**Quality** and **Access**]

Strength #4: In the Cardiovascular Conditions domain, **Aetna**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure increased by more than 13 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in adults' use of a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-6] [**Quality**, **Access**, and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Although **Aetna** improved the MI5.6 rate since SFY 2021, it continued to have a low MI5.6 rate in comparison to the other ICOs' reported rates. [**Quality** and **Timeliness**]

Why the weakness exists: **Aetna** did not leverage any of the medication reviews conducted by a clinical pharmacist.

Recommendation: HSAG recommends that **Aetna** prioritize leveraging its ICO clinical pharmacist to conduct medication reviews for members, as discussed during the virtual audit review. Leveraging clinical pharmacists to complete medication reviews will support timely quality care for members and provide **Aetna** with additional MI5.6 numerator compliant members, improving its overall rate.

Weakness #2: **Aetna** was required to update its Core Measure 9.3 source code and to resubmit Core Measure 9.3 data to Health Plan Management System (HPMS). [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **Aetna** did not update its source code to align with the Core Measure 9.3 Frequently Asked Questions (FAQs) that were released in December 2021, and **Aetna** incorrectly identified members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original institutional facility admission (IFA) discharge.

Recommendation: HSAG recommends that **Aetna** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **Aetna** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and

[3-5] 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 27, 2023.

[3-6] 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 27, 2023.

involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

Weakness #3: **Aetna** could not use data from one of its delegated PIHPs in the MI2.6 sample. [**Quality** and **Timeliness**]

Why the weakness exists: The PIHP had incorrectly reported a discharge status code that indicated the members were still inpatient; therefore, **Aetna** could not appropriately identify if a member had been discharged for inclusion in MI2.6.

Recommendation: Although not significantly impactful to the eligible population and therefore even less impactful to the denominator sample and the numerator, the MI2.6 data were still underreported as a result of this issue. HSAG therefore recommends that **Aetna** issue a formal CAP to the PIHP to ensure it provides accurate data reflecting members' hospital discharges so that **Aetna** can include these members in future MI2.6 reporting.

Weakness #4: For 33 of the 45 reported HEDIS measures (73 percent), **Aetna**'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, 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, Musculoskeletal Conditions, Behavioral Health, 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** was not performing as well as the other ICOs in some measures within these domains.

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

Weakness #5: In the Prevention and Screening domain, **Aetna**'s rate for the *COA—Care for Older Adults—Advance Care Planning* measure indicator decreased by more than 14 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that adult members 66 years of age and older were not always having advance care planning conducted to help optimize quality of life. Consideration should be given to an individual's own choices about end-of-life care; advance care plans should be executed.[3-7] [**Quality**]

Why the weakness exists: The rate for the *COA—Care for Older Adults—Advance Care Planning* measure indicator decreasing by more than 14 percentage points from MY 2020 to MY 2021 suggests that barriers exist for having advanced care planning during the measurement year for some adults 66 years of age and older. Potential barriers noted by **Aetna** were access to care due to the

[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 27, 2023.

coronavirus disease 2019 (COVID-19) public health emergency (PHE) and difficulty with medical record retrieval for hybrid measure rates.

Recommendation: HSAG recommends that **Aetna** conduct a root cause analysis or focused study to determine why some adults 66 years and older are not having advanced care planning completed. If it is determined that the COVID-19 PHE impacted performance for the *COA—Care for Older Adults—Advance Care Planning* measure indicator, **Aetna** should proactively alter its approach to advance care planning for its adult members. Additionally, if difficulty with medical record retrieval is identified as a root cause that impacted the rate for the *COA—Care for Older Adults—Advance Care Planning* measure indicator, **Aetna** should work toward strengthening its medical record retrieval process. Upon identification of a root cause, **Aetna** should implement appropriate interventions to improve the performance related to the *COA—Care for Older Adults—Advance Care Planning* measure indicator. **Aetna** 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 education).

Weakness #6: In the Access/Availability of Care domain, **Aetna**'s rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator decreased by more than 7 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults with a new episode of alcohol or other drug dependence were not always receiving timely treatment. Treatment, including medication-assisted treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-8] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator decreasing by more than 7 percentage points from MY 2020 to MY 2021 suggests that barriers exist for adults with a new episode of alcohol or other drug dependence to access timely treatment.

Recommendation: HSAG recommends that **Aetna** conduct a root cause analysis or focused study to determine why some adults with a new episode of alcohol or other drug dependence were not accessing timely treatment. Upon identification of a root cause, **Aetna** should implement appropriate interventions to improve the performance related to the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator. **Aetna** 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 education).

Weakness #7: **Aetna** identified a discrepancy with Core Measure 9.3 data element C after data had already been finalized in HPMS, following the conclusion of the SFY 2022 PMV activity.

Why the weakness exists: As a result of findings from the SFY 2022 PMV activity, **Aetna** updated its Core Measure 9.3 source code and resubmitted Core Measure 9.3 data to HPMS. Approximately

[3-8] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

four months following the resubmission of final data, **Aetna** identified that it did not rerun its code to recalculate data element C based on the updated members in data element A; therefore, data element C was reported incorrectly.

Recommendation: While **Aetna** indicated that it has since created a dashboard to help mitigate this type of oversight for future reporting, HSAG recommends that **Aetna** ensure all appropriate quality checks and assurance steps are in place in order to avoid this issue from recurring in the future. While this recommendation is related to appropriately recalculating Core Measure 9.3 data element C at any point when data element A is updated, this recommendation also applies to submission of any Michigan-specific and MMP Core measures to the FAI DCS and HPMS.

Compliance Review

Performance Results

Table 3-10 presents **Aetna**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Aetna** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Aetna**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-10—Standard Compliance Scores for AET

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2022)		
Standard I—Disenrollment: Requirements and Limitations[2]	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**65%**
Standard III—Emergency and Poststabilization Services[2]	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**92%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**73%**
Standard VII—Coverage and Authorization of Services	§438.210	**89%**
Year Two (SFY 2023)		
Standard VIII—Provider Selection	§438.214	—
Standard IX—Confidentiality	§438.224	—
Standard X—Grievance and Appeal Systems	§438.228	—
Standard XI—Subcontractual Relationships and Delegation	§438.230	—

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Standard XII—Practice Guidelines	§438.236	—
Standard XIII—Health Information Systems[3]	§438.242	—
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	—
Year Three (SFY 2024)		
Review of ICO's implementation of Year One and Year Two CAPs		

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[3] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

Dash (—): The ICO's compliance with Year Two standards will be reviewed and scored during the SFY 2023 compliance review activity.

Table 3-11 presents **Aetna**'s scores for each standard evaluated during the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Aetna**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2022 compliance review activity demonstrated how successful **Aetna** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-11—SFY 2022 Standard Compliance Scores for AET

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations[1]	9	6	6	0	3	**100%**
Standard II—Member Rights and Member Information	23	23	15	8	0	**65%**
Standard III—Emergency and Poststabilization Services[1]	13	13	13	0	0	**100%**
Standard IV—Availability of Services	13	13	12	1	0	**92%**
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
Standard VI—Coordination and Continuity of Care	31	30	22	8	1	**73%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Coverage and Authorization of Services	28	28	25	3	0	**89%**
Total	**121**	**117**	**97**	**20**	**4**	**83%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

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 achieved full compliance in the Assurances of Adequate Capacity and Services program area, demonstrating that the ICO maintained and monitored an adequate provider network that was sufficient to provide adequate capacity for all services (e.g., preventive, primary care, and specialty care) for its membership. [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: Aetna received a *Not Met* score for eight elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Aetna's member materials did not contain all required member rights, member materials critical to obtaining services did not comply with language requirements for taglines, the member handbook did not contain all mandatory components, there was no documentation available to support timely notice to members would occur due to a significant change impacting members' access to services and information about the managed care program, the provider directory did not include all required components, and the provider directory and formulary drug list were not available in a machine-readable format. Contributory factors included, but were not limited to, misinterpretation of model materials, instructions, and federal rule.

Recommendation: As **Aetna** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **Aetna** ensure it consistently uses the most current version of the model member materials.

Weakness #2: Aetna received a score of *Not Met* for eight elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Aetna did not consistently and timely review program-level data and utilization data to assign an initial risk stratification to each member, consistently and timely complete health risk screenings for its members to assess their healthcare needs, ensure all Level II assessment referrals and Level II assessments were completed timely, provide care coordinator contact information to members who refused the IICSP, or ensure all required components were included in the IICSP.

Recommendation: As **Aetna** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members. These efforts should support improved member health outcomes.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG's NAV results indicated that **Aetna** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. For Region 4, **Aetna** submitted additional data updates and final requests for exceptions to address provider types not meeting the minimum network requirements. MDHHS approved **Aetna**'s requested exception for the Adult Day Program and MIHP Agency provider types. Table 3-12 presents **Aetna**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception determinations.

Table 3-12—SFY 2022 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/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 Aids	*Met*	*Met*	*Met*
Hearing Examinations	*Met*	*Met*	*Met*
MIHP Agency	*Exception 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*
ECLS	*Met*	*Met*	*Met*
Environmental Modifications	*Met*	*Met*	*Met*
Fiscal Intermediary	*Met*	*Met*	*Met*
Home-Delivered Meals	*Met*	*Met*	*Met*
Medical Supplies (e.g., incontinence supplies)	*Met*	*Met*	*Met*
NEMT	*Met*	*Met*	*Met*
Non-Medical Transportation (waiver services only)	*Met*	*Met*	*Met*
Personal Care Services	*Met*	*Met*	*Met*
Personal Emergency Response System	*Met*	*Met*	*Met*
Preventive Nursing Services	*Met*	*Met*	*Met*
Private Duty Nursing	*Met*	*Met*	*Met*
Respite	*Met*	*Met*	*Met*

Provider Type	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
Skilled Nursing Home (report only beds certified for both Medicare and Medicaid)	*Met*	*Met*	*Met*
Percentage of Total Requirements Met*	**92%**	**100%**	**100%**

*The denominator for Percentage of Total Requirements Met includes all 25 standards regardless of whether an exception request was granted.

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 in Region 4, **Aetna** either met the minimum network requirements or was granted an exception to the minimum network requirements from MDHHS. [**Access**]

Strength #2: Aetna met all Medicaid and LTSS minimum network requirements for Region 7, indicating that **Aetna** maintains an adequate network for MI Health Link members in this region. [**Access**]

Strength #3: Aetna met all Medicaid and LTSS minimum network requirements for Region 9, indicating that **Aetna** maintains an adequate network for MI Health Link members in this region. [**Access**]

Weaknesses and Recommendations

Weakness #1: HSAG identified no specific weaknesses for **Aetna** based on the SFY 2022 NAV, as **Aetna** demonstrated that it contracted with all available providers for the provider types that did not meet minimum network requirements.

Why the weakness exists: Not applicable (NA)

Recommendation: Aetna should maintain an internal data verification process to continually identify and contract with Adult Day Program and MIHP Agency provider types as they become available 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.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 331 sampled provider locations (i.e., "cases") for **Aetna**, with an overall response rate of 65.3 percent (216 cases) among **Aetna**'s three MI Health Link regions. Region 4 had the highest response rate, and Region 9 had the lowest response rate. Table 3-13 summarizes the SFY 2022 secret shopper survey response rates for **Aetna**, and for each of **Aetna**'s contracted MI Health Link regions.

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

		Response Rate		Accepting ICO		Accepting MI Health Link		Accepting New Patients	
Region	Total Number of Cases	Cases Reached	Rate (%)	Accepting ICO	Rate (%)[1]	Accepting MI Health Link	Rate (%)[2]	Accepting New Patients	Rate (%)[3]
Region 4	85	57	67.1%	46	80.7%	15	32.6%	11	73.3%
Region 7	161	106	65.8%	74	69.8%	31	41.9%	28	90.3%
Region 9	85	53	62.4%	33	62.3%	14	42.4%	14	100%
AET Total	**331**	**216**	**65.3%**	**153**	**70.8%**	**60**	**39.2%**	**53**	**88.3%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and indicating that at least one practitioner at the location accepts the requested ICO.
[3] The denominator includes cases responding to the survey that accept the ICO and accept MI Health Link.

Table 3-14 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **Aetna**, and for each of **Aetna**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-14—Summary of AET Secret Shopper Survey Appointment Availability Results, by Region

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
Region 4	85	11	7	63.6%	8.2%	4	183	85	93

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
Region 7	161	28	9	32.1%	5.6%	0	158	30	2
Region 9	85	14	2	14.3%	2.4%	0	22	11	11
AET Total	**331**	**53**	**18**	**34.0%**	**5.4%**	**0**	**183**	**49**	**8**

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

[2] The denominator includes all cases included in the sample.

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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the cases accepting **Aetna** and MI Health Link, 88.3 percent (n=53) accepted new patients. [**Access**]

Weaknesses and Recommendations

Weakness #1: Of the 331 total survey cases, only 65.3 percent (n=216) of provider locations could be contacted. [**Quality** and **Access**]

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **Aetna**'s dental 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: HSAG recommends that **Aetna** 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** 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: Only 39.2 percent of sampled provider locations accepted and/or recognized the MI Health Link program. [**Access**]

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

Recommendation: HSAG recommends that **Aetna** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **Aetna** 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 #3: Of cases in which the survey respondent reported that the provider location accepted **Aetna**, the MI Health Link program, and new patients, appointment availability was reported for 34.0 percent of cases. However, this results in appointment availability for 5.4 percent of **Aetna**'s total sample. [**Access**]

Why the weakness exists: 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 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 identification (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** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Aetna** 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**; 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).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS 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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: As **Aetna**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level.

Weaknesses and Recommendations

Weakness #1: As **Aetna**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level.

Why the weakness exists: NA

Recommendation: While no **Aetna**-specific results could be presented, the statewide analysis identified four measures that had a mean score below 90 percent, with one of those measures, *Reliable and Helpful Staff*, demonstrating a statistically significant decline from the prior year, indicating opportunities for improvement for the MI Health Link program. Therefore, HSAG recommends that **Aetna** develop and implement interventions to improve member experience related to the *Reliable and Helpful Staff*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommend Homemaker* HCBS CAHPS Survey measures. Of note, the lowest performing CAHPS measure was *Planning Your Time and Activities* with a mean score of 73.5 percent, indicating that **Aetna** should prioritize its efforts to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.

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

HSAG performed a comprehensive assessment of **Aetna**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Aetna** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Aetna**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-15 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Aetna**'s Medicaid members.

Table 3-15—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality**—Through MDHHS' mandated QIP, **Aetna** identified a disparity between Black or African American members and White members diagnosed with diabetes who had HbA1c testing. While **Aetna** had opportunities for improvement related to its sampling method and conducting accurate statistical testing for comparison between the two population subgroups, the ICO used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. Interventions implemented through this QIP have the potential of reducing/eliminating the disparity between the two subgroups. **Aetna**'s health disparity QIP should also have a positive impact on the *CDC—Comprehensive Diabetes Care—HbA1c Testing* measure indicator. Proper diabetes management is essential to control blood glucose, reduce the risks for complications, and prolong life.[3-9] As demonstrated through the PMV activity, while the indicator rate for this measure improved in performance from the previous year, it remained below the statewide average. Additionally, **Aetna**'s quality program is required to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. **Aetna**'s quality program will be reviewed during the future SFY 2023 compliance review activity.
Preventive Care and Services	**Quality** and **Access**—**Aetna** demonstrated some improvement in members obtaining preventive care and services. As demonstrated through the PMV activity results, all four indicator rates under the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure improved from the previous year. Additionally, four of the six indicator rates under the Prevention and Screening domain improved from the previous year, and two of those rates, *COA—Care for Older Adults—Functional Status Assessment* and *COA—Care for Older Adults—Pain Assessment*, also ranked above the statewide average. As the population ages, physical and cognitive function can decline, and pain

[3-9] 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 27, 2023.

Performance Area	Overall Performance Impact
	becomes more prevalent. The performance measure results indicate that more of **Aetna**'s older members received a functional status assessment and a pain assessment to ensure they receive the care they need to optimize quality of life.[3-10] However, while **Aetna** demonstrated some strengths, continued opportunities exist to increase the number of members who access preventive care. While all indicator rates under the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure improved from the previous year, they ranked below the statewide average. **Aetna** should continue initiatives to promote ambulatory or preventive care visits for adult members to receive preventive services such as counseling on diet and exercise and to help address acute issues or manage chronic conditions.[3-11] Four of the six indicator rates under the Prevention and Screening domain also ranked below the statewide average with two of those rates, *BCS—Breast Cancer Screening* and *COA—Care for Older Adults—Advance Care Planning*, declining in performance from the previous year. Mammogram screening and early detection of breast cancer decreases the risk of mortality from breast cancer, leads to a greater range of treatment options, and lower healthcare costs.[3-12] Further, advance care plans should be executed to ensure a member's choice about end-of-life care is considered.[3-13] **Aetna** reported that it is developing a member incentive program in SFY 2023 that rewards preventive screenings. Additionally, the results of the secret shopper survey revealed that a high number of dental providers could not be reached due to invalid telephone numbers. Further, of the dental providers that were able to be contacted, many did not accept or did not recognize the MI Health Link program. For the dental providers that accepted new patients receiving benefits through **Aetna**'s MI Health Link program, appointment availability was low. These results indicate that **Aetna**'s members may not have access to accurate provider information and may be experiencing barriers in scheduling appointments for preventive dental care. Regular check-ups can find tooth decay, gum disease and other problems before they lead to more serious issues.[3-14]

[3-10] 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 27, 2023.

[3-11] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Feb 27, 2023.

[3-12] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 27, 2023.

[3-13] 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 27, 2023.

[3-14] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Oral Health is Important for Overall Health. Available at: https://www.cdc.gov/chronicdisease/resources/infographic/oralhealth.htm. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—As demonstrated through the results of the PMV activity, 14 of the 16 indicator rates under the Respiratory Conditions, Cardiovascular Conditions, Diabetes, and Musculoskeletal Conditions domains ranked below the statewide average with three of those rates demonstrating a decline in performance from the previous year. These results indicate multiple opportunities for **Aetna** to increase proper management of the use of spirometry testing in the assessment and diagnosis of COPD; COPD with a bronchodilator; hypertension; statin therapy for members with cardiovascular disease; diabetes; and osteoporosis in women following a fracture. **Aetna** was also the lowest performing ICO in three of the four measure indicator rates under the Cardiovascular domain: *CBP—Controlling High Blood Pressure*, *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy*, and *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%*. Chronic diseases are the leading cause of death and disability in the nation and the leading drivers of healthcare costs.[3-15] **Aetna** reported that it is developing a member incentive program in SFY 2023 that rewards chronic conditions management and is exploring the potential of a member engagement program that would send home testing kits to members with diabetes who have not have an HbA1c test or had the test but whose results were greater than 8 percent. However, **Aetna**'s indicator rates for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measures ranked above the statewide average and improved in performance from the previous year. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and reduce the costs of COPD.[3-16] Further, persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-17]

[3-15] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. About Chronic Diseases. Available at: https://www.cdc.gov/chronicdisease/about/index.htm. Accessed on: Feb 27, 2023.

[3-16] 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 27, 2023.

[3-17] 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 27, 2023.

Performance Area	Overall Performance Impact
Behavioral Health and Substance Use Disorders	**Quality**, **Timeliness**, and **Access—Aetna** demonstrated mixed results as it relates to behavioral healthcare. Both indicator rates under the *FUM—Follow-Up After Emergency Department Visit for Mental Illness* measure ranked above the statewide average, with one of those rates improving in performance from the previous year. Follow-up care for members diagnosed with a mental illness correlates to fewer repeat emergency visits, improved physical and mental function and increased compliance with follow-up instructions.[3-18] Additionally, while both indicator rates improved in performance for the *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days* measure, both rates ranked below the statewide average. Further, both indicator rates under the *AMM—Antidepressant Medication Management* measure ranked below the statewide average, with one rate improving in performance from the previous year and the other declining in performance from the previous year. Members hospitalized for a mental health disorder often do not receive adequate follow-up care which can improve outcomes, decrease the likelihood of re-hospitalization and overall costs of outpatient care.[3-19] Effective medication management of major depression can also improve a member's daily functioning and well-being and can reduce the risk of suicide.[3-20] Further, substance use disorder treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug abuse or dependence-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-21] However, while the indicator rate for the *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measure indicator ranked above the statewide average, it declined in performance from the previous year, and the indicator rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure also declined in performance from the previous year and ranked below the statewide average. Lastly, while some of **Aetna**'s indicator rates increased from the previous year or ranked above the statewide average, it should be noted the statewide average is relatively low for most related measures. Therefore, overall, **Aetna** has multiple opportunities to enhance proper management of behavioral health conditions and substance use disorders.

[3-18] 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 27, 2023.

[3-19] 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 27, 2023.

[3-20] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

[3-21] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
HCBS	**Quality**—Person-centered planning and the development of an IICSP are critical aspects of **Aetna**'s care coordination program for members who are receiving HCBS and supports. The IICSP allows the member, care coordinator, providers, and other care team members to stay informed of the member's health status; provides a description of the services and supports in place to meet the member's needs; and tracks the member's progress on meeting his or her goals. **Aetna** received a score of 73 percent for Standard VI—Coordination and Continuity of Care through the compliance review activity, indicating multiple opportunities for improvement in the development and implementation of the IICSP. Additionally, the HCBS CAHPS Survey was administered to **Aetna**-enrolled members to gather direct feedback from MI Health Link members receiving HCBS about their experiences and the quality of the LTSS they receive. Due to the low number of respondents to the survey, **Aetna**-specific results are unable to be presented; therefore, member experience was not able to be adequately assessed. While **Aetna**-specific results are not available, **Aetna**-enrolled members responding to the survey contributed to the overall MI Health Link program results, which are reported in Section 5. The NAV activity produced conflicting results. While **Aetna** met the minimum network requirements for most LTSS provider types, including providers rendering home-based services, or was granted an exception, **Aetna** did not meet network requirements for the Adult Day Program and MIHP Agency provider types in at least one service region. Lack of providers available in **Aetna**'s service region may pose barriers for members being able to access all HCBS covered under their benefit package. However, the NAV activity produced overall positive results as **Aetna** met the minimum network requirements, or was granted an exception, for all LTSS provider types including providers rendering home-based services. Further, as demonstrated through the PMV activity, **Aetna** reported the *Minimizing Institutional Length of Stay* core measure in alignment with the measure specifications. **Aetna** could accurately report on the number of admissions to institutional facilities, the total number of discharges from an institutional facility to the community, and the number of expected discharges to the community, indicating an effective mechanism to monitor member transitions to coordinate care. HCBS and supports provide the opportunity for members to safely receive services in their own home or community setting rather than in institutions or other isolated settings.

AmeriHealth Caritas VIP Care Plus

Validation of Quality Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **AmeriHealth**'s QIP (i.e., the QIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-16 displays the overall validation status and the baseline results for the performance indicators. The QIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-16—Overall Validation Rating for AMI

QIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Transitions of Care, Medication Reconciliation Post-Discharge	*Partially Met*	Medication Reconciliation Post-Discharge for Disparate Group: Members Identified as Black/African American.	66.2%			Yes
		Medication Reconciliation Post-Discharge for Comparison Group: Members Identified as White.	80.0%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **AmeriHealth**'s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-17 displays the interventions, as available, initiated by the ICO to support achievement of the QIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-17—Baseline Interventions for AMI

Intervention Descriptions	
Revised internal processes to include MRP [Medication Reconciliation Post-Discharge] as a required step. Nurse Care Coordinators to complete process with every TOC [transition of care], utilizing functionality within the ICO's medical record system, forwarding MRP to primary care providers, and including it in HEDIS data abstraction.	Notified providers that they will receive a $25 payment for submission of CPT [Current Procedural Terminology] II codes.

Intervention Descriptions	
Implemented automated fax notifications to providers of admission and discharge dates based on a daily report.	Requested new text campaign to remind members who have experienced TOC to follow up with the provider within 30 days.

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 QIP 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's Aim statement set the focus of the project and the eligible population was clearly defined. [**Quality**]

Strength #2: AmeriHealth used appropriate QI tools to conduct a causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: AmeriHealth received a *Met* score for only 82 percent of the requirements in the Design stage of the project, indicating gaps in the ICO's documentation. [**Quality**]

Why the weakness exists: AmeriHealth had opportunities for improvement in its documentation of its sampling methods. Specifically, **AmeriHealth** reported the sample size rather than the sampling frame size. For the sampling frame size, **AmeriHealth** should have reported how many members met the eligible population prior to sampling specific to each racial/ethnic subgroup. Additionally, without an accurate sampling frame size, the margin of error and whether the sample was generalizable to the eligible population could not be verified.

Recommendation: HSAG recommends that **AmeriHealth** review the QIP Completion Instructions to ensure that all requirements for each completed evaluation element have been addressed. **AmeriHealth** should seek technical assistance from HSAG throughout the QIP process to address any questions or concerns.

Performance Measure Validation

Performance Results

HSAG evaluated **AmeriHealth**'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 (i.e., claims and encounters), care coordination system (i.e., tracking and management of care transition record transmissions), medication review system (i.e., tracking and management of medication reviews), hybrid data collection and review, or data integration.

- **AmeriHealth** received a measure designation of *Reportable (R)* for all measures, signifying that **AmeriHealth** had reported the measures in compliance with the 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**'s audited HEDIS measures, rates for HEDIS MY 2020 and HEDIS MY 2021 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2021 with HEDIS MY 2020, and the HEDIS MY 2021 MI Health Link statewide average performance rates. HEDIS MY 2021 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 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening	50.86	46.82	−4.04	52.74
COL—Colorectal Cancer Screening	50.85	49.15	−1.70	56.03
COA—Care for Older Adults—Advance Care Planning	21.90	30.41	+8.51	41.07
COA—Care for Older Adults—Medication Review	44.77	85.89	+41.12	74.85
COA—Care for Older Adults—Functional Status Assessment	52.80	60.83	+8.03	58.42
COA—Care for Older Adults—Pain Assessment	60.58	74.45	+13.87	75.25
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	23.88	17.24	−6.64	22.93
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	65.38	55.10	−10.28	68.65
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	96.15	91.84	−4.31	89.67
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure	51.82	60.83	+9.01	60.52
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	100	100	0.00	95.25
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	76.70	84.92	+8.22	82.00
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	75.95	85.05	+9.10	84.22
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing	80.78	87.10	+6.32	87.50
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**	42.34	38.44	−3.90	43.53
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	50.12	54.26	+4.14	49.06
CDC—Comprehensive Diabetes Care—Eye Exam	53.28	52.55	−0.73	57.33
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	91.73	90.51	−1.22	90.01
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	51.82	54.50	+2.68	60.82
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	78.19	78.52	+0.33	76.83
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	75.79	72.17	−3.62	82.46

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Musculoskeletal Conditions				
OMW—Osteoporosis Management in Women Who Had a Fracture	0.00	40.00	+40.00	16.12
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	73.61	79.17	+5.56	75.06
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	59.72	59.72	0.00	60.75
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	15.22	17.07	+1.85	26.13
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	39.13	31.71	−7.42	50.22
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	22.22	22.22	0.00	33.87
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	41.67	40.74	−0.93	51.71
Medication Management and Care Coordination				
TRC—Transitions of Care—Notification of Inpatient Admission	11.68	2.19	−9.49	13.11
TRC—Transitions of Care—Receipt of Discharge Information	10.46	2.68	−7.78	12.77
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	72.75	74.70	+1.95	74.60
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	45.50	64.48	+18.98	43.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	18.36	18.82	+0.46	24.68
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**	32.48	27.68	−4.80	31.94
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**	10.05	11.54	+1.49	17.81
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	4.78	4.05	−0.73	5.50
*DAE—Use of High-Risk Medications in Older Adults—Total**	13.52	14.55	+1.03	21.56
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	76.66	78.63	+1.97	84.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	90.28	90.58	+0.30	93.49
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	85.48	87.28	+1.80	91.45

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	85.49	86.75	+1.26	90.77
IET—Initiation of Alcohol and Other Drug Dependence Treatment	42.33	40.41	−1.92	48.59
IET—Engagement of Alcohol and Other Drug Dependence Treatment	9.82	4.11	−5.71	6.53
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	1.09	1.80	+0.71	1.17
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	1.61	1.44	−0.17	1.20

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

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: AmeriHealth continued to demonstrate a general strength in completeness of claims data, as it reported a typical clean claims processing timeliness standard of approximately 100 percent within 60 days. Ensuring timely claims adjudication provides assurance that **AmeriHealth**'s Core Measure 9.1 and Core Measure 9.3 data are accurate, since both are based on claims data. It is also critical to have complete claims data for Core Measure 9.3 so that **AmeriHealth** 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. [**Quality** and **Timeliness**]

Strength #2: Although Core Measure 9.1 is a utilization measure and therefore does not have established benchmarks, **AmeriHealth** maintained a low Core Measure 9.1 rate in comparison to the other ICOs. **AmeriHealth** had established robust care coordination processes with its PIHP delegates, which included routinely using and maintaining PIHP contacts designated for ED admission notifications; conducting ICT meetings; holding routine operational meetings to discuss performance measurement; using daily Admission, Discharge, 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 behavioral health ED visit as well. **AmeriHealth** indicated that these PIHP processes provided assurance of timely follow-up with members after behavioral health ED visits, thereby reducing the risk of future behavioral health ED visits for **AmeriHealth**'s members. [**Quality** and **Timeliness**]

Strength #3: In the Prevention and Screening domain, **AmeriHealth**'s rate for the *COA—Care for Older Adults—Medication Review* measure indicator increased by more than 41 percentage points from MY 2020 to MY 2021, and the rate for the *COA—Care for Older Adults—Functional Status Assessment* measure indicator increased by more than 8 percentage points from MY 2020 to MY 2021. Additionally, both measure indicators exceeded the HEDIS MY 2021 MI Health Link statewide averages, suggesting strength and improvement in adult members 66 years and older having medication reviews and functional status assessments conducted during the measurement year. Screening of elderly patients is effective in identifying functional decline. Older adults may have more complex medication regimens.[3-22] [**Quality** and **Timeliness**]

Strength #4: In the Medication Management and Care Coordination domain, **AmeriHealth**'s rate for the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge* measure indicator increased by more than 18 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in timely medication reconciliation being performed for adult members following discharge from an inpatient facility. Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs.[3-23] [**Quality** and **Timeliness**]

Strength #5: In the Musculoskeletal Conditions domain, **AmeriHealth**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by 40 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in timely screening and treatment of women who suffered a fracture with either a bone mineral density test or a prescription for a drug to treat osteoporosis. 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.[3-24] [**Quality**, **Timeliness**, and **Access**]

[3-22] 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 27, 2023.

[3-23] National Committee for Quality Assurance. Transitions of Care (TRC). Available at: https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed on: Feb 27, 2023.

[3-24] 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/. Accessed on: Feb 27, 2023.

Strength #6: In the Cardiovascular Conditions domain, **AmeriHealth**'s rates for the *CBP—Controlling High Blood Pressure*, *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy*, and *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* measure indicators increased by more than 8 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide averages, suggesting strength in cardiovascular treatment and prevention for members. Cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease.[3-25] Additionally, controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-26] [**Quality**, **Access**, and **Timeliness**]

Strength #7: In the Behavioral Health domain, **AmeriHealth**'s rate for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator increased by more than 5 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in adults with a diagnosis of major depression, who were newly treated with antidepressant medication, remaining on antidepressant medication for at least 84 days. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[3-27] [**Quality**, **Access**, and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: AmeriHealth was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: AmeriHealth had numerous issues in reporting Core Measure 9.3, which included not appropriately aligning its source code with the Core Measure 9.3 FAQs that were released in December 2021, and incorrectly identifying members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge.

Recommendation: HSAG recommends that **AmeriHealth** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **AmeriHealth** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

3-25 National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/. Accessed on: Feb 27, 2023.

3-26 National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 27, 2023.

3-27 National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

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

Why the weakness exists: **AmeriHealth** continued to rely solely on administrative data for reporting MI2.6.

Recommendation: While **AmeriHealth** indicated that it believed the Continuity of Care Document (CCD) file process was improved since 2020 and that the process was working more consistently, and **AmeriHealth** had begun transmitting transition records directly, its MI2.6 rate remained low. Considering these process improvements and the continued low MI2.6 rate, HSAG recommends that **AmeriHealth** consider reporting MI2.6 following a hybrid methodology in future years.

Weakness #3: The MI5.6 data that **AmeriHealth** had submitted to the FAI Data Collection System (DCS) contained errors. [**Quality**]

Why the weakness exists: **AmeriHealth** indicated the root cause of these errors was that it had relied on personnel to complete the FAI DCS submission who did not typically manage the process, as the individuals typically accountable for the submission were dedicated to working on a CMS program audit.

Recommendation: HSAG recommends that **AmeriHealth** ensure its regulatory submissions quality assurance process be reevaluated to align with HSAG's previous recommendation for **AmeriHealth** to ensure the process is well documented internally for business continuity. Considering that the **AmeriHealth** personnel who submitted MI5.6 did not readily identify that a sample size of 387 should have been assessed for accuracy (i.e., Michigan-Specific Reporting Requirements indicate the minimum sample size should be 411 unless the eligible population is less than 411), HSAG further recommends that **AmeriHealth** provide adequate Michigan-Specific Reporting Requirements and MMP Core Reporting Requirements training to any personnel who could potentially assist with the FAI DCS and HPMS submissions.

Weakness #4: For 25 of the 45 reported HEDIS measures (56 percent), **AmeriHealth**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization. [**Quality**]

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

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

Weakness #5: In the Respiratory Conditions domain, **AmeriHealth**'s rates for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* and *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicators decreased by more than 6 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI

Health Link statewide average, indicating that some adult members with newly diagnosed or active COPD were not always receiving spirometry testing to confirm the diagnosis, and that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. Approximately 15 million adults in the United States have COPD, an irreversible disease that limits airflow to the lungs. Despite being the gold standard for diagnosis and assessment of COPD, spirometry testing is underused. Earlier diagnosis using spirometry testing supports a treatment plan that may protect against worsening symptoms and decrease the number of exacerbations.[3-28] COPD exacerbations or "flare-ups" make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD.[3-29] [**Quality** and **Access**]

Why the weakness exists: The rates for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* and *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicators decreasing by more than 6 percentage points from MY 2020 to MY 2021 suggest that barriers exist for receiving spirometry testing and appropriate medication therapy to manage exacerbation for some adult members with COPD.

Recommendation: HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving spirometry testing and appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* and *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicators. **AmeriHealth** 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).

Weakness #6: In the Medication Management and Care Coordination domain, **AmeriHealth**'s rates for the *TRC—Transitions of Care—Notification of Inpatient Admission* and *Receipt of Discharge Information* measure indicators decreased by more than 7 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults did not have documentation in the medical record of receipt of notification of inpatient admission or inpatient facility discharge information. Examining the admission and discharge processes can prevent rehospitalization, ED visits and other poor health outcomes.[3-30] [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: The rates for the *TRC—Transitions of Care—Notification of Inpatient Admission* and *Receipt of Discharge Information* measure indicators decreasing by more than

[3-28] 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 27, 2023.

[3-29] 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 27, 2023.

[3-30] National Committee for Quality Assurance. Transitions of Care (TRC). Available at: https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed on: Feb 27, 2023.

7 percentage points from MY 2020 to MY 2021 suggest that barriers exist for medical record documentation to consist of receipt of notification of inpatient admission or inpatient facility discharge information for some adults.

Recommendation: HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some adults did not have documentation in the medical record of receipt of notification of inpatient admission or inpatient facility discharge information. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *TRC—Transitions of Care—Notification of Inpatient Admission* and *Receipt of Discharge Information* measure indicators. **AmeriHealth** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of care coordination or provider education).

Weakness #7: In the Behavioral Health domain, **AmeriHealth**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator decreased by more than 7 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some members were not receiving follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. 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**]

Why the weakness exists: The rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator decreasing by more than 7 percentage points from MY 2020 to MY 2021 suggests that barriers exist for some members to receive follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. Potential barriers noted by **AmeriHealth** were a low measure denominator, difficulty reaching and re-engaging members after discharge, and member reluctance to use telehealth for follow-up visits.

Recommendation: HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. If it is determined that difficulty reaching and re-engaging members impacted performance, HSAG recommends that **AmeriHealth** consider other methods of outreach along with providing further education to members on the importance of follow-up and engagement in treatment when scheduling follow-up visits. Additionally, if reluctance to use telehealth for follow-up visits is identified as a root cause that impacted the rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator, **AmeriHealth** should consider identifying specific factors behind the reluctance to use telehealth in order to incorporate effective strategies for addressing the member-identified concerns. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *FUH—*

[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 27, 2023.

Follow-Up After Hospitalization for Mental Illness—30 Days measure indicator. **AmeriHealth** 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 education or staffing shortages).

Weakness #8: In the Access/Availability of Care domain, **AmeriHealth**'s rate for the *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measure indicator decreased by more than 5 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults with a new episode of alcohol or other drug dependence were not always receiving timely treatment. Treatment, including medication-assisted treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-32] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measure indicator decreasing by more than 5 percentage points from MY 2020 to MY 2021 suggests that barriers exist for some adults with a new episode of alcohol or other drug dependence to access timely treatment.

Recommendation: HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some adults with a new episode of alcohol or other drug dependence were not accessing timely treatment. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measure indicator. **AmeriHealth** 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 education).

Compliance Review

Performance Results

Table 3-20 presents **AmeriHealth**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **AmeriHealth** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **AmeriHealth**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

[3-32] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

Table 3-20—Standard Compliance Scores for AMI

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2022)		
Standard I—Disenrollment: Requirements and Limitations[2]	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**59%**
Standard III—Emergency and Poststabilization Services[2]	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**85%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**77%**
Standard VII—Coverage and Authorization of Services	§438.210	**89%**
Year Two (SFY 2023)		
Standard VIII—Provider Selection	§438.214	—
Standard IX—Confidentiality	§438.224	—
Standard X—Grievance and Appeal Systems	§438.228	—
Standard XI—Subcontractual Relationships and Delegation	§438.230	—
Standard XII—Practice Guidelines	§438.236	—
Standard XIII—Health Information Systems[3]	§438.242	—
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	—
Year Three (SFY 2024)		
Review of ICO's implementation of Year One and Year Two CAPs		

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[3] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

Dash (—): The ICO's compliance with Year Two standards will be reviewed and scored during the SFY 2023 compliance review activity.

Table 3-21 presents **AmeriHealth**'s scores for each standard evaluated during the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **AmeriHealth**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2022 compliance review activity demonstrated how successful **AmeriHealth** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-21—SFY 2022 Standard Compliance Scores for AMI

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations[1]	9	6	6	0	3	**100%**
Standard II—Member Rights and Member Information	23	22	13	9	1	**59%**
Standard III—Emergency and Poststabilization Services[1]	13	13	13	0	0	**100%**
Standard IV—Availability of Services	13	13	11	2	0	**85%**
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
Standard VI—Coordination and Continuity of Care	31	30	23	7	1	**77%**
Standard VII—Coverage and Authorization of Services	28	27	24	3	1	**89%**
Total	**121**	**115**	**94**	**21**	**6**	**82%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

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 achieved full compliance in the Assurances of Adequate Capacity and Services program area, demonstrating that the ICO maintained and monitored an adequate provider network that was sufficient to provide adequate capacity for all services (e.g., preventive, primary, specialty care, and LTSS) for its membership. [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: AmeriHealth received a score of *Not Met* for nine elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: AmeriHealth's member materials did not contain all required member rights, member materials critical to obtaining services did not comply with language requirements for taglines, there was no evidence of a process to inform members when a provider was terminated, the member handbook did not contain all mandatory components, member handbooks were not distributed to members timely, there was no documentation available to support timely notice to members would occur due to a significant change impacting members' access to services and information about the managed care program, the provider directory did not include all required components, and the formulary drug list was not available in a machine readable format. Contributory factors included, but were not limited to, lack of detail in policy or processes, differences between model materials and federal/contract requirements, staff turnover within the leadership team, and technological system limitations.

Recommendation: As **AmeriHealth** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **AmeriHealth** ensure that it consistently uses the most current version of the model member materials.

Weakness #2: AmeriHealth received a score of *Not Met* for seven elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: AmeriHealth did not ensure caseloads met the MDHHS 600-point threshold, consistently and timely review program-level data and utilization data to assign an initial risk stratification to each member, consistently ensure all required components were included in the IICSP, provide all members with a copy of their IICSP, or consistently review the IICSP with the member on a schedule specific to the member's risk stratification level. Contributory factors included, but were not limited to, global staffing issues and challenges in recruiting staff to fill positions, inconsistent monitoring, limitations of the clinical documentation system, and need for improved documentation strategies.

Recommendation: As **AmeriHealth** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members. These efforts should support improved member health outcomes.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG's NAV results indicated that **AmeriHealth** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. Table 3-22 presents **AmeriHealth**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception determinations.

Table 3-22—SFY 2022 NAV Results for AMI, by Region and Provider Type

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time/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 Aids	*Met*	*Met*
Hearing Examinations	*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*
ECLS	*Met*	*Met*
Environmental Modifications	*Met*	*Met*

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Fiscal Intermediary	*Met*	*Met*
Home-Delivered Meals	*Met*	*Met*
Medical Supplies (e.g., incontinence supplies)	*Met*	*Met*
NEMT	*Met*	*Met*
Non-Medical Transportation (waiver services only)	*Met*	*Met*
Personal Care Services	*Met*	*Met*
Personal Emergency Response System	*Met*	*Met*
Preventive Nursing Services	*Met*	*Met*
Private Duty Nursing	*Met*	*Met*
Respite	*Met*	*Met*
Skilled Nursing Home (report only beds certified for both Medicare and Medicaid)	*Met*	*Met*
Percentage of Total Requirements Met	**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 met all Medicaid and LTSS minimum network requirements for Region 7, indicating that **AmeriHealth** maintains an adequate network for MI Health Link members in this region. [**Access**]

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

Weaknesses and Recommendations

Weakness #1: HSAG identified no specific weaknesses for **AmeriHealth** based on the SFY 2022 NAV results.

Why the weakness exists: NA

Recommendation: AmeriHealth 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 44 sampled provider locations (i.e., "cases") for **AmeriHealth**, with an overall response rate of 63.6 percent (28 cases) among **AmeriHealth**'s two MI Health Link regions. Region 9 had the highest response rate, and Region 7 had the lowest response rate. Table 3-23 summarizes the SFY 2022 secret shopper survey response rates for **AmeriHealth**, and for each of **AmeriHealth**'s contracted MI Health Link regions.

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

		Response Rate		Accepting ICO		Accepting MI Health Link		Accepting New Patients	
Region	Total Number of Cases	Cases Reached	Rate (%)	Accepting ICO	Rate (%)[1]	Accepting MI Health Link	Rate (%)[2]	Accepting New Patients	Rate (%)[3]
Region 7	29	16	55.2%	12	75.0%	8	66.7%	8	100%
Region 9	15	12	80.0%	11	91.7%	9	81.8%	9	100%
AMI Total	**44**	**28**	**63.6%**	**23**	**82.1%**	**17**	**73.9%**	**17**	**100%**

[1] The denominator includes cases responding to the survey.

[2] The denominator includes cases responding to the survey and indicating that at least one practitioner at the location accepts the requested ICO.

[3] The denominator includes cases responding to the survey that accept the ICO and accept MI Health Link.

Table 3-24 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **AmeriHealth**, and for each of **AmeriHealth**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

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

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
Region 7	29	8	8	100%	27.6%	4	41	13	10
Region 9	15	9	7	77.8%	46.7%	1	112	28	18

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
AMI Total	44	17	15	88.2%	34.1%	1	112	20	11

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

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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the cases accepting **AmeriHealth** and MI Health Link, 100 percent (n=17) accepted new patients. [**Access**]

Strength #2: Of the 17 cases accepting **AmeriHealth**, MI Health Link, and new patients, 88.2 percent (n=15) offered the caller an appointment date. [**Access**]

Weaknesses and Recommendations

Weakness #1: Of the 44 total survey cases, only 63.6 percent (n=28) of provider locations were able to be contacted. [**Quality** and **Access**]

Why the weakness exists: In addition to limitations identified in Appendix A related to the secret shopper approach, **AmeriHealth**'s dental 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: HSAG recommends that **AmeriHealth** 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** 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: Of cases in which the survey respondent reported that the provider location accepted **AmeriHealth**, the MI Health Link program, and new patients, appointment availability was reported

for 88.2 percent of cases. However, this results in appointment availability for 34.1 percent of **AmeriHealth**'s total sample. [**Access**]

Why the weakness exists: 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 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** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **AmeriHealth** 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**; 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).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS 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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: As **AmeriHealth**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level.

Weaknesses and Recommendations

Weakness #1: As **AmeriHealth**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level.

Why the weakness exists: NA

Recommendation: While no **AmeriHealth**-specific results could be presented, the statewide analysis identified four measures that had a mean score below 90 percent, with one of those measures, *Reliable and Helpful Staff*, demonstrating a statistically significant decline from the prior year, indicating opportunities for improvement for the MI Health Link program. Therefore, HSAG recommends that **AmeriHealth** develop and implement interventions to improve member experience related to the *Reliable and Helpful Staff*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommend Homemaker* HCBS CAHPS Survey measures. Of note, the lowest performing CAHPS measure was *Planning Your Time and Activities* with a mean score of 73.5 percent, indicating that **AmeriHealth** should prioritize its efforts to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.

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

HSAG performed a comprehensive assessment of **AmeriHealth**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **AmeriHealth** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **AmeriHealth**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-25 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **AmeriHealth**'s Medicaid members.

Table 3-25—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality**—Through MDHHS' mandated QIP, **AmeriHealth** identified a disparity between Black/African American members and White members who had documentation of timely medication reconciliation after discharge from an acute or nonacute inpatient admission. While **AmeriHealth** had opportunities for improvement related to its sampling methods, the ICO used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. Interventions implemented through this QIP have the potential of reducing/eliminating the disparity between the two subgroups. **AmeriHealth**'s health disparity QIP should also have a positive impact on the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge* performance measure. Transitions from an inpatient setting back to home often results in poor care coordination, including intentional and unintentional medication changes. Adequate care coordination and poor care transitions can prevent readmissions, ED visits and poor health outcomes, and reduce unnecessary spending.[3-33] As demonstrated through the PMV activity, the rate

[3-33] National Committee for Quality Assurance. Transitions of Care (TRC). Available at: https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	for this measure ranked above the statewide average, and the rate improved in performance from the previous year. **AmeriHealth** reported it had implemented a process for its care coordinators to complete medication reconciliation after discharge from an acute or nonacute inpatient admission. Additionally, **AmeriHealth**'s quality program is required to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. **AmeriHealth**'s quality program will be reviewed during the future SFY 2023 compliance review activity.
Preventive Care and Services	**Quality** and **Access**—**AmeriHealth** demonstrated some improvement in members obtaining preventive care and services. As demonstrated through the PMV activity results, all four indicator rates under the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure improved in performance from the previous year. Additionally, four of the six indicator rates under the Prevention and Screening domain improved in performance from the prior year. Two of those indicator rates, *COA—Care for Older Adults—Medication Review* and *COA—Care for Older Adults—Functional Status Assessment*, also ranked above the statewide average. As the population ages, physical and cognitive function can decline, and older adults have more complex medication regimes. The PMV activity results indicate that more of **AmeriHealth**'s older members received a functional status assessment and a medication review to ensure they receive the care they need to optimize quality of life.[3-34] However, while **AmeriHealth** demonstrated some strengths, continued opportunities exist to increase the number of members who access preventive care. While all indicator rates under the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure improved in performance from the previous year, they ranked below the statewide average, and **AmeriHealth** was the lowest performing ICO for all four rates for this measure. **AmeriHealth** should continue initiatives to promote ambulatory or preventive care visits for adult members to receive preventive services such as counseling on diet and exercise and to help address acute issues or manage chronic conditions.[3-35] Additionally, four of the six indicator rates under the Prevention and Screening domain also ranked below the statewide average, with two of those indicator rates, *BCS—Breast Cancer Screening* and *COL—Colorectal Cancer Screening*, declining in performance from the previous year. Mammogram screening and early detection of breast cancer decreases the risk of mortality from breast cancer, leads to a greater range of treatment options, and lower healthcare

[3-34] 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 27, 2023.

[3-35] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	costs.[3-36] Further, colorectal cancer screening can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.[3-37] **AmeriHealth** was also the lowest performing ICO for the *BCS—Breast Cancer Screening* and *COL—Colorectal Cancer Screening* measures. **AmeriHealth** reported that it believed the lack of improvement in breast and colorectal cancer screening was due to the ongoing COVID-19 PHE causing member hesitancy to seek close contact services and limited provider capacity due to resource constraints. Additionally, the results of the secret shopper survey revealed that a high number of dental providers could not be reached due to invalid telephone numbers. Further, of the dental providers that were able to be contacted and accepted new patients receiving benefits through **AmeriHealth**'s MI Health Link program, appointment availability was low. These results indicate that **AmeriHealth**'s members may not have access to accurate provider information and may be experiencing barriers in scheduling appointments for preventive dental care. Regular check-ups can find tooth decay, gum disease and other problems before they lead to more serious issues.[3-38]
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—As demonstrated through the results of the PMV activity, 10 of the 16 indicator rates under the Respiratory Conditions, Cardiovascular Conditions, Diabetes, and Musculoskeletal Conditions domains ranked above the statewide average, indicating that many of **AmeriHealth**'s members received proper management of COPD exacerbation with a bronchodilator; hypertension; beta-blocker treatment after a heart attack; statin therapy for members with cardiovascular disease; and HbA1c control, medical attention for nephropathy, and statin therapy for members diagnosed with diabetes. Of note, within the Cardiovascular Conditions domain, all four indicator rates ranked above the statewide average, and improved in performance or remained at 100 percent. However, while **AmeriHealth** demonstrated several strengths in the management of chronic conditions, six of the 16 indicator rates declined in performance from the previous year, and six indicator rates ranked below the statewide average. The PMV activity confirmed continued opportunities for **AmeriHealth** to enhance proper management of chronic conditions such as the spirometry testing in the assessment and diagnosis of COPD; systemic corticosteroid therapy for COPD exacerbations; and HbA1c testing, eye exams, and blood pressure control for members diagnosed with diabetes. Chronic

[3-36] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 27, 2023.

[3-37] National Committee for Quality Assurance. Colorectal Cancer Screening (COL, COL-E). Available at: https://www.ncqa.org/hedis/measures/colorectal-cancer-screening/. Accessed on: Feb 27, 2023.

[3-38] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Oral Health is Important for Overall Health. Available at: https://www.cdc.gov/chronicdisease/resources/infographic/oralhealth.htm. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	diseases are the leading cause of death and disability in the nation and the leading drivers of healthcare costs.[3-39]
Behavioral Health and Substance Use Disorders	**Quality**, **Timeliness**, and **Access—AmeriHealth** demonstrated declining indicator rates from the previous year for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* and *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measures, and both measures ranked below the statewide average. Substance use disorder treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug abuse or dependence-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-40] Additionally, under the Behavioral Health domain, five of the six indicator rates ranked below the statewide average, with four of those rates declining in performance from the previous year or remaining unchanged, indicating opportunities for **AmeriHealth** to improve continued medication management for members diagnosed with major depression, and increase the number of follow-up care visits for members discharged from an inpatient admission or ED for a diagnosis of mental illness. Effective medication management of major depression can improve a member's daily functioning and well-being and can reduce the risk of suicide.[3-41] Follow-up care for members diagnosed with a mental illness correlates to fewer repeat emergency visits, improved physical and mental function, increased compliance with follow-up instructions, improved outcomes, and decrease the likelihood of re-hospitalization and cost of outpatient care.[3-42,3-43] Lastly, while some of **AmeriHealth**'s indicator rates increased from the previous year or ranked above the statewide average, it should be noted the statewide average is relatively low for most related measures. Therefore, overall, **AmeriHealth** has opportunities to enhance proper management of behavioral health conditions and substance use disorders.

[3-39] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. About Chronic Diseases. Available at: https://www.cdc.gov/chronicdisease/about/index.htm. Accessed on: Feb 27, 2023.

[3-40] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

[3-41] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

[3-42] 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 27, 2023.

[3-43] 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 27, 2023.

Performance Area	Overall Performance Impact
HCBS	**Quality**—Person-centered planning and the development of an IICSP are critical aspects of **AmeriHealth**'s care coordination program for members who are receiving HCBS and supports. The IICSP allows the member, care coordinator, providers, and other care team members to stay informed of the member's health status; provides a description of the services and supports in place to meet the member's needs; and tracks the member's progress on meeting his or her goals. **AmeriHealth** received a score of 77 percent for Standard VI—Coordination and Continuity of Care through the compliance review activity, indicating multiple opportunities for improvement in the development and implementation of the IICSP. Additionally, the HCBS CAHPS Survey was administered to **AmeriHealth**-enrolled members to gather direct feedback from MI Health Link members receiving HCBS about their experiences and the quality of the LTSS they receive. Due to the low number of respondents to the survey, **AmeriHealth**-specific results are unable to be presented; therefore, member experience was not able to be adequately assessed. While **AmeriHealth**-specific results are not available, **AmeriHealth**-enrolled members responding to the survey contributed to the overall MI Health Link program results, which are reported in Section 5. However, the NAV activity produced overall positive results as **AmeriHealth** met the minimum network requirements for all LTSS provider types including providers rendering home-based services. Further, as demonstrated through the PMV activity, **AmeriHealth** reported the *Minimizing Institutional Length of Stay* core measure in alignment with the measure specifications. **AmeriHealth** could accurately report on the number of admissions to institutional facilities, the total number of discharges from an institutional facility to the community, and the number of expected discharges to the community, indicating an effective mechanism to monitor member transitions to coordinate care. HCBS and supports provide the opportunity for members to safely receive services in their own home or community setting rather than in institutions or other isolated settings.

HAP Empowered

Validation of Quality Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **HAP**'s QIP (i.e., the QIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-26 displays the overall validation status and the baseline results for the performance indicators. The QIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-26—Overall Validation Rating for HAP

QIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members	*Met*	The percentage of African American members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	51.1%			Yes
		The percentage of Caucasian members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	74.2%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **HAP**'s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Caucasian) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-27 displays the interventions, as available, initiated by the ICO to support achievement of the QIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-27—Baseline Interventions for HAP

Intervention Descriptions	
Created an adherence report to ensure providers are monitoring members who have uncontrolled blood pressure readings.	Members who require supportive education on hypertension can have a scheduled appointment with the pharmacist to review medications and measures to help get their blood pressure under control.
Specific goals will be added, in partnership with the member, to the Individual Integrated Care and Support Plan (IICSP) if it is determined that a member has uncontrolled blood pressure.	Designed an incentive program to reward primary care providers for high-quality, cost-effective primary care services. This will encourage providers, who may have more updated contact information for members, to contact members and make appointments for a blood pressure check.
Updated its internal customer service resource tool which shows member-facing staff which HEDIS measures the members need. This enabled staff to discuss the member's gaps in care when the member calls HAP and update contact information as well.	Developed a data collection improvement project, including building the ability for providers to document blood pressure readings (and supportive medical records) into the provider portal. Additionally, the ICO modified supplemental data HEDIS extracts to include at-home and telehealth visit blood pressure readings.

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 QIP 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 designed a methodologically sound QIP supported by using key research principals. **HAP**'s Aim statement set the focus of the QIP, and the eligible population was clearly defined. **HAP** selected performance indicators based on data analysis showing opportunities for improvement within the targeted populations. The technical design of the QIP was sufficient to measure and monitor QIP outcomes. [**Quality**]

Strength #2: HAP met 100 percent of the requirements for data analysis and implementation of improvement strategies. **HAP** conducted accurate statistical testing between the two subgroups for the baseline measurement period to identify an existing disparity and provided a narrative interpretation of the results. Appropriate QI tools were used to conduct its causal/barrier analysis and to prioritize the identified barriers. Interventions were implemented in a timely manner, were reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **HAP** evaluate the effectiveness of the interventions initiated and use the outcomes to guide each intervention's next steps.

Performance Measure Validation

Performance Results

HSAG evaluated **HAP**'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 (i.e., claims and encounters), care coordination system (i.e., tracking and management of care transition record transmissions), medication review system (i.e., tracking and management of medication reviews), hybrid data collection and review, or data integration.

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

Table 3-28—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 3-29 shows each of **HAP**'s audited HEDIS measures, rates for HEDIS MY 2020 and HEDIS MY 2021 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2021 with HEDIS MY 2020, and the HEDIS MY 2021 MI Health Link

statewide average performance rates. HEDIS MY 2021 measure rates performing better than the statewide average are notated by green font.

Table 3-29—Measure-Specific Percentage Rates for HAP

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening	57.11	56.87	−0.24	52.74
COL—Colorectal Cancer Screening	60.98	63.04	+2.06	56.03
COA—Care for Older Adults—Advance Care Planning	55.23	55.28	+0.05	41.07
COA—Care for Older Adults—Medication Review	62.53	59.21	−3.32	74.85
COA—Care for Older Adults—Functional Status Assessment	62.53	63.88	+1.35	58.42
COA—Care for Older Adults—Pain Assessment	78.83	75.18	−3.65	75.25
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	25.22	25.26	+0.04	22.93
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	69.74	61.62	−8.12	68.65
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	94.74	88.89	−5.85	89.67
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure	59.61	61.31	+1.70	60.52
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	92.86	91.67	−1.19	95.25
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	84.41	79.40	−5.01	82.00
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	76.43	82.28	+5.85	84.22
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing	87.83	84.18	−3.65	87.50
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**	47.45	50.36	+2.91	43.53
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	45.74	44.28	−1.46	49.06
CDC—Comprehensive Diabetes Care—Eye Exam	55.47	60.34	+4.87	57.33
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	92.46	90.75	−1.71	90.01
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	54.99	60.58	+5.59	60.82
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	80.36	79.48	−0.88	76.83

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	81.23	81.86	+0.63	82.46
Musculoskeletal Conditions				
OMW—Osteoporosis Management in Women Who Had a Fracture	0.00	14.29	+14.29	16.12
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	71.20	70.54	−0.66	75.06
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	48.80	56.25	+7.45	60.75
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	14.75	16.25	+1.50	26.13
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	37.70	37.50	−0.20	50.22
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	21.13	12.90	−8.23	33.87
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	38.03	38.71	+0.68	51.71
Medication Management and Care Coordination				
TRC—Transitions of Care—Notification of Inpatient Admission	12.17	16.55	+4.38	13.11
TRC—Transitions of Care—Receipt of Discharge Information	8.76	14.84	+6.08	12.77
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	73.48	75.67	+2.19	74.60
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	35.04	39.17	+4.13	43.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	22.44	24.60	+2.16	24.68
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**	28.47	31.53	+3.06	31.94
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**	21.04	22.16	+1.12	17.81
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	4.33	5.03	+0.70	5.50
*DAE—Use of High-Risk Medications in Older Adults—Total**	23.64	25.41	+1.77	21.56
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	82.56	84.65	+2.09	84.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	91.82	93.23	+1.41	93.49

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	88.31	89.48	+1.17	91.45
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	88.50	89.80	+1.30	90.77
IET—Initiation of Alcohol and Other Drug Dependence Treatment	37.73	53.59	+15.86	48.59
IET—Engagement of Alcohol and Other Drug Dependence Treatment	7.27	7.18	−0.09	6.53
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	1.07	1.02	−0.05	1.17
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	1.19	1.11	−0.08	1.20

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

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: As a result of the MY 2020 PMV, HSAG recommended that **HAP** implement validation checks beyond the Millman MedInsight system that was used to compare institutional counts at a high level for Core Measure 9.3, data element A. **HAP** confirmed implementation of a variety of additional data reasonability and quality checks to evaluate all Core Measure 9.3 data elements, which included the business owner's routine review of the data, comparisons of prior year data element counts, and ongoing assessment of new IFAs to ensure alignment with the reporting requirements. Although HSAG requested that **HAP** update its Core Measure 9.3 source code for the MY 2021 PMV, in general, **HAP** improved its quality oversight and monitoring for this measure, as the source code updates were specific to a measure interpretation issue and not related to data quality. [**Quality**]

Strength #2: Throughout MY 2021, **HAP** continued to meet monthly with its delegates to discuss identified service data concerns such as volume, errors, and timely corrections. **HAP** indicated that this monthly review process allowed the ICO to maintain encounter data quality and timeliness. [**Quality** and **Timeliness**]

Strength #3: In the Access/Availability of Care domain, **HAP**'s rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator increased by more than 15 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in timely treatment of adults with a new episode of alcohol or other drug dependence. Treatment, including medication-assisted treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-44] [**Quality**, **Timeliness**, and **Access**]

Strength #4: In the Medication Management and Care Coordination domain, **HAP**'s rate for the *TRC—Transitions of Care—Receipt of Discharge Information* measure indicator increased by more than 6 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in documentation in the medical record of receipt of discharge information. Inadequate care coordination and poor care transitions can result in unnecessary spending.[3-45] [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Although Core Measure 9.1 is a utilization measure and therefore does not have established benchmarks, **HAP**'s MY 2021 Core Measure 9.1 rate was an outlier in comparison to the other ICOs. [**Quality** and **Access**]

Why the weakness exists: The reason for the high Core Measure 9.1 rate is unclear; however, the high rate indicates that **HAP**'s members are accessing the ED for behavioral health treatment at a higher rate in comparison to other ICOs.

Recommendation: HSAG recommends that **HAP** conduct a root cause analysis to evaluate why its Core Measure 9.1 rate is an outlier. This analysis should include an evaluation of members who are included in Core Measure 9.1 to determine contributing factors to their ED access. **HAP** should consider whether it needs to deploy new strategies to better support earlier identification of behavioral health conditions as well as earlier member engagement in treatment for these conditions. Additionally, **HAP** should assess whether these members are appropriately connected to fully integrated treatment providers if such providers are available in **HAP**'s primary care network of providers.[3-46]

[3-44] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

[3-45] National Committee for Quality Assurance. Transitions of Care (TRC). Available at: https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed on: Feb 27, 2023.

[3-46] The Centers for Medicare & Medicaid Services, "SMD # 18--011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," letter, November 13, 2018. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf Accessed on: Feb 27, 2023.

Weakness #2: **HAP** was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: **HAP** did not update its source code to align with the Core Measure 9.3 FAQs that were released in December 2021, and **HAP** incorrectly identified members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge.

Recommendation: HSAG recommends that **HAP** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **HAP** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

Weakness #3: For 25 of the 45 reported HEDIS measures (56 percent), **HAP**'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, Overuse/Appropriateness, 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, Overuse/Appropriateness, and Access/Availability of Care domains demonstrated worse performance than the statewide average, indicating **HAP** was not performing as well as the other ICOs in some measures within these domains.

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

Weakness #4: In the Respiratory Conditions domain, **HAP**'s rates for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators decreased by more than 5 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. COPD exacerbations or "flare-ups" make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD.[3-47] [**Quality** and **Access**]

Why the weakness exists: The rates for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators decreasing by more

[3-47] 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 27, 2023.

than 5 percentage points from MY 2020 to MY 2021 suggest that barriers exist for receiving medication therapy to manage exacerbation for some adult members with COPD.

Recommendation: HSAG recommends that **HAP** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **HAP** should implement appropriate interventions to improve the performance related to the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* measure indicators. **HAP** 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).

Weakness #5: In the Cardiovascular Conditions domain, **HAP**'s rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator decreased by approximately 5 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults with clinical atherosclerotic cardiovascular disease (ASCVD) were not receiving statin therapy. Cardiovascular disease is the leading cause of death in the United States. 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.[3-48] [**Quality** and **Access**]

Why the weakness exists: The rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator decreasing by approximately 5 percentage points from MY 2020 to MY 2021 suggests that barriers exist for some adults with ASCVD to receive statin therapy.

Recommendation: HSAG recommends that **HAP** conduct a root cause analysis or focused study to determine why some adults with ASCVD were not receiving statin therapy. Upon identification of a root cause, **HAP** should implement appropriate interventions to improve the performance related to the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator. **HAP** 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 education).

Weakness #6: In the Behavioral Health domain, **HAP**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measure indicator decreased by more than 8 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some members were not receiving follow-up care for mental illness within seven days of an ED visit. 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.[3-49] [**Quality**, **Timeliness**, and **Access**]

[3-48] National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/. Accessed on: Feb 27, 2023.

[3-49] 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 27, 2023.

Why the weakness exists: The rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measure indicator decreasing by more than 8 percentage points from MY 2020 to MY 2021 suggests that barriers exist for some members to receive follow-up care for mental illness within seven days of an ED visit.

Recommendation: HSAG recommends that **HAP** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness within seven days of an ED visit. Upon identification of a root cause, **HAP** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measure indicator. **HAP** 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 education or staffing shortages).

Compliance Review

Performance Results

Table 3-30 presents **HAP**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **HAP** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **HAP**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-30—Standard Compliance Scores for HAP

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2022)		
Standard I—Disenrollment: Requirements and Limitations[2]	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**61%**
Standard III—Emergency and Poststabilization Services[2]	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**75%**
Standard VI—Coordination and Continuity of Care	§438.208	**80%**
Standard VII—Coverage and Authorization of Services	§438.210	**86%**
Year Two (SFY 2023)		
Standard VIII—Provider Selection	§438.214	—
Standard IX—Confidentiality	§438.224	—
Standard X—Grievance and Appeal Systems	§438.228	—

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Standard XI—Subcontractual Relationships and Delegation	§438.230	—
Standard XII—Practice Guidelines	§438.236	—
Standard XIII—Health Information Systems[3]	§438.242	—
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	—
Year Three (SFY 2024)		
Review of ICO's implementation of Year One and Year Two CAPs		

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[3] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

Dash (—): The ICO's compliance with Year Two standards will be reviewed and scored during the SFY 2023 compliance review activity.

Table 3-31 presents **HAP**'s scores for each standard evaluated during the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **HAP**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2022 compliance review activity demonstrated how successful **HAP** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-31—SFY 2022 Standard Compliance Scores for HAP

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations[1]	9	6	6	0	3	**100%**
Standard II—Member Rights and Member Information	23	23	14	9	0	**61%**
Standard III—Emergency and Poststabilization Services[1]	13	13	13	0	0	**100%**
Standard IV—Availability of Services	13	13	13	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	4	4	3	1	0	**75%**
Standard VI—Coordination and Continuity of Care	31	30	24	6	1	**80%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Coverage and Authorization of Services	28	28	24	4	0	**86%**
Total	**121**	**117**	**97**	**20**	**4**	**83%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

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 achieved full compliance in the Availability of Services program area, demonstrating that the ICO maintained and monitored a network of appropriate providers, supported by written agreements, and sufficient to provide adequate access to all services. [**Access**]

Weaknesses and Recommendations

Weakness #1: HAP received a score of *Not Met* for nine elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: HAP's member materials did not contain all required member rights, member materials critical to obtaining services did not comply with language requirements for taglines, there was no evidence that members were informed when a provider or pharmacy was terminated, the member handbook did not contain all mandatory components, there was no documentation available to support timely notice to members would occur due to a significant change impacting members' access to services and information about the managed care program, the provider directory did not include all required components, and the provider directory and formulary drug list were not available in a machine readable format. Contributory factors included, but were

not limited to, misinterpretation of model materials and federal rules, staff misunderstanding of machine-readable content, and a lack of detail in policy or processes.

Recommendation: HAP was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **HAP** ensure that it consistently uses the most current version of the model member materials.

Weakness #2: HAP received a score of *Not Met* for six elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: HAP did not consistently and timely review program-level data and utilization data to assign an initial risk stratification to each member, consistently and timely complete health risk screenings for its members to assess their healthcare needs, ensure all appropriate Level II assessment referrals were completed timely, ensure all required components were included in the IICSP, or consistently review the IICSP with the member on a schedule specific to the member's risk stratification level. Contributory factors included, but were not limited to, staff unawareness of documenting review details, unclear training of requirements, lack of an established monitoring and oversight process, lack of reportable fields within the care management system configuration, and misinterpretation of IICSP requirements.

Recommendation: As **HAP** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

Weakness #3: HAP received a score of *Not Met* for four elements within the Coverage and Authorization of Services program area, indicating members' service requests were not consistently decided timely and adequately. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: HAP did not clearly define medically necessary services, consistently ensure LTSS service requests were required against Medicaid benefit, or consistently provide members with an integrated denial notice (IDN) when a denial of payment was made on a claim. Contributory factors included, but were not limited to, staff not following established processes and a misunderstanding of the federal rule.

Recommendation: As **HAP** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG's NAV results indicated that **HAP** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. Table 3-32 presents **HAP**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception determinations.

Table 3-32—SFY 2022 NAV Results for HAP, by Region and Provider Type

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time/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 Aids	*Met*	*Met*
Hearing Examinations	*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*
ECLS	*Met*	*Met*
Environmental Modifications	*Met*	*Met*
Fiscal Intermediary	*Met*	*Met*
Home-Delivered Meals	*Met*	*Met*
Medical Supplies (e.g., incontinence supplies)	*Met*	*Met*
NEMT	*Met*	*Met*
Non-Medical Transportation (waiver services only)	*Met*	*Met*

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Personal Care Services	*Met*	*Met*
Personal Emergency Response System	*Met*	*Met*
Preventive Nursing Services	*Met*	*Met*
Private Duty Nursing	*Met*	*Met*
Respite	*Met*	*Met*
Skilled Nursing Home (report only beds certified for both Medicare and Medicaid)	*Met*	*Met*
Percentage of Total Requirements Met	**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: HAP met all Medicaid and LTSS minimum network requirements for Region 7, indicating that **HAP** maintains an adequate network for MI Health Link members in this region. [**Access**]

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

Weaknesses and Recommendations

Weakness #1: HSAG identified no specific weaknesses for **HAP** based on the SFY 2022 NAV results.

Why the weakness exists: NA

Recommendation: HAP 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 271 sampled provider locations (i.e., "cases") for **HAP**, with an overall response rate of 87.1 percent (236 cases) among **HAP**'s two MI Health Link regions. Region 9 had the highest response rate, and Region 7 had the lowest response rate. Table 3-33 summarizes the SFY 2022 secret shopper survey response rates by visit scenario for **HAP**, and for each of **HAP**'s contracted MI Health Link regions.

Table 3-33—Summary of HAP Secret Shopper Survey Results for Routine Dental Visits, by Region

		Response Rate		Accepting ICO		Accepting MI Health Link		Accepting New Patients	
Region	Total Number of Cases	Cases Reached	Rate (%)	Accepting ICO	Rate (%)[1]	Accepting MI Health Link	Rate (%)[2]	Accepting New Patients	Rate (%)[3]
Region 7	159	138	86.8%	77	55.8%	40	51.9%	40	100%
Region 9	112	98	87.5%	47	48.0%	22	46.8%	22	100%
HAP Total	**271**	**236**	**87.1%**	**124**	**52.5%**	**62**	**50.0%**	**62**	**100%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and indicating that at least one practitioner at the location accepts the requested ICO.
[3] The denominator includes cases responding to the survey that accept the ICO and accept MI Health Link.

Table 3-34 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **HAP**, and for each of **HAP**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-34—Summary of HAP Secret Shopper Survey Appointment Availability Results, by Region

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
Region 7	159	40	19	47.5%	11.9%	0	88	22	11
Region 9	112	22	5	22.7%	4.5%	1	102	39	27
HAP Total	**271**	**62**	**24**	**38.7%**	**8.9%**	**0**	**102**	**26**	**12**

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

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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP had a survey response rate of 87.1 percent. [**Quality** and **Access**]

Strength #2: Of the cases accepting **HAP** and MI Health Link, 100 percent (n=62) accepted new patients. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 52.5 percent of sampled provider locations accepted and/or recognized the ICO, while only 50.0 percent of those cases accepted and/or recognized the MI Health Link program. [**Access**]

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

Recommendation: HSAG recommends that **HAP** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect ICO acceptance) to address the provider data deficiencies and educate provider offices on ICO and MI Health Link acceptance. Additionally, as MDHHS required **HAP** 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: Of cases in which the survey respondent reported that the provider location accepted **HAP**, the MI Health Link program, and new patients, appointment availability was reported for 38.7 percent of cases. However, this results in appointment availability for 8.9 percent of **HAP**'s total sample. [**Access**]

Why the weakness exists: 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 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** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **HAP** 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 **HAP**; 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).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS 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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: As **HAP**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level.

Weaknesses and Recommendations

Weakness #1: As **HAP**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level.

Why the weakness exists: NA

Recommendation: While no **HAP**-specific results could be presented, the statewide analysis identified four measures that had a mean score below 90 percent, with one of those measures, *Reliable and Helpful Staff*, demonstrating a statistically significant decline from the prior year, indicating opportunities for improvement for the MI Health Link program. Therefore, HSAG recommends that **HAP** develop and implement interventions to improve member experience related to the *Reliable and Helpful Staff*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommend Homemaker* HCBS CAHPS Survey measures. Of note, the lowest performing CAHPS measure was *Planning Your Time and Activities* with a mean score of 73.5 percent, indicating that **HAP** should prioritize its efforts to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.

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

HSAG performed a comprehensive assessment of **HAP**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **HAP** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **HAP**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-35 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **HAP**'s Medicaid members.

Table 3-35—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality**—Through MDHHS' mandated QIP, **HAP** identified a disparity between African American members and Caucasian members diagnosed with hypertension and whose blood pressure was controlled. **HAP** designed a methodologically sound QIP and used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. Interventions implemented through this QIP have the potential of reducing/eliminating the disparity between the two subgroups. **HAP**'s health disparity QIP should also have a positive impact on the *CBP—Controlling High Blood Pressure* performance measure. As demonstrated through the PMV activity, the rate for this measure ranked above the statewide average, and the rate improved in performance from the previous year. Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions.[3-50] Additionally, **HAP**'s quality program is required to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. **HAP**'s quality program will be reviewed during the future SFY 2023 compliance review activity.
Preventive Care and Services	**Quality** and **Access—HAP** demonstrated overall strength as it relates to members obtaining preventive care and services. As demonstrated through the PMV activity results, four of the six indicator rates under the Prevention and Screening domain, *BCS—Breast Cancer Screening*, *COL—Colorectal Cancer Screening*, *COA—Care for Older Adults—Advance Care Planning*, and *COA—Care for Older Adults—Functional Status Assessment*, ranked above the statewide average with three of those indicator rates improving in performance from the previous year, indicating many of **HAP**'s members received the recommended screening for breast cancer and colorectal cancer. Mammogram screening and early detection of breast cancer decreases the risk of mortality from breast cancer, leads to a greater range of treatment options, and lower

[3-50] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	healthcare costs.[3-51] Colorectal cancer screening can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.[3-52] The performance measure results indicate that more of **HAP**'s older members received a functional status assessment and advance care planning to ensure they receive the care they need to optimize quality of life and have their choices about end-of-life considered.[3-53] Additionally, while only one of the four indicator rates under the *AAP–Adults' Access to Preventive/Ambulatory Health Services* measure ranked above the statewide average, all indicator rates improved in performance from the previous year. **HAP** should continue initiatives to promote ambulatory or preventive care visits to ensure adult members receive preventive services such as counseling on diet and exercise and to help address acute issues or manage chronic conditions.[3-54] However, two indicator rates, *COA—Care for Older Adults—Medication Review* and *COA—Care for Older Adults—Pain Assessment*, under the Prevention and Screening domain ranked below the statewide average and declined in performance from the previous year. As the population ages, pain becomes more prevalent and older adults have more complex medication regimes; therefore, medication reviews and pain assessments are essential to ensure older adults receive the care they need to optimize quality of life.[3-55] Lastly, the results of the secret shopper survey revealed that a high number of dental providers did not accept or recognize the MI Health Link program. Further, of the dental providers that accepted new patients receiving benefits through **HAP**'s MI Health Link program, appointment availability was low. These results indicate that **HAP**'s members may be experiencing barriers in scheduling appointments for preventive dental care. Regular check-ups can find tooth decay, gum disease and other problems before they lead to more serious issues.[3-56]

[3-51] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 27, 2023.

[3-52] National Committee for Quality Assurance. Colorectal Cancer Screening (COL, COL-E). Available at: https://www.ncqa.org/hedis/measures/colorectal-cancer-screening/. Accessed on: Feb 27, 2023.

[3-53] 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 27, 2023.

[3-54] National Committee for Quality Assurance. Adults Access to Preventive/Ambulatory Health Services (AAP). Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Feb 27, 2023.

[3-55] 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 27, 2023.

[3-56] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Oral Health is Important for Overall Health. Available at: https://www.cdc.gov/chronicdisease/resources/infographic/oralhealth.htm. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—As demonstrated through the results of the PMV activity, 11 of the 16 indicator rates under the Respiratory Conditions, Cardiovascular Conditions, Diabetes, and Musculoskeletal Conditions domains ranked below the statewide average with seven of those 11 indicator rates demonstrating a decline in performance from the previous year. These results indicate multiple opportunities for **HAP** to increase proper management of COPD exacerbations; beta-blocker treatment after a heart attack; statin therapy for members with cardiovascular disease; osteoporosis in women following a fracture; and HbA1c testing, HbA1c control, blood pressure control, and statin therapy adherence for members diagnosed with diabetes. Chronic diseases are the leading cause of death and disability in the nation and the leading drivers of healthcare costs.[3-57] As it relates to osteoporosis in women following a fracture, **HAP** reported provider participation as a barrier (e.g., do not want to offer in-home testing and lack of understanding of the time frame window for compliance), but the ICO has implemented several initiatives and seen an improvement in rates. However, the PMV results also confirmed that five indicator rates ranked above the statewide average, demonstrating many of **HAP**'s members received proper management of the use of spirometry testing in the assessment and diagnosis of COPD; hypertension; and eye exams, medical attention for nephropathy, and statin therapy for members diagnosed with diabetes.
Behavioral Health and Substance Use Disorders	**Quality**, **Timeliness**, and **Access—**All six indicator rates within the Behavioral Health domain ranked below the statewide average, with two rates declining from the previous year, indicating opportunities for **HAP** to improve acute and continued medication management for members diagnosed with major depression, and increase the number of follow-up care visits for members discharged from an inpatient admission or ED for a diagnosis of mental illness. **HAP** was also the lowest performing ICO for the two indicator rates under the *FUM—Follow-Up After Emergency Department Visit for Mental Illness* measure. Effective medication management of major depression can improve a member's daily functioning and well-being and can reduce the risk of suicide.[3-58] Follow-up care for members diagnosed with a mental illness correlates to fewer repeat emergency visits, improved physical and mental function, increased compliance with follow-up instructions, improved outcomes, and decrease the

[3-57] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. About Chronic Diseases. Available at: https://www.cdc.gov/chronicdisease/about/index.htm. Accessed on: Feb 27, 2023.

[3-58] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	likelihood of re-hospitalization and cost of outpatient care.[3-59,3-60] As it relates to follow-up care after hospitalization, **HAP** reported implementing several interventions and has recently seen improvement in rates; however, inaccurate contact information for members and the lack of a manual tracking process of members after admission continue to be barriers. However, **HAP** demonstrated strong performance for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* and *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measures, as two indicator rates ranked above the statewide average with one rate improving in performance from the previous year. Substance use disorder treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug abuse or dependence-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-61] Lastly, while some of **HAP**'s indicator rates increased from the previous year or ranked above the statewide average, it should be noted the statewide average is relatively low for most related measures. Therefore, overall, **HAP** has opportunities to enhance proper management of behavioral health conditions and substance use disorders.
HCBS	**Quality**—Person-centered planning and the development of an IICSP are critical aspects of **HAP**'s care coordination program for members who are receiving HCBS and supports. The IICSP allows the member, care coordinator, providers, and other care team members to stay informed of the member's health status; provides a description of the services and supports in place to meet the member's needs; and tracks the member's progress on meeting his or her goals. **HAP** received a score of 80 percent for Standard VI—Coordination and Continuity of Care through the compliance review activity, indicating multiple opportunities for improvement in the development and implementation of the IICSP. Additionally, the HCBS CAHPS Survey was administered to **HAP**-enrolled members to gather direct feedback from MI Health Link members receiving HCBS about their experiences and the quality of the LTSS they receive. Due to the low number of respondents to the survey, **HAP**-specific results are unable to be presented; therefore, member experience was not able to be adequately assessed. While **HAP**-specific results are not available, **HAP**-enrolled members

3-59 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 27, 2023.

3-60 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 27, 2023.

3-61 National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	responding to the survey contributed to the overall MI Health Link program results, which are reported in Section 5. However, the NAV activity produced overall positive results as **HAP** met the minimum network requirements for all LTSS provider types including providers rendering home-based services. Further, as demonstrated through the PMV activity, **HAP** reported the *Minimizing Institutional Length of Stay* core measure in alignment with the measure specifications. **HAP** could accurately report on the number of admissions to institutional facilities, the total number of discharges from an institutional facility to the community, and the number of expected discharges to the community, indicating an effective mechanism to monitor member transitions to coordinate care. HCBS and supports provide the opportunity for members to safely receive services in their own home or community setting rather than in institutions or other isolated settings.

MeridianComplete

Validation of Quality Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Meridian**'s QIP (i.e., the QIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-36 displays the overall validation status and the baseline results for the performance indicators. The QIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-36—Overall Validation Rating for MER

QIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes	*Met*	HEDIS SPD adherence performance—African American/Black population—all regions.	74.2%			Yes
		HEDIS SPD adherence performance—White population—all regions.	85.8%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Meridian**'s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-37 displays the interventions, as available, initiated by the ICO to support achievement of the QIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-37—Baseline Interventions for MER

Intervention Descriptions	
Identified members who were not seen by their PCP in 2021 or 2022. The QI department conducted a member outreach campaign to assist with appointment scheduling and/or transportation needs. Utilized provider-facing staff for communication with providers about members who have not been seen. Offered My Meridian Rewards, a member incentive program for annual wellness visits.	Identified members who have not received cardiovascular testing (minimum LDL [low-density lipoprotein] test). The QI department conducted member outreach and offered assistance with appointment scheduling and/or transportation needs. Utilized provider-facing staff for communication with providers about members who are in need of cardiovascular testing (minimum LDL test).
Identified members who have a 30-day supply of statin therapy medication for conversion to a 90-day supply. Promoted the option for the mail order prescription program. Conducted a member outreach campaign to distribute transportation resources.	Developed and distributed culturally sensitive education material to the African American/Black population.
Addressed unable-to-reach members for education communication as well as appointment and testing reminders by using a phased method approach of communication. Methods included phone, text messages, mail, email, vendor support, and in-home visit options.	Developed a provider pay-for-performance bonus for HEDIS SPD adherence at 80 percent compliance. Identified low-performing PCPs and utilized provider-facing staff to promote evidence-based guidelines, Meridian's Provider HEDIS Quick Reference Guide, and Meridian's pay-for performance program.

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 QIP 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 designed a methodologically sound QIP supported by using key research principles. **Meridian**'s Aim statement set the focus of the QIP, and the eligible population was clearly defined. **Meridian** selected performance indicators based on data analysis showing opportunities for improvement within the targeted populations. The technical design of the QIP was sufficient to measure and monitor QIP outcomes. [**Quality**]

Strength #2: Meridian met 100 percent of the requirements for data analysis and implementation of improvement strategies. **Meridian** conducted accurate statistical testing between the two subgroups for the baseline measurement period to identify an existing disparity and provided a narrative interpretation of the results. Appropriate QI tools were used to conduct its causal/barrier analysis and to prioritize the identified barriers. Interventions were implemented in a timely manner, were

reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no significant identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Meridian** evaluate the effectiveness of the interventions initiated and use the outcomes to guide each intervention's next steps.

Performance Measure Validation

Performance Results

HSAG evaluated **Meridian**'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 (i.e., claims and encounters), care coordination system (i.e., tracking and management of care transition record transmissions), medication review system (i.e., tracking and management of medication reviews), hybrid data collection and review, or data integration.

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

Table 3-38—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*	**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 3-39 shows each of **Meridian**'s audited HEDIS measures, rates for HEDIS MY 2020 and HEDIS MY 2021 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2021 with HEDIS MY 2020, and the HEDIS MY 2021 MI Health Link statewide average performance rates. HEDIS MY 2021 measure rates performing better than the statewide average are notated by green font.

Table 3-39—Measure-Specific Percentage Rates for MER

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening	55.29	52.53	−2.76	52.74
COL—Colorectal Cancer Screening	59.21	56.45	−2.76	56.03
COA—Care for Older Adults—Advance Care Planning	20.92	27.74	+6.82	41.07
COA—Care for Older Adults—Medication Review	74.94	77.13	+2.19	74.85
COA—Care for Older Adults—Functional Status Assessment	22.63	28.47	+5.84	58.42
COA—Care for Older Adults—Pain Assessment	73.24	74.21	+0.97	75.25
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.17	22.22	−3.95	22.93
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	72.25	42.67	−29.58	68.65
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	86.13	87.33	+1.20	89.67
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure	62.77	66.18	+3.41	60.52
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	88.89	100	+11.11	95.25
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	80.09	79.74	−0.35	82.00
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	81.36	77.35	−4.01	84.22
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing	86.37	91.73	+5.36	87.50
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**	40.63	37.23	−3.40	43.53
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	51.34	54.26	+2.92	49.06
CDC—Comprehensive Diabetes Care—Eye Exam	60.34	61.07	+0.73	57.33

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	92.46	89.83	−2.63	90.01
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	62.29	66.18	+3.89	60.82
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	76.95	80.70	+3.75	76.83
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	83.76	80.39	−3.37	82.46
Musculoskeletal Conditions				
OMW—Osteoporosis Management in Women Who Had a Fracture	33.33	0.00	−33.33	16.12
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	71.57	72.46	+0.89	75.06
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	54.82	53.89	−0.93	60.75
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	18.60	26.32	+7.72	26.13
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	59.30	42.11	−17.19	50.22
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	41.07	47.62	+6.55	33.87
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	50.00	65.48	+15.48	51.71
Medication Management and Care Coordination				
TRC—Transitions of Care—Notification of Inpatient Admission	6.57	29.68	+23.11	13.11
TRC—Transitions of Care—Receipt of Discharge Information	10.95	29.93	+18.98	12.77
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	74.70	84.67	+9.97	74.60
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	33.82	62.29	+28.47	43.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	14.65	20.74	+6.09	24.68
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**	33.33	30.70	−2.63	31.94
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**	19.29	18.55	−0.74	17.81
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	7.21	5.92	−1.29	5.50

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
*DAE—Use of High-Risk Medications in Older Adults—Total**	23.81	22.53	−1.28	21.56
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	84.36	84.73	+0.37	84.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	94.55	93.65	−0.90	93.49
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	93.43	93.26	−0.17	91.45
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	92.07	91.62	−0.45	90.77
IET—Initiation of Alcohol and Other Drug Dependence Treatment	50.00	81.79	+31.79	48.59
IET—Engagement of Alcohol and Other Drug Dependence Treatment	8.98	11.43	+2.45	6.53
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	1.13	1.27	+0.14	1.17
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	0.84	1.31	+0.47	1.20

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

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: Following the guidance received in last year's PMV activities regarding MI2.6, **Meridian** implemented a workgroup to discuss creative ways to further engage providers, both hospital groups and provider offices, to ensure that care transition records are sent within two days after discharge to the PCP. [**Quality** and **Timeliness**]

Strength #2: Meridian demonstrated continued strength through its claims completeness factor calculation process, providing assurance that **Meridian**'s Core Measure 9.1 and Core Measure 9.3 data are accurate, since both are based on claims data. It is also critical that administrative data are complete for Core Measure 9.3 so that **Meridian** 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), ensuring the accuracy of data element B. [**Quality** and **Timeliness**]

Strength #3: Meridian transitioned care coordination to an in-house function in 2021 and began the process of requesting internal access to hospital system records. In addition, in alignment with HSAG's recommendation from the SFY 2021 PMV, **Meridian** restructured the MI2.6 process for 2021 by implementing the hybrid methodology for reporting MI2.6, which further ensured the accuracy, quality, and completeness of its MI2.6 reported data. [**Quality** and **Timeliness**]

Strength #4: In the Medication Management and Care Coordination domain, **Meridian**'s rates for the *TRC—Transitions of Care—Notification of Inpatient Admission*, *Receipt of Discharge Information*, *Patient Engagement After Inpatient Discharge*, and *Medication Reconciliation Post-Discharge* measure indicators increased by more than 9 percentage points from MY 2020 to MY 2021 and all exceeded the HEDIS MY 2021 MI Health Link statewide average, indicating strength in addressing key points of transitions of care for inpatient facility members. Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs.[3-62] [**Quality**, **Timeliness**, and **Access**]

Strength #5: In the Access/Availability of Care domain, **Meridian**'s rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator increased by more than 31 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in adults with a new episode of alcohol or other drug dependence receiving timely treatment. Treatment, including medication-assisted treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-63] [**Quality**, **Timeliness**, and **Access**]

Strength #6: In the Cardiovascular Conditions domain, **Meridian**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure increased by more than 11 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in adults' use of a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels.

3-62 National Committee for Quality Assurance. Transitions of Care (TRC). Available at: https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed on: Feb 27, 2023.

3-63 National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-64] [**Quality**, **Access**, and **Timeliness**]

Strength #7: In the Diabetes domain, **Meridian**'s rate for the *CDC—Comprehensive Diabetes Care—HbA1c Testing* measure indicator increased by more than 5 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in adult members with diabetes receiving HbA1c tests. 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.[3-65] [**Quality** and **Access**]

Strength #8: In the Behavioral Health domain, **Meridian**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days* measure indicator increased by more than 7 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting 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 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.[3-66] [**Quality**, **Timeliness**, and **Access**]

Strength #9: In the Behavioral Health domain, **Meridian**'s rates for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* and *30 Days* measure indicators increased by more than 6 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting 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.[3-67] [**Quality**, **Timeliness**, and **Access**]

[3-64] 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 27, 2023.

[3-65] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 27, 2023.

[3-66] 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 27, 2023.

[3-67] 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 27, 2023.

Weaknesses and Recommendations

Weakness #1: Meridian was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Meridian's source code did not align with the Core Measure 9.3 FAQs that were released in December 2021, which allowed for the potential to incorrectly identify members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge. Additionally, **Meridian** deviated from the measure specifications and the institutional facility value set codes for Core Measure 9.3 for data element A, as it was identified that **Meridian**'s source code was identifying IFA claims for data element A by bill types or bill types and revenue codes, which caused a narrower universe of claims to be reported than was intended. The measure specifications indicate to identify IFA claims by either bill types or revenue codes.

Recommendation: HSAG recommends that **Meridian** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **Meridian** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements. Additionally, HSAG recommends that **Meridian** put quality checks in place to ensure that the programming logic used for future data submissions is in alignment with the reporting requirements, is inclusive of all associated value set codes, and avoids limiting parameters.

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

Why the weakness exists: It was identified in **Meridian**'s member-level data submitted for Core Measure 9.3 that the file only included discharges from January through June 2021. **Meridian** indicated that its member-level submission was not capturing 2020 data due to the legacy **Meridian** ID number not being populated in its system and having different member AMISYS ID numbers. This caused members enrolled prior to 2020 to not meet the continuous enrollment criteria for data element A. **Meridian** updated its programming logic and submitted a revised Core Measure 9.3 member-level detail file to HSAG. Upon review of the revised member-level detail file, HSAG noted that the file appropriately included IFAs from July 2020 through June 2021, in alignment with the MMP Core Reporting Requirements for data element A. However, the file only included discharges that occurred for members who had admissions between January through June 2021. The member-level file should have reflected discharges that occurred for admissions from July 2020 through June 2021. **Meridian** updated and resubmitted its Core Measure 9.3 member-level detail file once more to include updated programming logic.

Recommendation: HSAG recommends that **Meridian** implement more stringent validation checks prior to submission of member-level data. These checks should include reviewing the member-level data to ensure alignment with the reporting requirements, especially in relation to time frame parameters required by the specifications for the performance measure.

Weakness #3: In the Respiratory Conditions domain, **Meridian**'s rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator decreased by more than 29 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. COPD exacerbations or "flare-ups" make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD.[3-68] [**Quality** and **Access**]

Why the weakness exists: The rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator decreasing by more than 29 percentage points from MY 2020 to MY 2021 suggests that barriers exist for receiving medication therapy to manage exacerbation for some adult members with COPD.

Recommendation: HSAG recommends that **Meridian** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **Meridian** should implement appropriate interventions to improve the performance related to the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator. **Meridian** 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).

Weakness #4: In the Musculoskeletal Conditions domain, **Meridian**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreased by more than 33 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, suggesting 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.[3-69] [**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 more than 33 percentage points from MY 2020 to MY 2021, 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 **Meridian** conduct a root cause analysis or focused study to determine why women were not always receiving timely bone mineral density tests or a

[3-68] 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 27, 2023.

[3-69] 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 27, 2023.

prescription to treat osteoporosis within six months of a fracture. Upon identification of a root cause, **Meridian** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **Meridian** 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).

Weakness #5: In the Behavioral Health domain, **Meridian**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator decreased by more than 17 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some members were not receiving follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. 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.[3-70] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator decreasing by more than 17 percentage points from MY 2020 to MY 2021 suggests that barriers exist for some members to receive follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm.

Recommendation: HSAG recommends that **Meridian** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. Upon identification of a root cause, **Meridian** should implement appropriate interventions to improve the performance related to the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator. **Meridian** 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 education or staffing shortages).

[3-70] 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 27, 2023.

Compliance Review

Performance Results

Table 3-40 presents **Meridian**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Meridian** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Meridian**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-40—Standard Compliance Scores for MER

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2022)		
Standard I—Disenrollment: Requirements and Limitations[2]	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**70%**
Standard III—Emergency and Poststabilization Services[2]	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**75%**
Standard VI—Coordination and Continuity of Care	§438.208	**73%**
Standard VII—Coverage and Authorization of Services	§438.210	**78%**
Year Two (SFY 2023)		
Standard VIII—Provider Selection	§438.214	–
Standard IX—Confidentiality	§438.224	–
Standard X—Grievance and Appeal Systems	§438.228	–
Standard XI—Subcontractual Relationships and Delegation	§438.230	–
Standard XII—Practice Guidelines	§438.236	–
Standard XIII—Health Information Systems[3]	§438.242	–
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	–
Year Three (SFY 2024)		
Review of ICO's implementation of Year One and Year Two CAPs		

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength

within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[3] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

Dash (—): The ICO's compliance with Year Two standards will be reviewed and scored during the SFY 2023 compliance review activity.

Table 3-41 presents **Meridian**'s scores for each standard evaluated during the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Meridian**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2022 compliance review activity demonstrated how successful **Meridian** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-41—SFY 2022 Standard Compliance Scores for MER

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations[1]	9	6	6	0	3	**100%**
Standard II—Member Rights and Member Information	23	23	16	7	0	**70%**
Standard III—Emergency and Poststabilization Services[1]	13	13	13	0	0	**100%**
Standard IV—Availability of Services	13	13	13	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	4	4	3	1	0	**75%**
Standard VI—Coordination and Continuity of Care	31	30	22	8	1	**73%**
Standard VII—Coverage and Authorization of Services	28	27	21	6	1	**78%**
Total	**121**	**116**	**94**	**22**	**5**	**81%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

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: Meridian achieved full compliance in the Availability of Services program area, demonstrating that the ICO maintained and monitored a network of appropriate providers, supported by written agreements, and sufficient to provide adequate access to all services. [**Access**]

Weaknesses and Recommendations

Weakness #1: Meridian received a score of *Not Met* for seven elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Meridian's member materials did not contain all required member rights, member materials critical to obtaining services did not comply with language requirements for taglines, there was no evidence that members were informed when a provider or pharmacy was terminated, the member handbook did not contain all mandatory components, the provider directory did not include all required components, and the formulary drug list was not available in a machine-readable format. Contributory factors included, but were not limited to, incomplete policies, misinterpretation of the federal rule, break down of processes as a result of a system integration, and inconsistencies between the paper and electronic provider directory.

Recommendation: As **Meridian** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **Meridian** ensure that it consistently uses the most current version of the model member materials.

Weakness #2: Meridian received a score of *Not Met* for eight elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Meridian did not ensure caseloads met the MDHHS 600-point threshold; consistently and timely review program-level data and utilization data, and assign an initial risk stratification to each member; consistently and timely complete health risk screenings for its members to assess their healthcare needs; ensure all required components were included in the

IICSP; review the IICSP with the member on a schedule specific to the member's risk stratification level; or ensure that ICT meetings were scheduled at the convenience of the member and included engagement of the member's PCP. Contributory factors included, but were not limited to, staff turnover and challenges in recruiting staff, staff deviation from processes, and inconsistent auditing and monitoring.

Recommendation: As **Meridian** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

Weakness #3: Meridian received a score of *Not Met* for six elements within the Coverage and Authorization of Services program area, indicating members' service requests were not consistently decided timely and adequately. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Meridian did not consistently ensure the appropriate IDN was sent to the member; ensure an alert or notification mechanism was in place for care coordinators to be made aware of ABDs; provide an ABD notice to members timely for the termination, suspension, or reduction of previously authorized services, including the exceptions to this federal requirement; or ensure that authorization decisions not made within the appropriate time frames were considered denials and notice provided to the member. Contributory factors included, but were not limited to, organizational and personnel changes and a lack of established processes.

Recommendation: As **Meridian** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG's NAV results indicated that **Meridian** met all Medicaid and LTSS minimum network requirements for Region 7. For Region 4 and Region 9, **Meridian** submitted additional data updates and final requests for exceptions to address provider types not meeting the minimum network requirements. MDHHS approved **Meridian**'s requested exception for the Adult Day Program provider type in Region 4. Table 3-42 presents **Meridian**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception determinations.

Table 3-42—SFY 2022 NAV Results for MER, by Region and Provider Type

Provider Type	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time/Distance Requirements			
Adult Day Program	*Exception Granted*	*Met*	*Not 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 Aids	*Met*	*Met*	*Met*
Hearing Examinations	*Met*	*Met*	*Met*
MIHP Agency	*Not Met*	*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	*Not Met*	*Met*	*Met*
Chore Services	*Met*	*Met*	*Met*
Community Transition Services	*Met*	*Met*	*Met*
ECLS	*Met*	*Met*	*Met*
Environmental Modifications	*Met*	*Met*	*Met*
Fiscal Intermediary	*Met*	*Met*	*Met*
Home-Delivered Meals	*Met*	*Met*	*Met*
Medical Supplies (e.g., incontinence supplies)	*Met*	*Met*	*Met*
NEMT	*Met*	*Met*	*Met*
Non-Medical Transportation (waiver services only)	*Met*	*Met*	*Met*
Personal Care Services	*Met*	*Met*	*Met*
Personal Emergency Response System	*Met*	*Met*	*Met*
Preventive Nursing Services	*Met*	*Met*	*Met*
Private Duty Nursing	*Met*	*Met*	*Met*
Respite	*Met*	*Met*	*Met*

Provider Type	Region 4 Validation Result	Region 7 Validation Result	Region 9 Validation Result
Skilled Nursing Home (report only beds certified for both Medicare and Medicaid)	*Met*	*Met*	*Met*
Percentage of Total Requirements Met*	**88%**	**100%**	**96%**

*The denominator for Percentage of Total Requirements Met includes all 25 standards regardless of whether an exception request was granted.

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

Weaknesses and Recommendations

Weakness #1: Meridian failed to meet the Assistive Technology—Van Lifts and Tie Downs 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 did not approve **Meridian**'s exception request for Assistive Technology—Van Lifts and Tie Downs providers in Region 4, as **Meridian** had not contracted with all available providers in the region.

Recommendation: HSAG recommends that **Meridian** identify and contract with additional Assistive Technology—Van Lifts and Tie Downs 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 2023 NAV.

Weakness #2: Meridian failed to meet the MIHP Agency 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 did not approve **Meridian**'s exception request for the MIHP Agency provider type in Region 4, as **Meridian** had not followed MDHHS' instructions to submit a complete and accurate exception request for MIHP Agency providers in Region 4.

Recommendation: HSAG recommends that **Meridian** follow MDHHS' instructions regarding the submission of the exception request form for all applicable provider types during the SFY 2023

NAV. Updated compliance for the MIHP Agency provider type in Region 4 will be evaluated during the SFY 2023 NAV.

Weakness #3: **Meridian** 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 did not approve **Meridian**'s exception request for the Adult Day Program provider type in Region 9, as **Meridian** had not contracted with all available providers in the region.

Recommendation: HSAG recommends that **Meridian** identify and contract with additional Adult Day Program providers in Region 9 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 9 will be evaluated during the SFY 2023 NAV.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 327 sampled provider locations (i.e., "cases") for **Meridian**, with an overall response rate of 81.3 percent (266 cases) among **Meridian**'s three MI Health Link regions. Region 9 had the highest response rate, and Region 4 had the lowest response rate. Table 3-43 summarizes the SFY 2022 secret shopper survey response rates for **Meridian**, and for each of **Meridian**'s contracted MI Health Link regions.

Table 3-43—Summary of MER Secret Shopper Survey Results for Routine Dental Visits, by Region

		Response Rate		Accepting ICO		Accepting MI Health Link		Accepting New Patients	
Region	Total Number of Cases	Cases Reached	Rate (%)	Accepting ICO	Rate (%)[1]	Accepting MI Health Link	Rate (%)[2]	Accepting New Patients	Rate (%)[3]
Region 4	78	59	75.6%	45	76.3%	30	66.7%	26	86.7%
Region 7	162	133	82.1%	109	82.0%	64	58.7%	61	95.3%
Region 9	87	74	85.1%	60	81.1%	31	51.7%	30	96.8%
MER Total	**327**	**266**	**81.3%**	**214**	**80.5%**	**125**	**58.4%**	**117**	**93.6%**

[1] The denominator includes cases responding to the survey.

[2] The denominator includes cases responding to the survey and indicating that at least one practitioner at the location accepts the requested ICO.

[3] The denominator includes cases responding to the survey that accept the ICO and accept MI Health Link.

Table 3-44 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **Meridian**, and for each of **Meridian**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-44—Summary of MER Secret Shopper Survey Appointment Availability Results, by Region

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
Region 4	78	26	20	76.9%	25.6%	15	273	95	66
Region 7	162	61	59	96.7%	36.4%	0	118	22	14
Region 9	87	30	27	90.0%	31.0%	1	209	26	16
MER Total	**327**	**117**	**106**	**90.6%**	**32.4%**	**0**	**273**	**37**	**18**

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

[2]The denominator includes all cases included in the sample.

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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian had a survey response rate of 81.3 percent. [**Quality** and **Access**]

Strength #2: Of the 117 cases accepting **Meridian**, the MI Health Link program, and new patients, 90.6 percent (n=106) offered the caller an appointment date. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Only 58.4 percent of sampled provider locations accepted and/or recognized 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, **Meridian**'s data included inaccurate information regarding the provider location's acceptance of the MI Health Link program.

Recommendation: HSAG recommends that **Meridian** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **Meridian** 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 cases were offered an appointment date with **Meridian**. [**Access**]

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. Considerations included members being required to complete pre-registration or provide additional personal information to schedule an appointment; being required to verify eligibility by providing a member Medicaid ID number; or being told that the location was accepting new patients, but booked for the foreseeable future. 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** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Meridian** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Weakness #3: Of the cases offered an appointment date with **Meridian** in Region 4, the average wait time for a routine dental visit was 95 days and the maximum wait time was 273 days. For new members attempting to identify available providers and schedule appointments, long wait times prevent timely access to care. [**Timeliness**]

Why the weakness exists: Survey responses indicated that the location was accepting new patients but booked for the foreseeable future or the office was short staffed.

Recommendation: HSAG recommends that **Meridian** work with its contracted providers to ensure members are able to access care and services in a timely manner and the wait times do not exceed the contractually allowable time frames.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **Meridian**; 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).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS 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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: As **Meridian**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level.

Weaknesses and Recommendations

Weakness #1: As **Meridian**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level.

Why the weakness exists: NA

Recommendation: While no **Meridian**-specific results could be presented, the statewide analysis identified four measures that had a mean score below 90, with one of those measures, *Reliable and Helpful Staff*, demonstrating a statistically significant decline from the prior year, indicating opportunities for improvement for the MI Health Link program. Therefore, HSAG recommends that **Meridian** develop and implement interventions to improve member experience related to the *Reliable and Helpful Staff*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommend Homemaker* HCBS CAHPS Survey measures. Of note, the lowest performing CAHPS measure was *Planning Your Time and Activities* with a mean score of 73.5, indicating that **Meridian** should prioritize its efforts to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.

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

HSAG performed a comprehensive assessment of **Meridian**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Meridian** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Meridian**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-45 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Meridian**'s Medicaid members.

Table 3-45—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality**—Through MDHHS' mandated QIP, **Meridian** identified a disparity between African American/Black members and White members diagnosed with diabetes who adhered to statin therapy. **Meridian** designed a methodologically sound QIP and used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. Interventions implemented through this QIP have the potential of reducing/eliminating the disparity between the two subgroups. **Meridian**'s health disparity QIP should also have a positive impact on the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* performance measure. As demonstrated through the PMV activity, the rate for this measure ranked below the statewide average, and the rate declined in performance from the previous year. Additionally, **Meridian**'s quality program is required to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. **Meridian**'s quality program will be reviewed during the future SFY 2023 compliance review activity.
Preventive Care and Services	**Quality** and **Access—Meridian** demonstrated overall strength as it relates to members obtaining preventive care and services. As demonstrated through the PMV activity results, while three of the four indicator rates under the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure declined slightly in performance from the previous year, all indicator rates ranked above the statewide average. **Meridian** should continue initiatives to promote ambulatory or preventive care visits for adult members to receive preventive services such as counseling on diet and exercise and to help address acute issues or manage chronic conditions.[3-71] Additionally, all four indicator rates under the *COA—Care for Older Adults* measure improved in performance from the previous year with one of those rates ranking above the statewide average. As it

[3-71] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	relates to the *COA—Care for Older Adults—Functional Status Assessment* and *COA—Care for Older Adults—Advance Care Planning* measures, **Meridian** reported lack of provider documentation and billing of appropriate codes, and the COVID-19 PHE as barriers. To mitigate these barriers, **Meridian** continued its PIP for the *COA—Care for Older Adults—Advance Care Planning* measure and initiated a new PIP for the *COA—Care for Older Adults—Functional Status Assessment* measure. While **Meridian** demonstrated internal performance improvement for the *COA—Care for Older Adults* measure indicator rates, three of the four rates demonstrated the lowest performance among the ICOs. **Meridian** should continue initiatives to increase the number of older members receiving a functional status assessment, medication review, pain assessment, and advance care planning to ensure they receive the care they need to optimize quality of life and have their choices about end-of-life considered.[3-72] Additionally, while the *COL—Colorectal Cancer Screening* indicator rate ranked above the statewide average, it declined in performance from the previous year as well as the rate for *BCS—Breast Cancer Screening*. Mammogram screening and early detection of breast cancer decreases the risk of mortality from breast cancer, leads to a greater range of treatment options, and lower healthcare costs.[3-73] Colorectal cancer screening can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.[3-74] Lastly, the results of the secret shopper survey revealed that a high number of dental providers did not accept or recognize the MI Health Link program. Further, of the dental providers that accepted new patients receiving benefits through **Meridian**'s MI Health Link program, the maximum wait time was excessively long. These results indicate that **Meridian**'s members may be experiencing barriers in scheduling appointments for preventive dental care. Regular check-ups can find tooth decay, gum disease and other problems before they lead to more serious issues.[3-75]

[3-72] 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 27, 2023.

[3-73] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 27, 2023.

[3-74] National Committee for Quality Assurance. Colorectal Cancer Screening (COL, COL-E). Available at: https://www.ncqa.org/hedis/measures/colorectal-cancer-screening/. Accessed on: Feb 27, 2023.

[3-75] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Oral Health is Important for Overall Health. Available at: https://www.cdc.gov/chronicdisease/resources/infographic/oralhealth.htm. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—As demonstrated through the results of the PMV activity, eight of the 16 indicator rates under the Respiratory Conditions, Cardiovascular Conditions, Diabetes, and Musculoskeletal Conditions domains ranked below the statewide average with seven of those eight indicator rates demonstrating a decline in performance from the previous year. These results indicate multiple opportunities for **Meridian** to increase proper management of the use of spirometry testing in the assessment and diagnosis of COPD, COPD exacerbations, statin therapy for members with cardiovascular disease, osteoporosis in women following a fracture, and medical attention for nephropathy and statin adherence for members diagnosed with diabetes. **Meridian** was also the lowest performing ICO for both indicator rates for the *PCE—Pharmacotherapy Management of COPD Exacerbation* measure. Chronic diseases are the leading cause of death and disability in the nation and the leading drivers of healthcare costs.[3-76] However, **Meridian**'s indicator rates for the remaining eight measures ranked above the statewide average with all rates improving in performance from the previous year, suggesting that **Meridian** implemented initiatives that were successful and positively impacted measures in the Cardiovascular Conditions and Diabetes domains. Specially related to the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure, **Meridian** reported that this measure continues to have a low denominator which results in low reliability; however, the indicator rate improved and achieved 100 percent.
Behavioral Health and Substance Use Disorders	**Quality**, **Timeliness**, and **Access—**Three indicator rates within the Behavioral Health domain ranked below the statewide average, with two rates declining in performance from the previous year, indicating opportunities for **Meridian** to improve acute and continued medication management for members diagnosed with major depression, and increase the number of follow-up care visits within 30 days for members discharged from an inpatient admission or ED for a diagnosis of mental illness. Effective medication management of major depression can improve a member's daily functioning and well-being and can reduce the risk of suicide.[3-77] Follow-up care for members diagnosed with a mental illness correlates to fewer repeat emergency visits, improved physical and mental function, increased compliance with follow-up instructions, improved outcomes, and decrease the likelihood of re-hospitalization and cost of outpatient care.[3-78,3-79]

[3-76] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. About Chronic Diseases. Available at: https://www.cdc.gov/chronicdisease/about/index.htm. Accessed on: Feb 27, 2023.

[3-77] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

[3-78] 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 27, 2023.

[3-79] 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 27, 2023.

Performance Area	Overall Performance Impact
	However, **Meridian** demonstrated strong performance for the *FUH—Follow-Up After Hospitalization for Mental Illness—7 Days*, *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days*, and *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measures as indicator rates ranked above the statewide average and improved in performance from the previous year. Further, the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* and *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measures also ranked above the statewide average with both rates improving in performance from the previous year, and the rates were the highest rates among the ICOs. Substance use disorder treatment, in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug abuse or dependence-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-80] Lastly, while some of **Meridian**'s indicator rates increased from the previous year or ranked above the statewide average, it should be noted the statewide average is relatively low for most of the related measures. Therefore, overall, **Meridian** has opportunities to enhance proper management of behavioral health conditions and substance use disorders.
HCBS	**Quality**—Person-centered planning and the development of an IICSP are critical aspects of **Meridian**'s care coordination program for members who are receiving HCBS and supports. The IICSP allows the member, care coordinator, providers, and other care team members to stay informed of the member's health status; provides a description of the services and supports in place to meet the member's needs; and tracks the member's progress on meeting his or her goals. **Meridian** received a score of 73 percent for Standard VI—Coordination and Continuity of Care through the compliance review activity, indicating multiple opportunities for improvement in the development and implementation of the IICSP. Additionally, the HCBS CAHPS Survey was administered to **Meridian**-enrolled members to gather direct feedback from MI Health Link members receiving HCBS about their experiences and the quality of the LTSS they receive. Due to the low number of respondents to the survey, **Meridian**-specific results are unable to be presented; therefore, member experience was not able to be adequately assessed. While **Meridian**-specific results are not available, **Meridian**-enrolled members responding to the survey contributed to the overall MI Health Link program results, which are reported in Section 5. However, the NAV activity produced conflicting results. While **Meridian** met the minimum network requirements for most LTSS provider types including

[3-80] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	providers rendering home-based services, or was granted an exception, **Meridian** did not meet network requirements for the Adult Day Program, MIHP Agency, and Assistive Technology—Van Lifts and Tie Downs provider types in at least one service region. Lack of providers available in **Meridian**'s service region may pose barriers for members being able to access all HCBS covered under their benefit package. Further, as demonstrated through the PMV activity, **Meridian** reported the *Minimizing Institutional Length of Stay* core measure in alignment with the measure specifications. **Meridian** could accurately report on the number of admissions to institutional facilities, the total number of discharges from an institutional facility to the community, and the number of expected discharges to the community, indicating an effective mechanism to monitor member transitions to coordinate care. HCBS and supports provide the opportunity for members to safely receive services in their own home or community setting rather than in institutions or other isolated settings.

Molina Dual Options MI Health Link

Validation of Quality Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Molina**'s QIP (i.e., the QIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-46 displays the overall validation status and the baseline results for the performance indicators. The QIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-46—Overall Validation Rating for MOL

QIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities in Controlling Blood Pressure	*Met*	Controlling high blood pressure—Black.	36.4%			Yes
		Controlling high blood pressure—White.	47.3%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Molina**'s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-47 displays the interventions, as available, initiated by the ICO to support achievement of the QIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-47—Baseline Interventions for MOL

Intervention Descriptions	
Provided digital blood pressure monitors to members with a diagnosis of hypertension and who are assigned to the Michigan Community Health Network or the United Outstanding Physicians Network.	Provided medical sites with two blood pressure monitor units to use to teach patients with hypertension the method they should use to take an accurate blood pressure reading at home.
Conducted hypertension education during Quarters 1 and 2, followed by a Quarter 3 medical record audit, scoring each site for compliance related to documentation and member blood pressure level compliance.	Encouraged providers—during virtual visits, on tip sheets within the HEDIS Provider Manual, and through fax blast reminders—to use CPT II codes to report blood pressure readings.

Intervention Descriptions	
Educated providers—during virtual visits, on tip sheets within the HEDIS Provider Manual, and through fax blast reminders—that they are allowed to collect blood level readings during telehealth/virtual visits.	Provided members with educational materials showing how to sit and position their arm when using a digital blood pressure monitor. Also provided tracking tools and instructions on when to call the provider if the reading is elevated.
Provided hypertension education to members electronically by email.	

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 QIP 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 designed a methodologically sound QIP supported by using key research principles. **Molina**'s Aim statement set the focus of the QIP, and the eligible population was clearly defined. Molina selected performance indicators based on data analysis showing opportunities for improvement within the targeted populations. The technical design of the QIP was sufficient to measure and monitor QIP outcomes. **[Quality]**

Strength #2: Molina conducted accurate statistical testing between the two subgroups for the baseline measurement period to identify an existing disparity and provided a narrative interpretation of the results. **Molina** used appropriate QI tools to conduct a causal/barrier analysis and interventions were reasonably linked to the identified barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: There were no significant identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends that **Molina** evaluate the effectiveness of the interventions initiated and use the outcomes to guide each intervention's next steps.

Performance Measure Validation

Performance Results

HSAG evaluated **Molina**'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 (i.e., claims and encounters), care coordination system (i.e., tracking and management of care transition record transmissions), medication review system (i.e., tracking and management of medication reviews), hybrid data collection and review, or data integration.

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

Table 3-48—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 3-49 shows each of **Molina**'s audited HEDIS measures, rates for HEDIS MY 2020 and HEDIS MY 2021 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2021 with HEDIS MY 2020, and the HEDIS MY 2021 MI Health Link statewide average performance rates. HEDIS MY 2021 measure rates performing better than the statewide average are notated by green font.

Table 3-49—Measure-Specific Percentage Rates for MOL

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening	58.73	54.67	−4.06	52.74
COL—Colorectal Cancer Screening	63.02	60.34	−2.68	56.03
COA—Care for Older Adults—Advance Care Planning	42.09	44.53	+2.44	41.07
COA—Care for Older Adults—Medication Review	70.80	77.62	+6.82	74.85
COA—Care for Older Adults—Functional Status Assessment	50.61	53.04	+2.43	58.42
COA—Care for Older Adults—Pain Assessment	71.29	78.10	+6.81	75.25
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	24.93	27.60	+2.67	22.93
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	71.73	71.31	−0.42	68.65
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	91.96	91.64	−0.32	89.67
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure	54.50	57.91	+3.41	60.52
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	91.43	97.06	+5.63	95.25
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	80.61	81.96	+1.35	82.00
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	84.74	95.35	+10.61	84.22
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing	87.10	89.05	+1.95	87.50
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**	41.36	43.55	+2.19	43.53
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	50.61	47.93	−2.68	49.06
CDC—Comprehensive Diabetes Care—Eye Exam	61.56	58.64	−2.92	57.33
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	91.24	90.51	−0.73	90.01
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	56.69	62.29	+5.60	60.82
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	76.57	76.56	−0.01	76.83
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	83.68	90.83	+7.15	82.46

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Musculoskeletal Conditions				
OMW—Osteoporosis Management in Women Who Had a Fracture	5.56	26.09	+20.53	16.12
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	71.31	84.70	+13.39	75.06
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	51.81	75.14	+23.33	60.75
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	40.34	28.85	−11.49	26.13
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	68.75	59.13	−9.62	50.22
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	29.59	28.89	−0.70	33.87
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	50.00	43.56	−6.44	51.71
Medication Management and Care Coordination				
TRC—Transitions of Care—Notification of Inpatient Admission	7.06	6.57	−0.49	13.11
TRC—Transitions of Care—Receipt of Discharge Information	8.52	7.06	−1.46	12.77
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	77.37	66.67	−10.70	74.60
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	21.41	28.71	+7.30	43.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	26.40	31.93	+5.53	24.68
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**	34.06	30.17	−3.89	31.94
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**	20.33	19.63	−0.70	17.81
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	4.45	4.22	−0.23	5.50
*DAE—Use of High-Risk Medications in Older Adults—Total**	22.82	22.28	−0.54	21.56
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	84.81	87.86	−3.05	84.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	94.96	95.36	+0.40	93.49
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	91.54	93.07	+1.53	91.45

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	91.60	92.98	+1.38	90.77
IET—Initiation of Alcohol and Other Drug Dependence Treatment	35.23	44.19	+8.96	48.59
IET—Engagement of Alcohol and Other Drug Dependence Treatment	4.10	3.95	−0.15	6.53
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	1.12	0.98	−0.14	1.17
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	1.10	1.14	+0.04	1.20

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

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 demonstrated continued strength through its claims completeness factor calculation process, providing assurance that **Molina**'s Core Measure 9.1 and Core Measure 9.3 data are accurate, since both are based on claims data. It is also critical that administrative data are complete for Core Measure 9.3 so that **Molina** 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), ensuring the accuracy of data element B. [**Quality** and **Timeliness**]

Strength #2: In relation to Core Measure 9.1, to improve its performance measure rate, **Molina** and its contracted PIHPs initiated a monthly care coordination meeting wherein updated demographic information was shared to help reduce unable to contact rates and hold Interdisciplinary Care Team meetings for members with high utilization patterns. [**Quality**, **Timeliness**, and **Access**]

Strength #3: In the Cardiovascular Conditions domain, **Molina**'s rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* measure indicator increased by more than 10 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in cardiovascular treatment for

members. Cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease.[3-81] [**Quality** and **Access**]

Strength #4: In the Musculoskeletal Conditions domain, **Molina**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by more than 20 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in women who suffered a fracture receiving a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. 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.[3-82] [**Quality**, **Timeliness**, and **Access**]

Strength #5: In the Behavioral Health domain, **Molina**'s rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators increased by more than 13 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide averages, suggesting strength and improvement in adults with a diagnosis of major depression, who were newly treated with antidepressant medication, remaining on antidepressant medication for at least 84 and 180 days. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[3-83] [**Quality**, **Access**, and **Timeliness**]

Strength #6: In the Prevention and Screening domain, **Molina**'s rates for the *COA—Care for Older Adults—Medication Review* and *Pain Assessment* measure indicators increased by more than 6 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide averages, suggesting strength and improvement in adult members 66 years and older having medication reviews and pain assessments conducted during the measurement year. As the

3-81 National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/. Accessed on: Feb 27, 2023.

3-82 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 27, 2023.

3-83 National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

population ages, physical and cognitive function can decline, and pain becomes more prevalent. Older adults may have more complex medication regimens.[3-84] [**Quality** and **Timeliness**]

Strength #7: In the Cardiovascular Conditions domain, **Molina**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator increased by more than 5 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in adults' use of a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-85] [**Quality**, **Access**, and **Timeliness**]

Strength #8: In the Diabetes domain, **Molina**'s rates for the *CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg* and *SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%* measure indicators increased by more than 5 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in adult members with diabetes having controlled blood pressure and receiving diabetic treatment. 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.[3-86] [**Quality** and **Access**]

Strength #9: For 28 of the 45 reported HEDIS measures (62 percent), **Molina** demonstrated better performance than the statewide average. Over half of the measures included in the Prevention and Screening, Respiratory Conditions, Diabetes, Behavioral Health, Access/Availability of Care, and Risk-Adjusted Utilization domains exceeded the HEDIS MY 2021 MI Health Link statewide average. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Molina's source code did not align with the Core Measure 9.3 FAQs that were released in December 2021, which allowed for the potential to incorrectly identify members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge.

3-84 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 27, 2023.

3-85 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 27, 2023.

3-86 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 27, 2023.

Recommendation: HSAG recommends that **Molina** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **Molina** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

Weakness #2: **Molina** was required to update its MI2.6 data to the FAI DCS due to issues identified in member-level data. [**Quality**]

Why the weakness exists: Corrected member-level detail file submissions were required for MI2.6 due to HSAG's identification of several cases that were either listed as compliant for data element C that had transition record transmission dates outside of two days after discharge or listed as noncompliant for data element C that had incorrect transition record transmission dates listed. **Molina** indicated that this was due to manual entry issues.

Recommendation: Although **Molina** noted future implementation of additional quality checks as a result of HSAG's findings for MI2.6, HSAG recommends that **Molina** ensure these quality checks are implemented in a timely manner and that they include reviewing the member-level data to ensure alignment with the reporting requirements, especially in relation to time frame parameters required by the specifications for the performance measure.

Weakness #3: In the Medication Management and Care Coordination domain, **Molina**'s rate for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator decreased by more than 10 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that there was not always evidence of patient engagement being provided within 30 days after discharge. Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs.[3-87] [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: The rate for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator decreasing by more than 10 percentage points from MY 2020 to MY 2021 suggests that barriers exist regarding evidence of patient engagement within 30 days after discharge for some members.

Recommendation: HSAG recommends that **Molina** conduct a root cause analysis or focused study to determine why there was not always evidence of patient engagement being provided within 30 days after discharge. Upon identification of a root cause, **Molina** should implement appropriate interventions to improve the performance related to the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator. **Molina** should consider the nature and

[3-87] National Committee for Quality Assurance. Transitions of Care (TRC). Available at: https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed on: Feb 27, 2023.

scope of the issue (e.g., whether the issues related to barriers such as a lack of care coordination or provider education).

Weakness #4: In the Behavioral Health domain, **Molina**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator decreased by more than 6 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some members were not receiving follow-up care for mental illness within 30 days of an ED visit. 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.[3-88] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator decreasing by more than 6 percentage points from MY 2020 to MY 2021 suggests that barriers exist for some members to receive follow-up care for mental illness within 30 days of an ED visit.

Recommendation: HSAG recommends that **Molina** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness within 30 days of an ED visit. Upon identification of a root cause, **Molina** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator. **Molina** 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 education or staffing shortages).

Compliance Review

Performance Results

Table 3-50 presents **Molina**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Molina** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Molina**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

[3-88] 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 27, 2023.

Table 3-50—Standard Compliance Scores for MOL

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2022)		
Standard I—Disenrollment: Requirements and Limitations[2]	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**70%**
Standard III—Emergency and Poststabilization Services[2]	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**80%**
Standard VII—Coverage and Authorization of Services	§438.210	**85%**
Year Two (SFY 2023)		
Standard VIII—Provider Selection	§438.214	—
Standard IX—Confidentiality	§438.224	—
Standard X—Grievance and Appeal Systems	§438.228	—
Standard XI—Subcontractual Relationships and Delegation	§438.230	—
Standard XII—Practice Guidelines	§438.236	—
Standard XIII—Health Information Systems[3]	§438.242	—
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	—
Year Three (SFY 2024)		
Review of ICO's implementation of Year One and Year Two CAPs		

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[3] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

Dash (—): The ICO's compliance with Year Two standards will be reviewed and scored during the SFY 2023 compliance review activity.

Table 3-51 presents **Molina**'s scores for each standard evaluated during the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Molina**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2022 compliance review activity demonstrated how successful **Molina** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-51—SFY 2022 Standard Compliance Scores for MOL

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations[1]	9	6	6	0	3	**100%**
Standard II—Member Rights and Member Information	23	23	16	7	0	**70%**
Standard III—Emergency and Poststabilization Services[1]	13	13	13	0	0	**100%**
Standard IV—Availability of Services	13	13	13	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
Standard VI—Coordination and Continuity of Care	31	30	24	6	1	**80%**
Standard VII—Coverage and Authorization of Services	28	27	23	4	1	**85%**
Total	**121**	**116**	**99**	**17**	**5**	**85%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

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 #3: Molina achieved full compliance in the Availability of Services program area, demonstrating that the ICO maintained and monitored a network of appropriate providers, supported by written agreements, and sufficient to provide adequate access to all services. [**Access**]

Strength #4: Molina achieved full compliance in the Assurances of Adequate Capacity and Services program area, demonstrating that the ICO maintained and monitored an adequate provider network that was sufficient to provide adequate capacity for all services (e.g., preventive, primary care, specialty care, and LTSS) for its membership. [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: Molina received a score of *Not Met* for seven elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Molina's member materials did not contain all required member rights, member materials critical to obtaining services did not comply with language requirements for taglines, the member handbook did not contain all mandatory components, there was no documentation available to support timely notice to members would occur due to a significant change impacting members' access to services and information about the managed care program, the provider directory did not include all required components, and the formulary drug list was not available in a machine-readable format. Contributory factors included, but were not limited to, lack of established processes, misinterpretation of the federal rule, and inconsistencies between the paper and online provider directory.

Recommendation: As **Molina** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **Molina** ensure that it consistently uses the most current version of the model member materials.

Weakness #2: Molina received a score of *Not Met* for six elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Molina did not ensure caseloads met the MDHHS 600-point threshold; consistently and timely review program-level data and utilization data, and assign an initial risk stratification to each member; consistently and timely complete Level II assessments; ensure all required components were included in the IICSP; or review the IICSP with the member on a schedule specific to the member's risk stratification level. Contributory factors included, but were not limited to, challenges in filling staffing positions, insufficient reporting to monitor pre-call reviews, insufficient oversight of the referral mailbox, and several process gaps to ensure care coordinators understand IICSP requirements.

Recommendation: As **Molina** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

Weakness #3: Molina received a score of *Not Met* for four elements within the Coverage and Authorization of Services program area, indicating members' service requests were not consistently decided timely and adequately. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Molina did not consistently use the most current IDN template; ensure the appropriate IDN was sent to the member; ensure an alert or notification mechanism was in place for care coordinators to be made aware of ABDs; consistently provide an ABD notice to members timely for the termination, suspension, or reduction of previously authorized services; or consistently provide members with an IDN when a denial of payment was made on a claim. Contributory factors included, but were not limited to, a gap in the process for the configuration or updated notices and communication to delegates, a gap in the denial report, and misinterpretation of the federal rule.

Recommendation: As **Molina** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG's NAV results indicated that **Molina** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. Table 3-52 presents **Molina**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception determinations.

Table 3-52—SFY 2022 NAV Results for MOL, by Region and Provider Type

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Provider Types With Travel Time/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 Aids	*Met*	*Met*
Hearing Examinations	*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*
ECLS	*Met*	*Met*
Environmental Modifications	*Met*	*Met*
Fiscal Intermediary	*Met*	*Met*
Home-Delivered Meals	*Met*	*Met*
Medical Supplies (e.g., incontinence supplies)	*Met*	*Met*
NEMT	*Met*	*Met*
Non-Medical Transportation (waiver services only)	*Met*	*Met*

Provider Type	Region 7 Validation Result	Region 9 Validation Result
Personal Care Services	*Met*	*Met*
Personal Emergency Response System	*Met*	*Met*
Preventive Nursing Services	*Met*	*Met*
Private Duty Nursing	*Met*	*Met*
Respite	*Met*	*Met*
Skilled Nursing Home (report only beds certified for both Medicare and Medicaid)	*Met*	*Met*
Percentage of Total Requirements Met	**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 met all Medicaid and LTSS minimum network requirements for Region 7, indicating that **Molina** maintains an adequate network for MI Health Link members in this region. [**Access**]

Strength #2: Molina met all Medicaid and LTSS minimum network requirements for Region 9, indicating that **Molina** 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** based on the SFY 2022 NAV evaluation.

Why the weakness exists: NA

Recommendation: Molina 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 192 sampled provider locations (i.e., "cases") for **Molina** with an overall response rate of 75.0 percent (144 cases) among **Molina**'s two MI Health Link regions. Region 9 had the highest response rate, and Region 7 had the lowest response rate. Table 3-53 summarizes the SFY 2022 secret shopper survey response rates for **Molina** and for each of **Molina**'s contracted MI Health Link regions.

Table 3-53—Summary of MOL Secret Shopper Survey Results for Routine Dental Visits, by Region

		Response Rate		Accepting ICO		Accepting MI Health Link		Accepting New Patients	
Region	Total Number of Cases	Cases Reached	Rate (%)	Accepting ICO	Rate (%)[1]	Accepting MI Health Link	Rate (%)[2]	Accepting New Patients	Rate (%)[3]
Region 7	100	70	70.0%	58	82.9%	41	70.7%	39	95.1%
Region 9	92	74	80.4%	61	82.4%	35	57.4%	30	85.7%
MOL Total	**192**	**144**	**75.0%**	**119**	**82.6%**	**76**	**63.9%**	**69**	**90.8%**

[1] The denominator includes cases responding to the survey.

[2] The denominator includes cases responding to the survey and indicating that at least one practitioner at the location accepts the requested ICO.

[3] The denominator includes cases responding to the survey that accept the ICO and accept MI Health Link.

Table 3-54 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **Molina**, and for each of **Molina**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-54—Summary of MOL Secret Shopper Survey Appointment Availability Results, by Region

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
Region 7	100	39	19	48.7%	19.0%	1	71	21	14
Region 9	92	30	8	26.7%	8.7%	0	132	46	44

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
MOL Total	192	69	27	39.1%	14.1%	0	132	28	21

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

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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the cases accepting **Molina** and MI Health Link, 90.8 percent (n=69) accepted new patients. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 63.9 percent of sampled provider locations accepted and/or recognized 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, **Molina**'s data included inaccurate information regarding the provider location's acceptance of the MI Health Link program.

Recommendation: HSAG recommends that **Molina** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **Molina** 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: Of the 69 cases accepting **Molina**, the MI Health Link program, and new patients, only 39.1 percent (n=27) offered the caller an appointment date. [**Access**]

Why the weakness exists: 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 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** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Molina** 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 **Molina**; 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).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS 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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: As **Molina**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level.

Weaknesses and Recommendations

Weakness #1: As **Molina**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level.

Why the weakness exists: NA

Recommendation: While no **Molina**-specific results could be presented, the statewide analysis identified four measures that had a mean score below 90 percent, with one of those measures, *Reliable and Helpful Staff*, demonstrating a statistically significant decline from the prior year, indicating opportunities for improvement for the MI Health Link program. Therefore, HSAG recommends that **Molina** develop and implement interventions to improve member experience

related to the *Reliable and Helpful Staff*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommend Homemaker* HCBS CAHPS Survey measures. Of note, the lowest performing CAHPS measure was *Planning Your Time and Activities* with a mean score of 73.5 percent, indicating that **Molina** should prioritize its efforts to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.

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

HSAG performed a comprehensive assessment of **Molina**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Molina** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Molina**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-55 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Molina**'s Medicaid members.

Table 3-55—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality**—Through MDHHS' mandated QIP, **Molina** identified a disparity between Black members and White members diagnosed with hypertension whose blood pressure was adequately controlled. **Molina** designed a methodologically sound QIP and used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. Interventions implemented through this QIP have the potential of reducing/eliminating the disparity between the two subgroups. **Molina**'s health disparity QIP should also have a positive impact on the *CPB—Controlling High Blood Pressure* performance measure. As demonstrated through the PMV activity, while the indicator rate for this measure improved in performance from the previous year, it ranked below the statewide average. Additionally, **Molina**'s quality program is required to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. **Molina**'s quality program will be reviewed during the future SFY 2023 compliance review activity.
Preventive Care and Services	**Quality** and **Access—Molina** demonstrated overall strength as it relates to members obtaining preventive care and services. As demonstrated through the PMV activity results, while one of the four indicator rates under the *AAP−Adults' Access to Preventive/Ambulatory Health Services* measure decreased in performance from the previous year, the remaining three rates increased in performance from the previous year, and all rates ranked above the statewide average. **Molina** should continue initiatives to promote ambulatory or preventive care visits for adult members to receive preventive services such as counseling

Performance Area	Overall Performance Impact
	on diet and exercise and to help address acute issues or manage chronic conditions.[3-89] Additionally, all four indicator rates under the *COA—Care for Older Adults* measure increased in performance from the previous year and three of those rates ranked above the statewide average, indicating that more of **Molina**'s older members received a functional status assessment, medication review, pain assessment, and advance care planning to ensure they receive the care they need to optimize quality of life and have their choices about end-of-life considered.[3-90] As it relates to the *COA—Care for Older Adults—Functional Status Assessment* and *COA—Care for Older Adults—Advance Care Planning* measures, **Molina** reported it completed a review of medical records to identify issues with documentation and had conversations with the providers and staff to determine if there were processes in place to review advance care planning and functional status with the patients annually. **Molina** conducted education with providers and staff, which included written tips that covered proper documentation in the medical record and the appropriate codes to submit the information electronically. However, while the *COL—Colorectal Cancer Screening* and *BCS—Breast Cancer Screening* indicator rates ranked above the statewide average, both declined in performance from the previous year. Mammogram screening and early detection of breast cancer decreases the risk of mortality from breast cancer, leads to a greater range of treatment options, and lower healthcare costs.[3-91] Colorectal cancer screening can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.[3-92] Lastly, the results of the secret shopper survey revealed that a high number of dental providers did not accept or recognize the MI Health Link program. Further, of the dental providers that accepted new patients receiving benefits through **Molina**'s MI Health Link program, the maximum wait time was excessively long. These results indicate that **Molina**'s members may be experiencing barriers in scheduling appointments for preventive dental care.

[3-89] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Feb 27, 2023.

[3-90] 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 27, 2023.

[3-91] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 27, 2023.

[3-92] National Committee for Quality Assurance. Colorectal Cancer Screening (COL, COL-E). Available at: https://www.ncqa.org/hedis/measures/colorectal-cancer-screening/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	Regular check-ups can find tooth decay, gum disease and other problems before they lead to more serious issues.[3-93]
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—As demonstrated through the results of the PMV activity, 11 of the 16 indicator rates under the Respiratory Conditions, Cardiovascular Conditions, Diabetes, and Musculoskeletal Conditions domains ranked above the statewide average with six of those 11 rates demonstrating an increase in performance from the previous year. These results indicate that many of **Molina**'s members received proper management of the use of spirometry testing in the assessment and diagnosis of COPD; COPD exacerbations; beta-blocker treatment following a heart attack; statin therapy for members with cardiovascular disease; osteoporosis in women following a fracture; and HbA1c testing, eye exam, nephropathy, blood pressure control, and statin therapy adherence for members diagnosed with diabetes. Additionally, within the Cardiovascular Conditions domain, while the *CBP—Controlling High Blood Pressure* and *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measures ranked below the statewide average, both indicator rates increased in performance from the previous year. Chronic diseases are the leading cause of death and disability in the nation and the leading drivers of healthcare costs.[3-94] However, within the Diabetes domain, three indicator rates ranked below the statewide average, and while one indicator rate remained relatively stable, two rates declined in performance from the previous year: *CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)* and *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*. 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.[3-95]

[3-93] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Oral Health is Important for Overall Health. Available at: https://www.cdc.gov/chronicdisease/resources/infographic/oralhealth.htm. Accessed on: Feb 27, 2023.

[3-94] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. About Chronic Diseases. Available at: https://www.cdc.gov/chronicdisease/about/index.htm. Accessed on: Feb 27, 2023.

[3-95] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
Behavioral Health and Substance Use Disorders	**Quality**, **Timeliness**, and **Access—Molina** demonstrated strong performance for both indicator rates under the *AMM—Antidepressant Medication Management* measure. Both indicator rates ranked above the statewide average and increased in performance from the previous year. **Molina** was also the highest performing ICO for both *AMM—Antidepressant Medication Management* measure indicator rates. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.[3-96] Additionally, the two indicator rates under the *FUH—Follow-Up After Hospitalization for Mental Illness* measure ranked above the statewide average; however, both rates declined in performance from the previous year, indicating continued opportunities for improvement. The two *FUM—Follow-Up After Emergency Department Visit for Mental Illness* measure indicator rates also declined in performance from the previous year and ranked below the statewide average. Follow-up care for members diagnosed with a mental illness correlates to fewer repeat emergency visits, improved physical and mental function, increased compliance with follow-up instructions, improved outcomes, and decrease the likelihood of re-hospitalization and cost of outpatient care.[3-97,3-98] Further, while the indicator rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure increased in performance from the previous year, this rate and the *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measure indicator rate ranked below the statewide average. Treatment, including medication-assisted treatment in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-99] Lastly, while some of **Molina**'s indicator rates increased from the previous year or ranked above the statewide average, it should be noted the statewide average is relatively low for most related measures. Therefore, overall, **Molina** has opportunities to enhance proper management of behavioral health conditions and substance use disorders.

3-96 National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

3-97 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 27, 2023.

3-98 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 27, 2023.

3-99 National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
HCBS	**Quality**—Person-centered planning and the development of an IICSP are critical aspects of **Molina**'s care coordination program for members who are receiving HCBS and supports. The IICSP allows the member, care coordinator, providers, and other care team members to stay informed of the member's health status; provides a description of the services and supports in place to meet the member's needs; and tracks the member's progress on meeting his or her goals. **Molina** received a score of 80 percent for Standard VI—Coordination and Continuity of Care through the compliance review activity, indicating multiple opportunities for improvement in the development and implementation of the IICSP. Additionally, the HCBS CAHPS Survey was administered to **Molina-**enrolled members to gather direct feedback from MI Health Link members receiving HCBS about their experiences and the quality of the LTSS they receive. Due to the low number of respondents to the survey, **Molina-**specific results are unable to be presented; therefore, member experience was not able to be adequately assessed. While **Molina-**specific results are not available, **Molina-**enrolled members responding to the survey contributed to the overall MI Health Link program results, which are reported in Section 5. However, the NAV activity produced overall positive results as **Molina** met the minimum network requirements for all LTSS provider types including providers rendering home-based services. Further, as demonstrated through the PMV activity, **Molina** reported the *Minimizing Institutional Length of Stay* core measure in alignment with the measure specifications. **Molina** could accurately report on the number of admissions to institutional facilities, the total number of discharges from an institutional facility to the community, and the number of expected discharges to the community, indicating an effective mechanism to monitor member transitions to coordinate care. HCBS and supports provide the opportunity for members to safely receive services in their own home or community setting rather than in institutions or other isolated settings.

Upper Peninsula Health Plan MI Health Link

Validation of Quality Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **UPHP**'s QIP (i.e., the QIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-56 displays the overall validation status and the baseline results for the performance indicators. The QIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-56—Overall Validation Rating for UPHP

QIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Annual Dental Care	*Met*	Annual dental visit for UPHP American Indian/Alaskan Native MHL members.	22.7%			Yes
		Annual dental visit for UPHP White MHL members.	34.6%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **UPHP**'s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (American Indian/Alaskan Native) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-57 displays the interventions, as available, initiated by the ICO to support achievement of the QIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-57—Baseline Interventions for UPHP

Intervention Descriptions	
Specific education was provided during member outreach regarding the importance of dental visits even when no teeth are present or when dentures are being used as well as education on the denture benefit.	General education was provided to members on the importance of preventive dental care and benefit availability.
Members were provided education on the provider network and connection with the ICO transportation service.	The ICO collected data during member outreach to determine any impact of out-of-network dental providers for 2023 interventions.

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 QIP 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: UPHP designed a methodologically sound QIP supported by using key research principles. **UPHP**'s Aim statement set the focus of the QIP, and the eligible population was clearly defined. **UPHP** selected performance indicators based on data analysis showing opportunities for improvement within the targeted populations. The technical design of the QIP was sufficient to measure and monitor QIP outcomes. [**Quality**]

Strength #2: UPHP met 100 percent of the requirements for data analysis and implementation of improvement strategies. **UPHP** conducted accurate statistical testing between the two subgroups for the baseline measurement period to identify an existing disparity and provided a narrative interpretation of the results. Appropriate QI tools were used to conduct its causal/barrier analysis and to prioritize the identified barriers. Interventions were implemented in a timely manner, were reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: There were no significant identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends that **UPHP** evaluate the effectiveness of the interventions initiated and use the outcomes to guide each intervention's next steps.

Performance Measure Validation

Performance Results

HSAG evaluated **UPHP**'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 (i.e., claims and encounters), care coordination system (i.e., tracking and management of care transition record transmissions), medication review system (i.e., tracking and management of medication reviews), hybrid data collection and review, or data integration.

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

Table 3-58—Measure-Specific Validation Designation for UPHP

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 3-59 shows each of **UPHP**'s audited HEDIS measures, rates for HEDIS MY 2020 and HEDIS MY 2021 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2021 with HEDIS MY 2020, and the HEDIS MY 2021 MI Health Link statewide average performance rates. HEDIS MY 2021 measure rates performing better than the statewide average are notated by green font.

Table 3-59—Measure-Specific Percentage Rates for UPHP

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
Prevention and Screening				
BCS—Breast Cancer Screening	66.26	62.90	−3.36	52.74
COL—Colorectal Cancer Screening	64.72	65.94	+1.22	56.03
COA—Care for Older Adults—Advance Care Planning	76.16	78.35	+2.19	41.07
COA—Care for Older Adults—Medication Review	89.78	92.46	+2.68	74.85
COA—Care for Older Adults—Functional Status Assessment	81.27	84.43	+3.16	58.42
COA—Care for Older Adults—Pain Assessment	92.21	92.21	0.00	75.25
Respiratory Conditions				
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	31.13	19.59	−11.54	22.93

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	85.00	87.80	+2.80	68.65
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	94.00	91.87	−2.13	89.67
Cardiovascular Conditions				
CBP—Controlling High Blood Pressure	78.10	84.91	+6.81	60.52
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	100	88.89	−11.11	95.25
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	85.27	89.86	+4.59	82.00
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	86.36	84.21	−2.15	84.22
Diabetes				
CDC—Comprehensive Diabetes Care—HbA1c Testing	91.48	93.67	+2.19	87.50
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**	26.03	25.79	−0.24	43.53
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	63.26	65.21	+1.95	49.06
CDC—Comprehensive Diabetes Care—Eye Exam	68.86	69.83	+0.97	57.33
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	91.48	92.46	+0.98	90.01
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	81.51	85.16	+3.65	60.82
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	74.40	73.60	−0.80	76.83
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	86.36	81.07	−5.29	82.46
Musculoskeletal Conditions				
OMW—Osteoporosis Management in Women Who Had a Fracture	9.09	23.08	+13.99	16.12
Behavioral Health				
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	72.88	67.62	−5.26	75.06
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	61.86	53.33	−8.53	60.75
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	61.11	39.39	−21.72	26.13
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	81.48	65.15	−16.33	50.22
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	35.85	48.78	+12.93	33.87

HEDIS Measure	HEDIS MY 2020 (%)	HEDIS MY 2021 (%)	HEDIS MY 2020 vs. MY 2021	Statewide Average (%)
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	52.83	65.85	+13.02	51.71
Medication Management and Care Coordination				
TRC—Transitions of Care—Notification of Inpatient Admission	51.34	48.66	−2.68	13.11
TRC—Transitions of Care—Receipt of Discharge Information	44.04	42.09	−1.95	12.77
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	88.56	89.54	+0.98	74.60
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	75.67	79.56	+3.89	43.96
Overuse/Appropriateness				
*PSA—Non-Recommended PSA-Based Screening of Older Men**	19.86	23.10	+3.24	24.68
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**	42.98	41.28	−1.70	31.94
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**	19.53	20.42	+0.89	17.81
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	7.76	9.77	+2.01	5.50
*DAE—Use of High-Risk Medications in Older Adults—Total**	24.96	26.99	+2.03	21.56
Access/Availability of Care				
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	88.58	89.32	+0.74	84.27
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	94.73	95.86	+1.13	93.49
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	92.80	95.76	+2.96	91.45
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	92.81	94.69	+1.88	90.77
IET—Initiation of Alcohol and Other Drug Dependence Treatment	18.78	22.40	+3.62	48.59
IET—Engagement of Alcohol and Other Drug Dependence Treatment	3.05	3.20	+0.15	6.53
Risk-Adjusted Utilization				
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	1.23	1.10	−0.13	1.17
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	1.23	0.93	−0.30	1.20

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

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: As applicable to MI2.6, **UPHP** continued to make strides toward increasing timely care transition record notifications through continued facility engagement in the Upper Peninsula Health Information Exchange (UPHIE) to include ADT alerts instead of using manual updates. **UPHP** had 15 in-network hospitals within the Upper Peninsula Region, and all were currently submitting ADTs through the UPHIE portal for timely notifications. In addition, there are currently 31 clinics, four tribal health centers, five community mental health centers, and two skilled nursing facilities connected to UPHIE. [**Quality** and **Timeliness**]

Strength #2: UPHP demonstrated continued strength through its claims completeness factor calculation process, providing assurance that **UPHP**'s Core Measure 9.1 and Core Measure 9.3 data are accurate, since both are based on claims data. It is also critical that administrative data are complete for Core Measure 9.3 so that **UPHP** 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), ensuring the accuracy of data element B. [**Quality** and **Timeliness**]

Strength #3: For 32 of the 45 reported HEDIS measures (71 percent), **UPHP** demonstrated better performance than the statewide average. 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 exceeded the HEDIS MY 2021MI Health Link statewide average. [**Quality**]

Strength #4: In the Cardiovascular Conditions domain, **UPHP**'s rate for the *CBP—Controlling High Blood Pressure* measure indicator increased by more than 6 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength in cardiovascular treatment and controlling high blood pressure for members. Cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease.[3-100] Additionally, controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney

[3-100] National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/. Accessed on: Feb 27, 2023.

disease, and in reducing the risk of developing other serious conditions.[3-101] [**Quality**, **Access**, and **Timeliness**]

Strength #5: In the Musculoskeletal Conditions domain, **UPHP**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by more than 13 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting strength and improvement in women who suffered a fracture receiving a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. 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.[3-102] [**Quality**, **Timeliness**, and **Access**]

Strength #6: In the Behavioral Health domain, **UPHP**'s rates for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* and *30 Days* measure indicators increased by more than 12 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average, suggesting 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.[3-103] [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: UPHP was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: UPHP's source code did not align with the Core Measure 9.3 Core Reporting Requirements, as it was not limiting identification of data element A to only paid claims.

Recommendation: HSAG recommends that **UPHP** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements to confirm that its programming logic fully aligns with the reporting requirements and guidance. **UPHP** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

[3-101] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Feb 27, 2023.

[3-102] 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 27, 2023.

[3-103] 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 27, 2023.

Weakness #2: **UPHP** was required to update its MI5.6 source code and to resubmit MI5.6 data to the FAI DCS. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: During the virtual review, it was discussed that as a result of source code review, **UPHP** had updated its logic for MI5.6 to exclude hospice members, in alignment with the Michigan-Specific Reporting Requirements. This update resulted in 17 members who needed to be removed from inclusion in data element A due to hospice encounter/intervention claims, and one member who was erroneously included in data element B due to the hospice encounter/intervention logic omission. **UPHP** indicated that removal of the one member from data element B would reduce the data element B sample size to 410. HSAG advised **UPHP** to reach out to the National Opinion Research Center (NORC) help desk to request next steps, as a sample size of 410 did not align with the Michigan-Specific Reporting Requirements hybrid sampling methodology.

Recommendation: HSAG recommends that **UPHP** ensure it carefully reviews the annual release of the Michigan-Specific Reporting Requirements to confirm its programming logic fully aligns with the reporting requirements. Additionally, for future reporting of MI5.6, **UPHP** should also ensure that it follows the hybrid sampling methodology outlined in the Michigan-Specific Reporting Requirements and should determine an appropriate oversample to guarantee that the targeted sample size of 411 is always met.

Weakness #3: In the Respiratory Conditions domain, **UPHP**'s rate for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator decreased by more than 11 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adult members with newly diagnosed or active COPD were not always receiving spirometry testing to confirm the diagnosis. Approximately 15 million adults in the United States have COPD, an irreversible disease that limits airflow to the lungs. Despite being the gold standard for diagnosis and assessment of COPD, spirometry testing is underused. Earlier diagnosis using spirometry testing supports a treatment plan that may protect against worsening symptoms and decrease the number of exacerbations.[3-104] [**Quality** and **Access**]

Why the weakness exists: The rate for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator decreasing by more than 11 percentage points from MY 2020 to MY 2021 suggests that barriers exist for receiving spirometry testing for some adult members with COPD.

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

[3-104] 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 27, 2023.

Weakness #4: In the Cardiovascular Conditions domain, **UPHP**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased by more than 11 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adult members were not using a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.[3-105] [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: The rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreasing by more than 11 percentage points from MY 2020 to MY 2021 suggests that barriers exist for some adult members to use a beta-blocker as treatment after a heart attack.

Recommendation: HSAG recommends that **UPHP** conduct a root cause analysis or focused study to determine why some adults were not using a beta-blocker after a heart attack. Upon identification of a root cause, **UPHP** should implement appropriate interventions to improve the performance related to the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator. **UPHP** 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).

Weakness #5: In the Behavioral Health domain, **UPHP**'s rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreased by more than 5 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults with a diagnosis of major depression, who were newly treated with antidepressant medication, did not remain on antidepressant medication for at least 84 and 180 days. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[3-106] [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: The rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreasing by more than 5 percentage points from MY 2020 to MY 2021 suggest that barriers exist for some adult members with a diagnosis of major depression to remain on antidepressant medication.

Recommendation: HSAG recommends that **UPHP** conduct a root cause analysis or focused study to determine why some adults with a diagnosis of major depression did not remain on antidepressant

[3-105] 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 27, 2023.

[3-106] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

medication. Upon identification of a root cause, **UPHP** should implement appropriate interventions to improve the performance related to the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. **UPHP** 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 patient education).

Compliance Review

Performance Results

Table 3-60 presents **UPHP**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **UPHP** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **UPHP**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-60—Standard Compliance Scores for UPHP

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2022)		
Standard I—Disenrollment: Requirements and Limitations[2]	§438.56	**89%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**73%**
Standard III—Emergency and Poststabilization Services[2]	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**85%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**75%**
Standard VI—Coordination and Continuity of Care	§438.208	**77%**
Standard VII—Coverage and Authorization of Services	§438.210	**100%**
Year Two (SFY 2023)		
Standard VIII—Provider Selection	§438.214	—
Standard IX—Confidentiality	§438.224	—
Standard X—Grievance and Appeal Systems	§438.228	—
Standard XI—Subcontractual Relationships and Delegation	§438.230	—
Standard XII—Practice Guidelines	§438.236	—
Standard XIII—Health Information Systems[3]	§438.242	—
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	—

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Year Three (SFY 2024)		
Review of ICO's implementation of Year One and Year Two CAPs		

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[3] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

Dash (—): The ICO's compliance with Year Two standards will be reviewed and scored during the SFY 2023 compliance review activity.

Table 3-61 presents **UPHP**'s scores for each standard evaluated during the SFY 2022 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **UPHP**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2022 compliance review activity demonstrated how successful **UPHP** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-61—SFY 2022 Standard Compliance Scores for UPHP

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations[1]	9	9	8	1	0	**89%**
Standard II—Member Rights and Member Information	23	22	16	6	1	**73%**
Standard III—Emergency and Poststabilization Services[1]	13	13	13	0	0	**100%**
Standard IV—Availability of Services	13	13	11	2	0	**85%**
Standard V—Assurances of Adequate Capacity and Services	4	4	3	1	0	**75%**
Standard VI—Coordination and Continuity of Care	31	30	23	7	1	**77%**
Standard VII—Coverage and Authorization of Services	28	27	27	0	1	**100%**
Total	**121**	**118**	**101**	**17**	**3**	**86%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.
[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

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: UPHP achieved full compliance in the Coverage and Authorization of Services program area, demonstrating that the ICO members' service requests were consistently decided timely and adequately. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: UPHP received a score of *Not Met* for six elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: UPHP's member materials did not contain all required member rights, member materials critical to obtaining services did not comply with language requirements for taglines, the member handbook did not contain all mandatory components, there was no documentation available to support timely notice to members would occur due to a significant change impacting members' access to services and information about the managed care program, and the provider directory did not include all required components. Contributory factors included, but were not limited to, out-of-date policies, staff did not compare model materials to federal rule, and misinterpretation of federal rule.

Recommendation: As **UPHP** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **UPHP** ensure that it consistently uses the most current version of the model member materials.

Weakness #2: UPHP received a score of *Not Met* for seven elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: UPHP did not ensure caseloads met the MDHHS 600-point threshold; consistently and timely review program-level data and utilization data, and assign an initial risk stratification to each member; consistently and timely complete health risk screenings for its members to assess their healthcare needs; make appropriate outreach attempts to contact the member; consistently and timely conduct Level II assessments within 15 calendar days; ensure all required components were included in the IICSP; or review the IICSP with the member on a schedule specific to the member's risk stratification level. Contributory factors included, but were not limited to, challenges in hiring staff, lack of established processes, insufficient oversight, system automations that did not pull in all information in the IICSP, and incorrect implementation of processes by staff.

Recommendation: As **UPHP** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG's NAV results indicated that **UPHP** did not meet all Medicaid and LTSS minimum network requirements for Region 1. **UPHP** submitted additional data updates and final requests for exceptions to address provider types not meeting the minimum network requirements. MDHHS approved **UPHP**'s requested exceptions for the Adult Day Program, Dental, Hearing Aids, Hearing Examinations, MIHP Agency, and NEMT provider types in Region 1. Table 3-62 presents **UPHP**'s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS' exception determinations.

Table 3-62—SFY 2022 NAV Results for UPHP, by Region and Provider Type

Provider Type	Region 1 Validation Result
Provider Types With Travel Time/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 Aids	*Exception Granted*
Hearing Examinations	*Exception Granted*

Provider Type	Region 1 Validation Result
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*
ECLS	*Met*
Environmental Modifications	*Met*
Fiscal Intermediary	*Met*
Home-Delivered Meals	*Met*
Medical Supplies (e.g., incontinence supplies)	*Met*
NEMT	*Exception Granted*
Non-Medical Transportation (waiver services only)	*Met*
Personal Care Services	*Met*
Personal Emergency Response System	*Met*
Preventive Nursing Services	*Met*
Private Duty Nursing	*Met*
Respite	*Met*
Skilled Nursing Home (report only beds certified for both Medicare and Medicaid)	*Met*
Percentage of Total Requirements Met*	**76%**

*The denominator for Percentage of Total Requirements Met includes all 25 standards regardless of whether an exception request was granted.

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, **UPHP** 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 **UPHP** based on the SFY 2022 NAV, as **UPHP** 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: NA

Recommendation: **UPHP** should maintain an internal data verification process to continually identify and contract with Adult Day Program, Dental, Hearing Aids, Hearing Examinations, MIHP Agency, and NEMT 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 24 sampled provider locations (i.e., "cases") for **UPHP**, with an overall response rate of 83.3 percent (20 cases) within **UPHP**'s MI Health Link region. Table 3-63 summarizes the SFY 2022 secret shopper survey response rates by visit scenario for **UPHP**, and for each of **UPHP**'s contracted MI Health Link regions.

Table 3-63—Summary of UPHP Secret Shopper Survey Results for Routine Dental Visits, by Region

		Response Rate		Accepting ICO		Accepting MI Health Link		Accepting New Patients	
Region	Total Number of Cases	Cases Reached	Rate (%)	Accepting ICO	Rate (%)[1]	Accepting MI Health Link	Rate (%)[2]	Accepting New Patients	Rate (%)[3]
Region 1	24	20	83.3%	18	90.0%	11	61.1%	10	90.9%
UPHP Total	**24**	**20**	**83.3%**	**18**	**90.0%**	**11**	**61.1%**	**10**	**90.9%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and indicating that at least one practitioner at the location accepts the requested ICO.
[3] The denominator includes cases responding to the survey that accept the ICO and accept MI Health Link.

Table 3-64 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **UPHP**, and for **UPHP**'s contracted MI Health Link region. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-64—Summary of UPHP Secret Shopper Survey Appointment Availability Results, by Region

			Cases Offered an Appointment			Appointment Wait Time (Days)			
Region	Total Survey Cases	Cases Contacted and Accepting New Patients	Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
UPHP Region 1	24	10	8	80.0%	33.3%	6	236	99	61
UPHP Total	**24**	**10**	**8**	**80.0%**	**33.3%**	**6**	**236**	**99**	**61**

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

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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: UPHP had a survey response rate of 83.3 percent. [**Quality** and **Access**]

Strength #2: Of the cases accepting **UPHP** and MI Health Link, 90.9 percent (n=10) accepted new patients. [**Access**]

Weaknesses and Recommendations

Weakness #1: A limited number of callers were offered appointment dates and times. [**Access**]
Why the weakness exists: 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 being required to complete pre-registration or provide additional personal information to schedule an appointment; being required to verify eligibility by providing a member Medicaid ID number; or

being told that the location was accepting new patients, but booked for the foreseeable future. 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 **UPHP** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **UPHP** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Weakness #2: Of the 33.3 percent of cases offered an appointment, the average wait time was 99 days, and the longest wait time for a routine dental appointment was 236 days. For new members attempting to identify available providers and schedule appointments, long wait times prevent timely access to care. [**Timeliness**]

Why the weakness exists: Survey responses indicated that the location was accepting new patients but booked for the foreseeable future or the office was short staffed.

Recommendation: HSAG recommends that **UPHP** work with its contracted providers to ensure that members are able to access care and services in a timely manner and the wait times do not exceed the contractually allowable time frames.

Weakness #3: Only 61.1 percent of sampled provider locations accepted and/or recognized the MI Health Link program. [**Access**]

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

Recommendation: HSAG recommends that **UPHP** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **UPHP** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in **UPHP**; 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).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS 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 any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: As **UPHP**-specific results could not be presented due to low response rates, no substantial strengths could be presented at the individual ICO level.

Weaknesses and Recommendations

Weakness #1: As **UPHP**-specific results were not available due to low response rates, no substantial weaknesses could be presented at the individual ICO level.

Why the weakness exists: NA

Recommendation: While no **UPHP**-specific results could be presented, the statewide analysis identified four measures that had a mean score below 90, with one of those measures, *Reliable and Helpful Staff*, demonstrating a statistically significant decline from the prior year, indicating opportunities for improvement for the MI Health Link program. Therefore, HSAG recommends that **UPHP** develop and implement interventions to improve member experience related to the *Reliable and Helpful Staff*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommend Homemaker* HCBS CAHPS Survey measures. Of note, the lowest performing CAHPS measure was *Planning Your Time and Activities* with a mean score of 73.5, indicating that **UPHP** should prioritize its efforts to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.

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

HSAG performed a comprehensive assessment of **UPHP**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **UPHP** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **UPHP**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-65 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **UPHP**'s Medicaid members.

Table 3-65—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality**—Through MDHHS' mandated QIP, **UPHP** identified a disparity between American Indian/Alaskan Native members and White members who had an annual dental visit. **UPHP** designed a methodologically sound QIP and used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. Interventions implemented through this QIP have the potential of reducing/eliminating the disparity between the two subgroups. Additionally, **UPHP**'s quality program is required to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. **UPHP**'s quality program will be reviewed during the future SFY 2023 compliance review activity.
Preventive Care and Services	**Quality** and **Access—UPHP** demonstrated overall strength as it relates to members obtaining preventive care and services. As demonstrated through the PMV activity results, all indicator rates under the Prevention and Screening domain ranked above the statewide average, with five of those rates improving in performance or remaining stable, indicating many of **UPHP**'s members received recommended breast cancer and colorectal screenings. Mammogram screening and early detection of breast cancer decreases the risk of mortality from breast cancer, leads to a greater range of treatment options, and lower healthcare costs.[3-107] Colorectal cancer screening can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.[3-108] Additionally, more of **UPHP**'s older members received a functional status assessment, medication review, pain assessment, and advance care planning to ensure they receive the care they need to optimize quality of life and have their choices about end-of-life considered.[3-109] Further, the results of the PMV activity suggested that **UPHP** implemented initiatives to promote ambulatory or preventive care visits for adult members to receive preventive services such as counseling on diet and exercise and to help address acute issues or manage chronic conditions,[3-110] as all four indicator rates under the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure ranked above the statewide average and improved in performance from

[3-107] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Feb 27, 2023.

[3-108] National Committee for Quality Assurance. Colorectal Cancer Screening (COL, COL-E). Available at: https://www.ncqa.org/hedis/measures/colorectal-cancer-screening/. Accessed on: Feb 27, 2023.

[3-109] 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 27, 2023.

[3-110] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services (AAP). Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
	the previous year. **UPHP** was also the highest performing ICO within the Prevention and Screening domain, and for the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure. However, the results of the secret shopper survey revealed that a high number of dental providers did not accept or recognize the MI Health Link program. Further, a limited number of callers were offered an appointment. These results indicate that **UPHP**'s members may be experiencing barriers in scheduling appointments for preventive dental care. Regular check-ups can find tooth decay, gum disease and other problems before they lead to more serious issues.[3-111]
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—As demonstrated through the results of the PMV activity, 11 of the 16 indicator rates under the Respiratory Conditions, Cardiovascular Conditions, Diabetes, and Musculoskeletal Conditions domains ranked above the statewide average with 10 of those 11 rates demonstrating an improvement in performance from the previous year. These results indicate that many of **UPHP**'s members received proper management of COPD exacerbations, hypertension, statin therapy for members with cardiovascular disease, diabetes, and osteoporosis in women following a fracture. Further, **UPHP** was the highest performing ICO among all indicator rates for the *CDC—Comprehensive Diabetes Care* measure. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from healthcare providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active and quitting smoking.[3-112] However, the indicator rates for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*, *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%*, and *SPD—Statin Therapy for Patients With Diabetes* measures ranked below the statewide average and indicate opportunities for improvement to enhance proper management of chronic conditions. Chronic diseases are the leading cause of death and disability in the nation and the leading drivers of healthcare costs.[3-113]

[3-111] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Oral Health is Important for Overall Health. Available at: https://www.cdc.gov/chronicdisease/resources/infographic/oralhealth.htm. Accessed on: Feb 27, 2023.

[3-112] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Feb 27, 2023.

[3-113] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. About Chronic Diseases. Available at: https://www.cdc.gov/chronicdisease/about/index.htm. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
Behavioral Health and Substance Use Disorders	**Quality**, **Timeliness**, and **Access—UPHP** demonstrated mixed results as it relates to management of behavioral health and substance use disorders. While all four indicator rates for the *FUH—Follow-Up After Hospitalization for Mental Illness* and *FUM—Follow-Up After Emergency Department Visit for Mental Illness* measures ranked above the statewide average and the two rates for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness* measure improved in performance from the previous year, the two rates for the *FUH—Follow-Up After Hospitalization for Mental Illness* measure declined in performance from the previous year. 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. However, individuals hospitalized for mental health disorders often do not receive adequate follow-up care.[3-114] Additionally, while the two indicator rates for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* and *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measures ranked below the statewide average, both rates demonstrated some improvement from the previous year. Treatment, including medication-assisted treatment in conjunction with counseling or other behavioral therapies, has been shown to reduce alcohol and other drug-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.[3-115] However, **UPHP** demonstrated poorer performance for the *AMM—Antidepressant Medication Management* measure as both indicator rates ranked below the statewide average and declined in performance from the previous year. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects.[3-116] Lastly, while some of **UPHP**'s indicator rates increased from the previous year or ranked above the statewide average, it should be noted the statewide average is relatively low for most related measures. Therefore, overall, **UPHP** has opportunities to enhance proper management of behavioral health conditions and substance use disorders.

[3-114] 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 27, 2023.

[3-115] National Committee for Quality Assurance. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Available at: https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/. Accessed on: Feb 27, 2023.

[3-116] National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/. Accessed on: Feb 27, 2023.

Performance Area	Overall Performance Impact
HCBS	**Quality**—Person-centered planning and the development of an IICSP are critical aspects of **UPHP**'s care coordination program for members who are receiving HCBS and supports. The IICSP allows the member, care coordinator, providers, and other care team members to stay informed of the member's health status; provides a description of the services and supports in place to meet the member's needs; and tracks the member's progress on meeting his or her goals. **UPHP** received a score of 77 percent for Standard VI—Coordination and Continuity of Care through the compliance review activity, indicating multiple opportunities for improvement in the development and implementation of the IICSP. Additionally, the HCBS CAHPS Survey was administered to **UPHP**-enrolled members to gather direct feedback from MI Health Link members receiving HCBS about their experiences and the quality of the LTSS they receive. Due to the low number of respondents to the survey, **UPHP**-specific results are unable to be presented; therefore, member experience was not able to be adequately assessed. While **UPHP**-specific results are not available, **UPHP**-enrolled members responding to the survey contributed to the overall MI Health Link program results, which are reported in Section 5. However, the NAV activity produced conflicting results. While **UPHP** met the minimum network requirements for most LTSS provider types including providers rendering home-based services, or was granted an exception, **UPHP** did not meet network requirements for the Adult Day Program, Dental, Hearing Aids, Hearing Examinations, MIHP Agency, and NEMT provider types in its service region. Lack of providers available in **UPHP**'s service region may pose barriers for members being able to access all HCBS covered under their benefit package. However, **UPHP** did provide supplemental documentation that detailed alternative approaches used to ensure adequate services for its membership. Further, as demonstrated through the PMV activity, **UPHP** reported the *Minimizing Institutional Length of Stay* core measure in alignment with the measure specifications. **UPHP** could accurately report on the number of admissions to institutional facilities, the total number of discharges from an institutional facility to the community, and the number of expected discharges to the community, indicating an effective mechanism to monitor member transitions to coordinate care. HCBS and supports provide the opportunity for members to safely receive services in their own home or community setting rather than in institutions or other isolated settings.

4. Follow-Up on Prior External Quality Review Recommendations for Integrated Care Organizations

From the findings of each ICO's performance for the SFY 2021 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 2021 External Quality Review Technical Report for Integrated Care Organizations* are summarized in Table 4-1 through Table 4-6. 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 4-6.

Aetna Better Health Premier Plan

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** should develop evaluation methods for each intervention to demonstrate its effectiveness on the study indicator outcomes and to guide decisions for QI efforts. • **Aetna** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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)***: • 1: **Aetna** 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] • Aetna is developing a Behavioral Health (BH) Utilization Dashboard designed to measure BH utilization to measure the impact of increased outpatient (OP) utilization of BH services to the decrease in Inpatient (IP) utilization of BH services. This dashboard and its data will be ready for trending and reporting by end of Q2 2023. • Aetna has also started to track IP BH utilization in our existing Care Management Dashboard to determine if increased member engagement has impacted either OP BH utilization or follow-up after discharge of IP BH services. Aetna expects to have the capacity to trend and report on the results of this tracking in Q1 2023. • Aetna is reviewing current behavioral health reporting to determine if there are gaps in data collection that can guide future quality improvement initiatives. The need for any additional reporting to track the effectiveness of interventions will be evaluated in 2023.

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
• 2: **Aetna** 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] • In response to the COVID-19 Public Health Emergency (PHE) Aetna highlighted access to BH telehealth appointments. o Members were educated on access to BH telehealth services through: ▯ The Pre-paid Inpatient Health Plan (PIHP) partnership, care coordinators, and updated educational materials ▯ Billing systems were adjusted to accommodate for new codes/modifiers. ▯ Telehealth was also extended to support transportation barriers ▯ As a result of COVID-19, the PIHP partners experienced an increase in call volume on our Crisis Line. o The PIHP was awarded a grant that has allowed the hiring of additional staff for the Crisis Center, who have been instrumental in helping answer these calls, and address member concerns.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • At present we do not have reporting to demonstrate performance improvement that directly correlates to the interventions proposed.
c. Identify any barriers to implementing initiatives: • There are no barriers to report at this time, however, as data from the behavioral health dashboard and care management dashboard is available for analysis the plan will document identified barriers to improvement and/or intervention success.
HSAG Assessment: HSAG has determined that **Aetna** addressed the prior year's recommendations. The ICO described a plan for evaluating the effectiveness of the initiated interventions and developed specific and targeted interventions to address barriers associated with the PHE.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • As discussed during PMV, **Aetna** should continue working with its certified HEDIS software vendor to explore programming MI5.6 sample logic into its annual hybrid sample process, which is already used for **Aetna**'s HEDIS reporting. **Aetna** should improve the accuracy of its sampling process by removing the manual sorting step. If the vendor is unable to accommodate this request, **Aetna** should 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. • **Aetna** should 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** 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

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
reconciliation and care coordination following discharge is important, as it helps to avoid negative consequences that may impact quality of life. • **Aetna** should focus on improving performance for measures included in these domains. • **Aetna** should 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** 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** 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** should identify factors related to the COVID-19 PHE and its impact on conducting medication reviews, advanced care planning, and pain assessments. • **Aetna** should 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** should implement appropriate interventions to improve the performance related to the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator. **Aetna** 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** should identify factors related to the COVID-19 PHE and its impact on diabetes management.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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)***: • 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] • The error that occurred when pulling the sample for MI5.6 in 2020, was rectified with the creation of a custom measure in our HEDIS software using the platform's systematic sampling methodology approved by National Opinion Research Center (NORC). There were no issues with the 2021 sample and no issues are expected for future reporting. • 2: Aetna Better Health of Michigan had a low MI5.6 rate in comparison to the other ICOs' reported rates. [Quality and Timeliness] • Aetna recognized the declined performance in the 2020MY rate at the time of the submission in 2021, and believe the steep decline had a direct correlation to the need to repull the sample late in the process resulting in the inability to receive all records in time for medical record review before submission deadlines. Please see response #1 above addressing that issue. • In Q3 2022, Aetna implemented a strategy dedicating clinical pharmacists for medication reviews for MI5.6. Aetna recognizes the importance of medication review and reconciliation to avoid unnecessary ED utilization, IP admissions, or readmissions after discharge. • Based the resolution to the issue with the sample in 2022 combined with ongoing continuous improvement efforts regarding provider location and chase analysis clean-up, and the implementation of the clinical pharmacist review, the plan expects to see continued improvement in this measure for 2022MY.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
• 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] • Aetna acknowledges the thirty-three metrics that measured below the statewide average in the 2020MY year and effort was made to address those issues directly related to the Covid-19 Public Health Emergency (PHE). Access to care whether in terms of its availability or the member's willingness to seek care was impacted in the 2020MY due to the COVID-19 PHE. In addition to accessibility issues, the 2021 record retrieval also impacted rates for hybrid measures (13 of the 33 measures that performed below the state average). All of the hybrid metrics show performance improvement in the 2021MY and we attribute this improve to both a willingness of members to seek care, greater uptake of telehealth utilization, and improved medical record collection yields during chart retrieval and medical record review in 2022. • Efforts to improve prospective clinical gaps in care include: • Aetna added actionable gaps to member charts that allow care managers to address said gaps during regularly scheduled outreach. • Provider engagement specifically focused on addressing clinical gaps in care and best practice education continues to improve collaborative efforts with the Plan in 2022MY and is expected to contribute to continued improvement in all metrics (both hybrid and admin only). • In terms of enhanced member engagement, Aetna is developing a member incentive program that rewards preventive screening and chronic condition management to launch in 2023MY. • 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. [Quality and Access] • The primary issues impacting this weakness have been addressed in #2 and #3 of this response. • All sub-numerators of the Care of Older Adults metric in the 2021MY showed considerable improvement over the 2020MY with successes attributable to those efforts documented in #2 and #3 of this response and there is expectation that these rates will continue to improve with forecasted rates for the 2022MY between 7-13 points higher than 2021 rates. • 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

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
management is essential to control blood glucose, reduce risks for complications, and prolong life. [Quality and Access] • The primary causes for this weakness have been addressed in #3 of this response. All of these metrics demonstrated notable improvement in the 2021MY with expectation of continued improvements in the 2022MY. • Aetna expects that the implementation of the member incentive program in 2023MY will continue to improve member outcomes in these metrics throughout the 2023MY. Additionally, Aetna is exploring a member engagement program to send home testing kits to members who either did not have a an HbA1c test or for those members who did have the test but whose results are >=8. This initiative, if approved, would launch in Q2/Q3 of 2023. • Aetna is also developing special member and provider education on the importance of regular diabetic eye screens as an important part of managing this chronic condition.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Improvements as a result of initiatives are discussed within Section A.
c. Identify any barriers to implementing initiatives: • Barriers to implementation across initiatives include: • Provider willingness to engage in education, requests for medical records, and collaborative execution of clinical gap closure initiatives. Targeted efforts in 2022 to engage key impacting providers in quality improvement efforts (including year round medical record reviews) have had positive impacts on mitigating this barrier. • In relation to the MI5.6 metric, from the perspective of the technical specifications, the licensures required (clinical pharmacist or prescribing practitioner) to perform medication reviews are limiting factors. HEDIS Medication Reconciliation Post Discharge allows for RN-credentialed case managers to perform med rec reviews. If licensure requirements were aligned, existing workflows and staff resources could be leveraged as a part of improvement effort.
HSAG Assessment: HSAG has determined that **Aetna** partially addressed the prior year's recommendations. **Aetna** addressed the prior year's recommendation to work with its certified HEDIS software vendor to explore programming MI5.6 sample logic into its annual hybrid sample process and remove the manual sorting step. **Aetna** worked with its certified HEDIS software vendor to program MI5.6 sample logic into its annual hybrid sample process, which was already in place for **Aetna**'s HEDIS reporting. **Aetna** therefore improved the accuracy of its sampling process by removing the manual sorting step which caused an error in the SFY 2021 PMV. **Aetna** partially addressed the prior year's recommendation to explore options to increase the medication reviews conducted by clinical pharmacists and prescribing practitioners. While **Aetna** improved the MI5.6 rate since SFY 2021, it continued to have a low MI5.6 rate in comparison to the other ICOs' reported rates. **Aetna** did not leverage any of the medication reviews conducted by a clinical pharmacist. As such, HSAG recommends that **Aetna** prioritize leveraging its ICO clinical pharmacist to conduct medication reviews for members, as discussed during the SFY 2022 virtual audit review. **Aetna** has put forth effort to improve performance for measures 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. **Aetna** added actional clinical gaps to member charts for care managers to work toward addressing during regularly

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
scheduled outreach to members. Additionally, **Aetna** engaged with its providers on addressing clinical gaps in care, provided best practice education to its providers, and began developing a member incentive program that rewards preventive screening and chronic condition management. However, over half of the measures in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization domains remain below the statewide average for MY 2021. As such, **Aetna** should continue to monitor and focus its efforts on improving measures in these domains. This should include timely application of interventions when performance continues to be low. Additionally, **Aetna** continues to demonstrate low performance for the *COA—Care for Older Adults—Advance Care Planning* measure indicator, as the rate decreased by over 14 percentage points from MY 2020 to MY 2021. As such, HSAG recommends that **Aetna** work toward increased advance care planning for its adult members 66 years of age and older and continue to monitor the impact of the interventions on the *COA—Care for Older Adults—Advance Care Planning* measure indicator to ensure improved performance. **Aetna** demonstrated improved performance for the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator, as its rate increased by over 9 percentage points from MY 2020 to MY 2021. Additionally, **Aetna** has put forth effort to further improve performance for the *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator by exploring the potential for a member engagement program that would send home testing kits to members who do not have an HbA1c test or had the test but whose results were greater than 8.0 percent.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Aetna** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Aetna submitted action plans to address all deficiencies identified in the SFY2021 Compliance Review activity. Actions taken include process updates, adding staff, and implementing quality and monitoring processes to improve adherence to federal and State requirements. • Authorization of Services: Aetna updated our Integrated Denial (IDN) Letter process and implemented a collaboration process with our dental vendor to address IDN letter language and format improvements. • Credentialing: Credentialing updated processes to ensure all required documents for Medicaid credentialing are obtained. Additionally, quality check and audit processes were implemented to verify completed credentialing files include Medicaid-required documents. • Grievance and Appeals: Aetna implemented meetings and collaboration oversight with the Pre-Paid Inpatient Health Plans (PIHPs) to ensure the grievance process is managed in accordance with requirements. Aetna added clinical staff to the appeals team to improve appeal letter clinical language. A quality review process was implemented to review resolution letters prior to printing to identify and correct any spelling, grammar, or content errors prior to sending.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Department quality reviews and compliance continuous monitoring activities ensure process outcomes sustain improved performance and adherence to requirements.
c. Identify any barriers to implementing initiatives: • There were no significant barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that **Aetna** addressed the prior year's recommendations based on the ICO's narrative and the SFY 2021 compliance review remediation plan. The SFY 2022 compliance review activity also confirmed **Aetna** successfully remediated the authorization services findings as the ICO did not receive a deficiency specifically related to the content/language included in the IDNs or authorization turnaround times. However, HSAG was unable to confirm if **Aetna** successfully remediated findings related to credentialing, grievances, and appeals as these areas were not included in the scope of the SFY 2022 compliance review activity and will be reviewed during the future SFY 2023 activity.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Aetna** should identify and contract with all available Hearing Aids 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 Aids and MIHP Agency provider types in Region 4 will be evaluated in the SFY 2022 NAV.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 Aetna Better Health Premier Plan network team recruited additional hearing aid providers into its Region 4 network since the last submission of the SFY2021 NAV. Aetna expects to be compliant with hearing aids in Region 4 for the SFY 2022 NAV submission. There are no additional MIHP providers to contract within Region 4 which would allow Aetna to meet compliance. Based upon the state of Michigan's MIHP directory, there no more available providers for which the health plan is not already contracted.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Aetna anticipates improved compliance with hearing aid providers for Region 4 in the SFY 2022 Network Adequacy Validation.
c. Identify any barriers to implementing initiatives: • Many hearing aid providers are not willing to participate in a program that is tied to Medicaid. There are not enough MIHP providers available to contract and meet network adequacy.
HSAG Assessment: HSAG has determined that **Aetna** addressed the prior year's recommendations. The SFY 2022 NAV activity confirmed **Aetna** met the minimum network requirements for the Hearing Aids provider type in Region 4. While **Aetna** did not meet the minimum network requirements for the MIHP Agency provider type in Region 4 during SFY 2022, the ICO demonstrated that it contracted with all available MIHP Agency providers in the region.

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
HSAG recommended the following: • **Aetna** 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. Additionally, as MDHHS required **Aetna** to submit a CAP, the ICO should fully implement its remediation plans and continue to monitor for provider-related data concerns. • **Aetna** should work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. Further, **Aetna** should consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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)***: Provider Data Accuracy: • On a quarterly basis, Aetna's Directory team submits a file to a Data Validation Vendor of all participating individual practitioners participating within a Commercial, Medicare and/or First Health Product. The Data Validation Vendor will complete a comparison against their data base and will

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
return the results back to Aetna's team. Additionally, Aetna will append recent claim and prescriber data with the returned results. • Based on Vendor and Data Analytics results, Aetna will identify Provider/Location combinations in which we have: o High confidence provider is practicing at location – No Action Taken o Medium/Low confidence provider is practicing at location – Phone outreach will be made to validate directory information for provider/service location combination o Approximately 7,000 outreach calls are made on a daily basis nationally in which provider directory information is validated o Aetna has added online provider contact information and roster updating capability to its provider portal. o Aetna is onboarding credentialing team members and coordinating with support departments to mitigate any backlogs in roster update requests. Appointment Availability: • Aetna is posting the contractual standards to every quarterly provider newsletters, to the provider manual. Aetna periodically manually distributes the standards to providers upon request or when necessary (individual corrective action plans or onboarding new providers). • Aetna conducts yearly Access surveys and Availability surveys to our provider network. Surveys seek to make after-hours contact to ensure and answering service are available and secret shoppers seek to schedule appointments with various provider specialties and with various levels of exigence (regular, emergency, urgent, etc.). • Aetna will use the raw survey data to do educational follow up to providers that do not pass their surveys
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Improvements are ongoing and appointment availability survey results are pending.
c. Identify any barriers to implementing initiatives: • Appointment Availability – the process for provider education requires manual intervention. We are working on updating our fax blast system. We anticipate completion by early Quarter 4 2022. Once complete, appointment availability standards can be more easily faxed and emailed to our provider network.
HSAG Assessment: HSAG has determined that **Aetna** addressed the prior year's recommendations. However, since the SFY 2022 survey did not evaluate the same provider types, HSAG could not evaluate whether the initiatives were successful or effective.

AmeriHealth Caritas VIP Care Plus

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: • **AmeriHealth** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 2021, Quality Management ensured articles were included in member newsletters reminding of and explaining the telehealth benefit option. • Care Coordinators continued to provide both referrals and scheduling support for telehealth benefits to support gap closure, for example in instances where transportation was identified as a barrier, presenting telehealth as an option to complete timely visits. Additionally, transitions of care setting discharge instructions which included a follow up appointment both Care Coordinators and non-clinical staff supported members with arranging telehealth visits. • Care Management teams continued to receive feedback relative to an expressed hesitancy to leave home as a result of COVID fears. Members were educated on precautionary measures to help promote safety and facilitate adherence to follow up visit recommendations. • Care Coordinators follow up on all transitions, wherein AmeriHealth is notified, which includes facilitating adherence to follow up visits after hospitalization. • Care Management teams host bi-weekly Integrated Care Team Meetings with both PIHP's to discuss aligned members, including transition issues such as completing follow up visit post hospitalization.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The rate for the Follow-up after Hospitalization for Mental Illness HEDIS measure (FUH) did not improve in MY2021 compared to MY2020. Contributing factors included low measure denominator (41), difficulty reaching and re-engaging members after discharge, and member reluctance to use telehealth for this type of visit.
c. Identify any barriers to implementing initiatives: • Hesitancy from Members to leave home due to COVID fears. • Telehealth participation was low as a result of Member's equipment and/or familiarity with technology to participate. Concerns were further expressed relative to sharing sensitive information over a computer interface. • Hampered ability to locate Members without field and limited hospital access. • Increase in unresponsiveness by Members as result of only phone and correspondence contact.
HSAG Assessment: HSAG has determined that **AmeriHealth** addressed the prior year's recommendations. The ICO identified barriers associated with the PHE and developed specific and targeted interventions to address those barriers, such as encouraging telehealth visits. The ICO documented that the PHE continues to be a barrier to care.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures

HSAG recommended the following:

- **AmeriHealth** should 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. Further, **AmeriHealth** should 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.
- **AmeriHealth** should 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, **AmeriHealth** should consider reporting MI2.6 following hybrid methodology in future years. If **AmeriHealth** identifies that the low rate reflected a true lack of timely transmissions of member transition records, **AmeriHealth** should 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** 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.
- **AmeriHealth** should focus on improving performance for measures included in these domains.
- **AmeriHealth** should 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** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **AmeriHealth** 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** should identify factors related to the COVID-19 PHE and its impact on the management and treatment of women with fractures.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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)***:

Core Measure 9.3

- AmeriHealth Caritas has identified opportunities relative to regulatory reporting integrity of programming logic and output validation. The Plan has transitioned to a new operating model wherein a dedicated team of programmers and data analysts support AmeriHealth Caritas Michigan's regulatory and operational oversight data. Core 9.3 is in process of transitioning to the new dedicated team structure. The team also consists of coordinators responsible for validation of data prior to submission to ensure quality and accuracy of reported data.

Core Measure 2.6

- AmeriHealth Caritas acknowledges opportunity at the administrative data level and well as the process level. Moving forward, the Plan will evaluate reporting this measure under the hybrid methodology as

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
appropriate. From an administrative data level perspective AmeriHealth Caritas will move to the hybrid methodology because of ongoing deficiencies in receiving transition records. In addition, AmeriHealth Caritas has updated its process to implement a proactive approach to transmit its available transition records directly to providers rather than waiting for the hospital or facility to transmit records. AmeriHealth Caritas continues to educate providers to ensure timely transition record transmission and care coordination following discharge. Improving Performance Measures • AmeriHealth Caritas MI selected the following measures to focus on in 2021: o Adults Access to Ambulatory/Preventive Health Services (AAP) o Breast and colorectal cancer screenings (BCS and COL) o Care of Older Adults (COA) Medication Review o Comprehensive Diabetes Care (CDC) o Controlling Blood Pressure (CBP) o Follow-up After Hospitalization for Mental Illness (FUH) o Medication Reconciliation Post-Discharge (MRP) • The following interventions were implemented in MY2021 including: o Monthly text reminders to members; Reminder member mailings; Articles in member newsletters; Reminders regarding availability of telehealth service; Provider incentive payment for submission of CPTII codes; Provider scorecards distributed monthly; Medication reviews completed by ICO pharmacist; Regular meetings with PIHPs; Process for ICO RN care coordinators to complete MRPs. • Results were monitored monthly and reported quarterly to the Quality Assessment and Performance Improvement (QAPI) Committee. Osteoporosis Management • Root cause of low measure rate is very small eligible population: 1 member for HEDIS MY2018 and 4 members for MY2020, which resulted in a NA designation for HEDIS reporting both years. o Numerator compliance MY2018 = 1, resulting in 25% rate. o Numerator compliance MY2020 = 0, resulting in 0% rate. • Interventions included member education regarding safety and fall prevention and importance of medication adherence was provided via member newsletters. • In 2022, AmeriHealth Caritas will explore process to partner with Pharmacy Benefit Manager (PBM) to increase member monitoring and outreach in 2023.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Core Measure 9.3 • AmeriHealth Caritas has initiated recoding of this report and is already realizing improvement in the data quality of the outputs. Core Measure 2.6 • Real time monitoring is supporting gap closure with more timely interventions with the Care Coordination team. Improving Performance Measures • Based on HEDIS MY2021 rates, improvement was noted as follows when compared to HEDIS MY2020: o AAP: +10.09%

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
○ CBP: +9.01% ○ COA Med Review: +41.12% ○ CDC: HgbA1c Testing: +6.32%; HgbA1c Control (<9): +3.9% ○ MRP: +18.98% • The interventions noted above were continued into MY2022. Osteoporosis Management • Measure denominator for HEDIS MY2021 was 5, resulting again in NA designation for the measure again for reporting. • Numerator compliance MY2021 = 2, resulting in 40% rate.
c. Identify any barriers to implementing initiatives: Core Measure 9.3 • AmeriHealth Caritas received additional guidance and programming code trouble shooting support in the CY2022 PMV audit which also reviewed Core Measure 9.3. Code review is currently ongoing to ensure alignment with the requirements. Core Measure 2.6 • Monitoring is also allowing AmeriHealth Caritas to further define the root cause relationship between data administrative barriers and process deficiencies to further define remediation. Improving Performance Measures • The rates for BCS, COL, and CDC Eye Exam did not improve in MY2021 compared to MY2020. This is believed to be due to the ongoing COVID-19 PHE, which resulted in high positive case rates and hospitalizations within the ICO service area in 2021, which in turn caused member hesitancy to seek these "up close and personal" services along with limited provider capacity due to resource constraints. • The rate for FUH did not improve in MY2021 compared to MY2020. Contributing factors included low measure denominator (41), difficulty reaching and re-engaging members after discharge, and member reluctance to use telehealth for this type of visit. Osteoporosis Management • No barriers identified at this time.
HSAG Assessment: HSAG has determined that **AmeriHealth** partially addressed the prior year's recommendations. **AmeriHealth** put forth effort to address the prior year's recommendation to implement more stringent validation checks prior to Core Measure 9.3 data submission and quality checks to ensure that programming logic is inclusive of all associated value set codes and avoids limiting parameters. **AmeriHealth** transitioned to a new operating model with a dedicated team of programmers and data analysts who support regulatory and operational oversight of data and coordinators responsible for validation of data prior to submission. Additionally, **AmeriHealth** began the process of transitioning Core Measure 9.3 to the new dedicated team structure. However, during the SFY 2022 PMV activity, HSAG identified numerous issues in **AmeriHealth**'s reporting of Core Measure 9.3, and source code updates and resubmission of its Core Measure 9.3 data to HPMS was required. As such, HSAG recommends that **AmeriHealth** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **AmeriHealth** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures

AmeriHealth put forth effort to address the prior year's recommendation to explore whether its low MI2.6 rate was due to transition records not transmitting or due to relying on administrative data for reporting the measure. **AmeriHealth** updated its process to implement a proactive approach for transmitting available transition records directly to providers, continues to provide education to providers on timely transition record transmission and care coordination following discharge, and has plans to evaluate reporting MI2.6 using the hybrid methodology for future reporting. While **AmeriHealth** indicated during the SFY 2022 PMV activity that it believed the CCD file process was improved since 2020 and that the process was working more consistently, and **AmeriHealth** had begun transmitting transition records directly, its MI2.6 rate remained low. Considering these process improvements and the continued low MI2.6 rate, HSAG recommends that **AmeriHealth** consider reporting MI2.6 following a hybrid methodology in future years.

AmeriHealth has put forth effort to improve performance for measures in the Prevention and Screening, Diabetes, Behavioral Health, Cardiovascular Conditions, Medication Management and Care Coordination, and Access/Availability of Care domains. **AmeriHealth** implemented various interventions in MY 2021 including monthly text reminders to members, mailings to members, articles in member newsletters, reminders of availability for telehealth services, provider incentive payments, provider monthly scorecards, medication reviews by ICO pharmacists, regular meetings with PIHPs, and completion of medication reviews by ICO registered nurse (RN) care coordinators. However, over half of the measures in the Prevention and Screening, Behavioral Health, and Access/Availability of Care domains remain below the statewide average for MY 2021. As such, **AmeriHealth** should continue to monitor and focus its efforts on improving measures in these domains. This should include timely application of interventions when performance continues to be low.

AmeriHealth demonstrated improved performance for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator, as its rate increased by 40 percentage points from MY 2020 to MY 2021 and exceeded the HEDIS MY 2021 MI Health Link statewide average. Additionally, **AmeriHealth** has put forth effort to further improve performance for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator by conducting a root cause analysis for the low MY 2020 rate, providing member education on fall prevention and medication adherence via member newsletters, and exploring the process for partnering with a pharmacy benefit manager (PBM) to increase member monitoring and outreach.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- In addition to developing a CAP to mitigate the gaps within its processes and documentation, **AmeriHealth** 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.
- In addition to developing a CAP to mitigate the gaps within its processes and documentation, **AmeriHealth** 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.
- 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.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• In addition to developing a CAP to mitigate the gaps within its processes and documentation, **AmeriHealth** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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)***: Utilization Management • AmeriHealth Caritas Utilization Management team has established processes to review all policies and standard operating procedures related to coverage and authorization of services standards, as well as evidence of coverage, and benefit summary at least annually and as updates are issued by federal or State entities. We monitor for updates via Medicare alerts that capture updates from CMS and State, and regularly reference CMS resources such as Parts C and D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. Utilization Management and Compliance teams have started meeting monthly to review any updates needed to remain in compliance. Credentialing • Ownership Disclosure forms are maintained in our Credentialing database as a standard part of the credentialing process. AmeriHealth Caritas also collects Dual Demonstration forms which capture this information. While Quality of Care and Service related grievances are included in our internal recredentialing process, at this time AmeriHealth Caritas is developing a process with our credentialing delegate to ensure these grievances are included as part of their re-credentialing process. Grievance • The grievance team has implemented the following: • Inventory reporting is reviewed daily to ensure timely resolution of grievance cases. • Updates to the dashboard that tracks grievance touches is currently underway to ensure frequent touches on grievances to avoid late notes and timely mailing of resolution letters. • Resolution letter reviews to ensure appropriate and correct information is included in the resolution letter to each member. Appeals • Appeals team has implemented the following: • Team created Processes and Procedures outlining expectations for all appeal types and levels • Team education/training sessions were completed for Part B, Part C and Part D appeals • Appeals team worked with Reporting Team to ensure data was captured to monitor compliance and appeal inventory • Lead was hired to assist team with questions and provide direction • Updated our Appeals system to capture data that was not being captured and had to be pulled manually • Implemented a Quality Review Process whereas the Quality Assurance team reviews appeal case files for accuracy and letters for accuracy

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Utilization Management • Through these improved and streamlined processes, the Utilization Management team has been able update policies timely in response to most recent update of Parts C and D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance and initiate timely configuration of the CY2023 denial notice. Credentialing • No noted performance improvement at this time. Grievance • August 2022, the volume of untimely resolution of grievance cases has decreased significantly due to increased oversight of inventory. All resolved grievance require a resolution letter to be sent to the member. In addition, we have added in resolution letter reviews to ensure accuracy which includes review of member information, grievance notes, and grammar/spelling Appeals • Appeals team has noted improvements in both compliance scores the quality of cases.
c. Identify any barriers to implementing initiatives: Utilization Management • The Utilization Management team has had no barriers to implementation of this process. Credentialing • AmeriHealth Caritas has identified the need for updates to delegate contractual agreements extending the duration of remediation. Grievance • Resource issues can create potential barriers in ensuring appropriate investigation and timely resolution of grievances. Currently in the process of bringing on additional staff to assist with increased volume of grievances. Appeals • Certain system modifications must be tied to a release schedule, there manual reviews of appeals must be done at some points.
HSAG Assessment: HSAG has determined that **AmeriHealth** addressed the prior year's recommendations based on the ICO's narrative and the SFY 2021 compliance review remediation plan. The SFY 2022 compliance review activity also confirmed **AmeriHealth** successfully remediated the authorization services findings as the ICO did not receive a deficiency specifically related to the content and reading-grade level of IDNs. However, HSAG was unable to confirm if **AmeriHealth** successfully remediated findings related to credentialing, grievances, and appeals as these areas were not included in the scope of the SFY 2022 compliance review activity and will be reviewed during the future SFY 2023 activity.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **AmeriHealth** 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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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)***: • Quarterly monitoring of LTSS Network was established, although AmeriHealth Caritas continues to build this process out with the support of the newly established Medicare Performance Team, a performance oversight team established 2022. • Establishing analytics support to measure time and distance requirements • AmeriHealth Caritas has also incorporated a check of our data against the Michigan.gov MIHP Directory • In addition, AmeriHealth Caritas is exploring opportunities to identify additional external vendors to support as back up when our existing network cannot support.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • External delegates and vendors are more accustomed to this annual audit and have reporting more readily available to address this request.
c. Identify any barriers to implementing initiatives: • AmeriHealth Caritas continues to implement process improvement.
HSAG Assessment: HSAG has determined that **AmeriHealth** addressed the prior year's recommendations. The SFY 2022 NAV activity confirmed **AmeriHealth** met the minimum network requirements for all provider types in Region 7 and Region 9.

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
HSAG recommended the following: • **AmeriHealth** 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. Additionally, as MDHHS required **AmeriHealth** to submit a CAP, the ICO should fully implement its remediation plans and continue to monitor for provider-related data concerns. • **AmeriHealth** should work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. Further, **AmeriHealth** should consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 Secret Shopper Survey
Provider Data • The Provider Data team started a monthly provider data validation process. Each month a provider profile is mailed to providers so they can either attest to the accuracy of their data (demographics, panel status and office hours) or make corrections. Profiles returned with corrections are processed and the provider is reminded to notify the plan about changes and the notification process. Profiles returned in the mail due to bad addresses are investigated and the associated providers are placed on corrective action. Appointment Availability • The PN 159.500 Network Sufficiency, Access, and Availability policy and procedure was updated to include Acute Specialty within 5 business days of request, dental appointment standards and the access and availability verification process. Moving forward, the plan will ensure that the sample of providers included in the annual access and availability study include each provider type. Non-compliant providers will be addressed via corrective action plans with AmeriHealth Caritas delegate, SkyGen. Additionally, the Dental Services Agreement with our dental vendor, SKYGEN was amended to require SKYGEN to contract with locations of participating providers that will ensure reasonable access to dental care services for members as required in the Tri-Party Contract. They are also required to conduct an annual access and availability study of its network and submit the results to AmeriHealth Caritas. Dental providers who are out of compliance with access and availability requirements will be placed on corrective action by SKYGEN.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None.
c. Identify any barriers to implementing initiatives: • None.
HSAG Assessment: HSAG has determined that **AmeriHealth** addressed the prior year's recommendations. However, since the SFY 2022 survey did not evaluate the same provider types, HSAG could not evaluate whether the initiatives were successful or effective.

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: • **HAP** should implement interventions which 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 MCE's Response section was provided by the MCE 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)***: • For the FUH Quality Improvement Project, HAP Empowered continued working with a quality improvement workgroup consisting of representatives from the Quality Management, Performance Improvement/HEDIS, Outreach, and Care Management departments. This workgroup meets bimonthly to discuss ongoing barriers, interventions, and strategies to improve metrics and increase members' health outcomes. The workgroup completed the following activities: o Reviewed HEDIS performance data o Identified key drivers and areas in need of improvement utilizing the fishbone diagram o Developed action and work plans o Monitored intervention performance and outcomes • The two main areas of focus were PIHP collaboration and case management follow-up interventions. Below are the initiatives implemented: PIHP Collaboration: • Established process to discuss shared members with PIHPs on a monthly basis for care coordination of hospitalized members. • 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 and monitor follow-up visits. • HAP Empowered developed and distributed a desk level process (DLP) to standardize the way care coordinators follow up with members who had a Behavioral Health hospitalization. • Education regarding this DLP is an ongoing process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HAP Empowered has improved the performance of this measure from 37.5% in MY 2021 to 45.45% as of July for MY 2022.
c. Identify any barriers to implementing initiatives: • Admission is a manual process.
HSAG Assessment: HSAG has determined that **HAP** addressed the prior year's recommendations. The ICO identified two main areas of focus impacting the QIP indicator and developed targeted interventions to address

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
those areas. The ICO reassessed the identified barriers to care to determine if new barriers exist that require the development of interventions.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **HAP** should 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, **HAP** should 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. • **HAP** should 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. • **HAP** should 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). • **HAP** should 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** should implement appropriate interventions to improve performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **HAP** 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** should identify factors related to the COVID-19 PHE and its impact on the management and treatment of women with fractures. • **HAP** should 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** 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** 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** should identify factors related to the COVID-19 PHE and its impact on accessing timely follow-up care with a mental health provider.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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
Reporting • HAP Empowered implemented quality checks for Core 9.3, including an independent internal audit of the data results. Processes during the internal audit included an independent review of institutional stays, validating lengths of stay, actual admission dates, verification of subsequent stays, and additional checks. Osteoporosis Management in Women Who Had a Fracture • HAP Empowered has implemented telephonic outreach to women who have suffered a fracture and fall into the denominator for Osteoporosis Management in Women Who Had a Fracture (OMW). This outreach focuses on scheduling the member for a bone density test within 6 months of the fracture. Through this effort, 2 root causes were identified for untimely bone density testing and treatment of osteoporosis after a fracture: • The HAP MI Health Link population is less likely to answer their phone and, therefore, are much more difficult to reach regarding their bone density test and treatment for osteoporosis compared to the HAP Medicare Advantage population. • The MI Health Link population is more likely to change their primary care providers without informing HAP Empowered. • In addition to the root causes listed above, the denominator for this measure has historically been very small. As of August 2022, the denominator for MY 2022 is only 10 members. FUH 30 days • Continued the Quality workgroup to discuss ongoing barriers, root cause, interventions, and strategies to improve metrics and increase members' health outcomes. • Standardized the desk level procedure process for targeted member outreach to improve FUH performance outcomes. • Enhanced Care Management collaboration efforts with the PIHPs. • 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): Reporting • The increased focus on quality has resulted in a more streamlined process. Osteoporosis Management in Women Who Had a Fracture • Due to the root causes that were identified, HAP Empowered has implemented the following initiatives to support rate improvement for this measure: • In-Home Bone Density Exams – HAP Empowered conducts outreach via member letters, provider letters and telephone calls to offer in-home bone mineral density (BMD) tests to members who have had a fracture. • Monthly Reports to Provider Offices – HAP Empowered sends monthly lists of members who need a BMD test along with the due dates to providers. • Member Incentive – Starting in mid-2022, members who complete a bone density test (either through their primary care provider or through the in-home exam) receive a $50 gift card. • As a result, HAP Empowered has improved the performance of this measure from 0.00% in MY 2020 to 14.29% in MY 2021 and is now currently at 20.00% for MY 2022.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
FUH • HAP Empowered has improved the performance of this measure from 37.5% in MY 2021 to 45.45% as of July for MY 2022.
c. Identify any barriers to implementing initiatives: Reporting • HAP has encountered no barriers implementing our initiatives. Osteoporosis Management in Women Who Had a Fracture • HAP Empowered has identified the following barrier to implementing programs to improve the rate for this measure: Provider Participation • There are some provider groups that do not want their patients offered an in-home BMD test and instead would like the patient to schedule an appointment directly with them. This has reduced access to a convenient BMD test for the members assigned to those providers. Additionally, some provider offices don't understand the six-month compliance window to complete the BMD test and prefer to provide the test at the member's next scheduled visit. FUH • Tracking and following up with members after admission is a manual process. • Inaccurate contact information makes it difficult to reach members.
HSAG Assessment: HSAG has determined that **HAP** partially addressed the prior year's recommendations. **HAP** addressed the prior year's recommendation for Core Measure 9.3 to implement more stringent validation checks prior to data submission, including selecting cases with identical *service from* and *service to* dates to ensure appropriate discharge dates are captured within the data output. **HAP** confirmed during the SFY 2022 PMV activity implementation of a variety of additional data reasonability and quality checks to evaluate all Core Measure 9.3 data elements, which included the business owner's routine review of the data, comparisons of prior year data element counts, and ongoing assessment of new IFAs to ensure alignment with the reporting requirements. Although HSAG requested that **HAP** update its Core Measure 9.3 source code for the MY 2021 PMV, in general, **HAP** improved its quality oversight and monitoring for this measure, as the source code updates were specific to a measure interpretation issue and not related to data quality. **HAP** partially addressed the prior year's recommendation for Core Measure 9.3 to 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. During the SFY 2022 PMV activity, HSAG did not have any findings related to limiting parameters or missing value set codes when reviewing **HAP**'s programming logic. However, **HAP** was required to update its programming logic to align with the Core Measure 9.3 FAQs that were released in December 2021, and **HAP** incorrectly identified members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge. As such, HSAG recommends that **HAP** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **HAP** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HAP addressed the prior year's recommendation for Core Measure 9.3 to implement validation checks beyond the Millman MedInsight system, which was used to compare institutional counts at a high level for data element A. During the SFY 2022 PMV activity, **HAP** confirmed implementation of a variety of additional data reasonability and quality checks to evaluate all Core Measure 9.3 data elements, which included the business owner's routine review of the data, comparisons of prior year data element counts, and ongoing assessment of new IFAs to ensure alignment with the reporting requirements. **HAP** demonstrated improved performance for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator, as its rate increased by over 14 percentage points from MY 2020 to MY 2021. Additionally, **HAP** has put forth effort to further improve performance for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator by conducting a root cause analysis and identifying factors that led to the low MY 2020 rate and by implementing telephonic outreach to women who suffered a fracture and fall to schedule a bone density test within six months of the fracture. **HAP** has put forth effort to improve performance for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator. **HAP** continued its quality workgroup, standardized its desk-level procedure process to target member outreach to improve upon *FUH* performance, standardized its *FUH* reporting template, and enhanced its collaborative efforts with its contracted PIHPs. However, **HAP** continues to demonstrate low performance for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator, as the rate slightly decreased from MY 2020 to MY 2021. As such, HSAG recommends that **HAP** continue to monitor and expand upon interventions currently in place to improve performance related to the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP** 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** should work with its dental delegate to ensure appropriate prior authorization policies and procedures are in place and followed. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **HAP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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)*:

Dental Provider Education

- Delta Dental has begun performing a monthly Secret Shopper survey of network providers. Delta and HAP Empowered review the results on a quarterly basis to identify the effectiveness of provider training and determine any needed changes in training. HAP Empowered has also arranged meetings with other ICOs to examine additional training methods.

Prior Authorization Policies & Procedures

- HAP Empowered has worked with our dental delegate as well as MDHHS to review Delta Dental's current pre-determination policies and procedures (pre-authorization is not required for any services provided by Delta Dental) and more importantly to understand the reasons behind any member liability. Activities have included review of the current policies and procedures, discussion of member liability with both Delta Dental and MDHHS, responding to detailed questions from MDHHS regarding member liability, and regular collection of prior determination data from Delta Dental.
- At this time, as the three-way contract does not require prior authorization for any services and because HAP Empowered and Delta Dental view a mandatory authorization as a deterrent to a member receiving services, we have not pursued implementing a mandatory requirement, instead focusing on member liability and the reasons why members incur liability. We have focused on the main reasons that members incur liability (use of non-network providers and receipt of non-covered services) and worked on solutions, focusing on improved communication with both members and providers.

Provider Credentialing

- HAP Empowered assures that all practitioners applying for affiliation meet rigorous credentialing standards prior to providing care to members following all federal and State obligations. The provider must submit information and documentation of his/her education, qualification, and certification which qualifies them to be identified as a specialist in a particular field of medicine. It is anticipated that the services to HAP Empowered members performed by that provider would be consistent with the medical specialty for which the provider applied and was evaluated and credentialed. Credentialed specialists are accordingly expected to provide covered services to HAP Empowered members that are within the scope of the specialty credentialed by HAP Empowered after review of the providers' application. The Credentialing Committee decision-making is governed by a simple majority vote, and it is nondiscriminatory. Practitioners will undergo the recredentialing process within 36 months of the previous credentialing decision. The Credentialing Manager reviews with the Medical Director the credentialing policies to ensure compliance. The policy is reviewed at a minimum annually and more frequently if needed to meet any changes to the regulatory requirements. The Credentialing Policies are formally approved by the Credentialing Committee and Compliance Department. Any updates to the process and policies are distributed to the Credentialing Team, along with a training session to ensure compliance. The completed provider's credentialing file is peer reviewed to ensure compliance and that all regulatory requirements are met.
- HAP Empowered assures that all organizational providers applying for affiliation meet the credentialing standards prior to providing care to members following all federal and State obligations. The same process is followed for the organizational providers.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
Grievance and Appeal Processes • The HAP Empowered Appeal and Grievances (A&G) department continually evaluates its overall operating model and performance which includes but is not limited to staffing and skill assessment, revised/enhanced process reviews, annual updating of policy and procedures and training needs along with implementing improved reporting and system tracking for case handling and notification timeliness. Throughout the calendar year 2021 and into 2022, the HAP Empowered A&G management team performed a comprehensive department assessment which resulted in several improvements. Extensive product and regulatory re-training occurred in the second quarter of 2021 reinforcing all State/federal and product requirements. The training included correct case identification, processing timeframes, payment and clinical decision-making requirements, use of extensions and required notifications and content development. A&G management also developed enhanced inventory reporting which included a "7-day case closure" report that identifies appeals and grievances nearing their due date. This report is reviewed by A&G management daily and distributed to the A&G staff to assist in managing and preventing late cases. A&G managers now meet weekly with staff to review each analyst's weekly workload and to identify any barriers to complete case handling under the regulatory requirements utilizing the enhanced inventory reporting. In addition, the A&G team converted to a new A&G tracking and reporting system which increased/enhanced reporting capabilities. Due to the system conversion, all staff underwent case handling and system training from December 2021 through March 2022, and desk level procedures were updated. An annual review of all required member and provider notifications and letters has been implemented along with an annual policy review in coordination with HAP Compliance. New and updated regulatory changes are tracked and reported through the Compliance Medicaid and MMP Sub-committee. Ongoing, A&G reports monthly metrics to Compliance and if a late case were to occur, a written corrective action response is submitted with each late case. A&G management is now able to perform better root cause analysis at the department and organizational level due to the improved reporting. Last, A&G revised its departmental case quality assurance program to ensure case documentation, timeliness and notifications are reviewed daily and in accordance with MDHSS appeal and grievance contracts.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Dental Provider Education • Initial review of results of Delta's Secret Shopper survey showed an increase in recognition for MI Health Link and HAP Empowered. Because of this increase, no change in training was suggested. HAP Empowered and Delta will continue to review these results on a regular basis. Prior Authorization Policies & Procedures • We have noticed that the number of procedures that would have required prior-authorization (using the Medicaid fee-for-service list) was extremely low (only 2 out of 333 reviewed claims). We have seen member liability decrease in both the use of network provider and non-covered service categories. Grievance & Appeal Processes • There has been noted improvement in case handling and timeframes along with the Appeal and Grievances analysts proactively seeking assistance and guidance on complex cases. In addition, the enhanced inventory and other reporting has allowed identification of case trends and root cause analysis to drive improvements and/or process gaps across the organization. This data has been shared in various management and operational meetings and provides a direct line of sight regarding the member's experience and areas of opportunity for improvement across clinical and operational areas.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
c. Identify any barriers to implementing initiatives: Dental Provider Education • No barriers have been identified. Prior Authorization Policies & Procedures • Education of members regarding use of network providers and liability when non-covered services are received is challenging. HAP Empowered continues to work with Delta Dental to address these issues. Grievance & Appeal Processes • There have been no barriers to implementing initiatives. Retaining and hiring the appropriate skilled and experienced staff has been a challenge post-pandemic and remains a priority for the unit.
HSAG Assessment: HSAG has determined that **HAP** addressed the prior year's recommendations based on the ICO's narrative and the SFY 2021 compliance review remediation plan. The SFY 2022 compliance review activity also confirmed **HAP** successfully remediated two of the authorization services findings as the ICO did not receive a deficiency specifically related to the content/language included in the IDNs. However, HSAG was unable to confirm if **HAP** successfully remediated findings related to credentialing, grievances, and appeals as these areas were not included in the scope of the SFY 2022 compliance review activity and will be reviewed during the future SFY 2023 activity.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **HAP** should 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. • **HAP** should 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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 has contracts with two direct contracted vendor partners for Personal Emergency Response System (PERS): Guardian Medical Monitoring and NationsResponse. Guardian has had a relationship with HAP Empowered since 2010. NationsResponse was added in 2021. Additionally, HAP Empowered has access to PERS providers through the delegated entities Area Agency on Aging 1B for Region 9 and Detroit Area Agency on Aging 1A/The Senior Alliance for Region 7. These combined sources allow for HAP Empowered to offer well above the required two providers for enrollees to utilize for this service.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • [no narrative provided by the ICO]

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
c. Identify any barriers to implementing initiatives: • [no narrative provided by the ICO]
HSAG Assessment: HSAG has determined that **HAP** addressed the prior year's recommendations. The SFY 2022 NAV activity confirmed **HAP** met the minimum network requirements for the Personal Emergency Response System provider type in Region 7 and Region 9.

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
HSAG recommended the following: • **HAP** 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. Additionally, as MDHHS required **HAP** to submit a CAP, the ICO should fully implement its remediation plans and continue to monitor for provider-related data concerns. • **HAP** should work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. Further, **HAP** should consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 initiatives include enhancing the monitoring and validation of the provider directory accuracy by utilizing directory auditors to monitor and conduct mock audits. Identified inaccuracies are immediately remediated to ensure that educated decisions can be made by members seeking care. HAP Empowered continues to look for new opportunities to enhance directory access processes to remain compliant. • HAP Empowered reviewed the results of the Secret Shopper Survey and corrected any provider demographic data that was incorrect. Steps were also taken to educate applicable providers on participation with the plan. Education occurred through calls, emails, and fax. HAP Empowered also conducted multiple outreaches to providers to educate them on access and availability standards and requirements as participating providers. Initial education was done which also required providers to comply with the standards within 90 days. Following the 90 days, additional outreach was completed to ensure compliance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of the outreach noted above, all providers who were educated and required to achieve compliance with access and availability standards were compliant after the 90-day follow-up outreach was completed.
c. Identify any barriers to implementing initiatives: • Although all identified providers were compliant after 90 days, providers did express concern with some access and availability standards due to staffing and resource issues in the practices. They communicated concern with the ability to maintain those standards.
HSAG Assessment: HSAG has determined that **HAP** addressed the prior year's recommendations. However, since the SFY 2022 survey did not evaluate the same provider types, HSAG could not evaluate whether the initiatives were successful or effective.

MeridianComplete

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: • Although there were no identified weaknesses, **Meridian** 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 MCE's Response section was provided by the MCE 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 review of the FY [fiscal year] 2021 EQRO report, Meridian completed the recommended revisit of the causal/barrier analysis for the Follow Up After Hospitalization – 30 Days HEDIS® measures and focus of the prior Quality Improvement Project. Meridian confirmed the identified barriers continue to exist for this measure. Meridian continues to work in partnership with Pre-Paid Inpatient Health Plans (PHIPs) for coordination of behavioral health services and reporting of lead indicator metrics. To improve communication and distribution of real time data, Meridian, the Michigan Department of Health and Human Services, (MDHHS), Michigan Health Integrated Network (MiHIN) and PHIPs are collaborating on Consolidated Clinical Document Architecture (CCDA) use case data transfers between Meridian and each PIHP. Meridian will ensure to evaluate for new and continued barriers and develop interventions to address those barriers in the new QIP cycle.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In review of the FY 2021 EQRO report, Meridian completed the recommended revisit of the causal/barrier analysis for the Follow Up After Hospitalization – 30 Days HEDIS® measures and focus of the prior Quality Improvement Project. Meridian confirmed the identified barriers continue to exist for this measure. Meridian continues to work in partnership with Pre-Paid Inpatient Health Plans (PHIPs) for coordination of behavioral health services and reporting of lead indicator metrics. To improve communication and distribution of real time data, Meridian, the Michigan Department of Health and Human Services, (MDHHS), Michigan Health Integrated Network (MiHIN) and PHIPs are collaborating on Consolidated Clinical Document Architecture (CCDA) use case data transfers between Meridian and each PIHP. Meridian will ensure to evaluate for new and continued barriers and develop interventions to address those barriers in the new QIP cycle.
c. Identify any barriers to implementing initiatives: • Technical delays have been identified in development of the CCDA use case data transfers.
HSAG Assessment: HSAG has determined that **Meridian** addressed the prior year's recommendations. The ICO revisited the causal/barrier analysis and determined that the barriers to care continue to exist for the target population. The ICO stated that it will continue to evaluate the effectiveness of the initiated interventions.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • While **Meridian** 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, **Meridian** should 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. Further, **Meridian** should 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. • **Meridian** should 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. • **Meridian** should 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** 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** 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** should identify factors related to the COVID-19 PHE and its impact on conducting advance care planning and functional status assessments. • **Meridian** should 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** should implement appropriate interventions to improve the performance related to the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator. **Meridian** 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** 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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 order to ensure validation of ongoing data submissions, our team updated the Structured Query Language (SQL) code to replace Medicaid Number with Medicare Beneficiary Id/Master Person ID. • Meridian is now using the hybrid methodology for reporting MI 2.6 to ensure quality and completeness of data. Meridian employs skilled Quality Improvement Abstractors with experience retrieving and

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
qualifying the appropriate medical records. Meridian has transitioned systems and processes that align with Centene's best practices. • In review of the FY 2021 EQRO report, Meridian completed the recommended root cause analysis on HEDIS® measures; COA- Advanced Care Planning and Functional Status Assessment. This analysis identified weaknesses in provider documentation and billing of appropriate codes. In addition, the COVID -19 pandemic continued to be a barrier for members, providers, and the health plan. As a result of these findings Meridian will continue the Process Improvement Plan (PIP) for the COA - Advanced Care Planning measure and implement a new PIP of the COA- Functional Status Assessment measure. A focus of the PIP is providing education and an attestation tool to provider practices through quality facing provider staff. The PIP process allows Meridian to track HEDIS® measure rates and review the progress of interventions dedicated to achieving the targeted benchmarks. The PIP results are shared during the quarterly Quality Improvement Committee meeting. Also, Meridian monitors the impact of the historical Michigan Complete Health population on HEDIS® rates and quality improvement activities. In 2022, the Provider HEDIS® Quick Reference Guide, a one stop HEDIS® educational resource, will be distributed to all Meridian MMP providers. • In review of the FY 2021 EQRO report, Meridian completed the recommended root cause analysis on the HEDIS® measure Persistence of Beta-Blocker Treatment after Heart Attack (PBH). This analysis identified a small denominator of 12 members for the measurement year. The COVID -19 pandemic continued to be a barrier for members, providers, and the health plan. Meridian monitors the impact of the historical Michigan Complete Health population on HEDIS® rates and quality improvement activities. In 2022, the Provider HEDIS® Quick Reference Guide, a one stop HEDIS® educational resource will be distributed to all Meridian MMP providers. Meridian will monitor the HEDIS® PBH measure through monthly tracking and scorecards and continue to assess for opportunities for intervention.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian members transitioned to Centene systems effective 1/1/2021 and aligned with Centene CORE reporting standards where the data mapping inconsistencies noted during the audit is no longer applicable. In 2021 we updated the SQL code used to account for the additional check implemented to be used in future reporting. • In utilizing the hybrid methodology, the MY2021 MI 2.6 rate was 54.74% compared the MY2020 rate, which was unreportable. • The MY2021 COA-Care Planning rate of 27.74% increased by 6.82 percentage points when compared to the MY2020 rate of 20.92%. In addition, the MY2021 COA-Functional Status Assessment rate of 28.47% increased by 5.84 percentage points when compared to the MY2020 rate of 22.63%. • The MY2021 PBH measure rate of 100% increased by 11.11 percentage points when compared to the MY2020 rate of 88.89%.
c. Identify any barriers to implementing initiatives: • The original chart chase logic for MI 2.6 hybrid data collection only included provider records. Because of this barrier, the logic was adjusted to also include discharging facilities. • The PBH measure continues to have a low denominator, which results in low reliability for the measure.
HSAG Assessment: HSAG has determined that **Meridian** partially addressed the prior year's recommendations. **Meridian** addressed the prior year's recommendation to consider using the hybrid methodology for future reporting of MI2.6. **Meridian** restructured the MI2.6 process for 2021 by implementing

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
the hybrid methodology for reporting MI2.6, which further ensured the accuracy, quality, and completeness of its MI2.6 reported data. **Meridian** put forth effort to address the prior year's recommendation for Core Measure 9.3 to implement more stringent validation checks prior to data submission, as **Meridian** made updates to its programming logic. However, during the SFY 2022 PMV activity, the member-level data provided to HSAG for PMV contained errors that resulted in resubmission of Core Measure 9.3 data to HPMS. As such, HSAG continues to recommend that **Meridian** implement more stringent validation checks prior to submission of member-level data. These checks should include reviewing the member-level data to ensure alignment with the reporting requirements, especially in relation to time frame parameters required by the specifications for the performance measure. **Meridian** demonstrated improved performance for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator, as its rate increased by over 11 percentage points from MY 2020 to MY 2021. Additionally, **Meridian** has put forth effort to further improve performance for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator by conducting a root cause analysis and identifying factors that led to the low MY 2020 rate, distributing education to providers, and monitoring performance through monthly tracking and scorecards. **Meridian** demonstrated improved performance for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators, as its rates increased by over 5 percentage points from MY 2020 to MY 2021. Additionally, **Meridian** has put forth effort to further improve performance for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators by conducting a root cause analysis and identifying factors that led to the low MY 2020 rate, distributing education to providers, focusing on the PIP currently in place for the *Advance Care Planning* measure indicator, and planning to implement a new PIP for the *Functional Status Assessment* measure indicator.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Meridian** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to delegation standards.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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's membership transitioned to Centene systems effective 1/1/2021 and aligned with Centene's standards for all areas reviewed during the EQR. • Authorization of services standards – Meridian reviews our delegates IDN letters based on feedback received during the 2021 EQR focus review. • Organizational credentialing standards – Corporate Credentialing instated a requirement for ownership disclosure forms to be presented at the initial and re-credentialing phases for all providers. • Grievance standards – The Grievances team implemented an intake email box is monitored 3x a day by their team. When a case is received, a response is sent back to MDHHS immediately to acknowledge the complaint. The impacted member is contacted with acknowledgement and a resolution within 48 hours of receipt of the complaint from MDHHS. • Appeal standards - An updated letter for extension on appeals was approved through the appropriate channels and instated for use. • Delegation standards - Meridian updated deficient contract agreements to include all the required language in 2021.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In the 2022 Compliance Review, Meridian received passing scores for Authorization of services standards. • The updated intake email box for Grievances has met the timely notification requirements by immediately notifying MDHHS upon receipt of a complaint.
c. Identify any barriers to implementing initiatives: • None currently.
HSAG Assessment: HSAG has determined that **Meridian** addressed the prior year's recommendations based on the ICO's narrative and the SFY 2021 compliance review remediation plan. The SFY 2022 compliance review activity also confirmed **Meridian** successfully remediated two of the three authorization services findings as the ICO did not receive a deficiency specifically related to the content/language included in the IDNs. However, the SFY 2022 compliance review activity confirmed that **Meridian**'s dental delegate was using an outdated version of the IDN, which was also a finding during the SFY 2021 compliance review activity. **Meridian** remediated the 2021 review findings but appears to not have implemented a process to ensure its delegates are provided with updated letter templates timely, and on an ongoing basis. As such, HSAG recommends that **Meridian** develop oversight processes to address this continued finding. Additionally, HSAG was unable to confirm if **Meridian** successfully remediated findings related to credentialing, grievances, appeals, and delegation as these areas were not included in the scope of the SFY 2022 compliance review activity and will be reviewed during the future SFY 2023 activity.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Meridian** should 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 these provider types in Region 4 will be evaluated during the SFY 2022 NAV.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 order to fulfil the gaps identified in our hearing network, Meridian has executed a contract with AudioNet America, which has provided our MI Health Link members hearing exam and hearing aid access across the state of Michigan.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian is now meeting the time/distance standards in Region 4 with an ample amount of servicing Providers for our MI Health Link members.
c. Identify any barriers to implementing initiatives: • None at this time.
HSAG Assessment: HSAG has determined that **Meridian** addressed the prior year's recommendations. The SFY 2022 NAV activity confirmed **Meridian** met the minimum network requirements for the Hearing Examinations and Hearing Aids provider types in Region 4.

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
HSAG recommended the following: • **Meridian** 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. Additionally, as MDHHS required **Meridian** to submit a CAP, the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns. • **Meridian** should work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. Further, **Meridian** should consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 prioritizes easy access and availability for our enrollment, strong partnerships and communication with our provider network, and accurate directory data. In response to the Primary Care Provider secret shopper survey, in December 2021 and January 2022 Meridian educated the primary care provider network on access/ availability requirements via our monthly provider newsletter. In

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
addition, Meridian implemented a new front-end process to ensure our members can access the most up to date and accurate information in our Provider Directory.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Provider education via Provider Newsletter December 2021, January 2022 • New front-end process to enroll providers and make demographic changes Q2 2022 • This will allow data changes, phone numbers, open/accepting status, office hours, etc. to be updated as timely as possible and available for the enrollment to view.
c. Identify any barriers to implementing initiatives: • None at this time.
HSAG Assessment: HSAG has determined that **Meridian** addressed the prior year's recommendations. However, since the SFY 2022 survey did not evaluate the same provider types, HSAG could not evaluate whether the initiatives were successful or effective.

Molina Dual Options MI Health Link

Table 4-5—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: • Although there were no identified weaknesses, **Molina** 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 MCE's Response section was provided by the MCE 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 continues to evaluate all interventions and outcomes to determine next steps. • Based on this review and results of the cause/barrier analysis identified and opportunity to improve the data sharing process. Molina has implemented weekly data sharing reports capturing admission, discharge, and transfer data will continue to be shared between the ICO and PIHP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • At this time our modification to the weekly data sharing initiative has not been in process long enough to conduct a thorough evaluation. Molina will be evaluating on a quarterly basis.
c. Identify any barriers to implementing initiatives: • Currently, there are no barriers to implementing the initiatives. Molina will monitor for changes and determine next steps for intervention as needed
HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations. The ICO revisited the causal/barrier analysis and identified additional opportunities for improvement for the target population. The ICO stated that it will continue to evaluate the effectiveness of the initiated interventions.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **Molina** should 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. • **Molina** should 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. • **Molina** should 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.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
Upon identification of a root cause, **Molina** 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** 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** should identify factors related to the COVID-19 PHE and its impact on conducting advance care planning and functional status assessments.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 has conducted a review of 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. Molina has updated the process to include a Care Review Clinician to advise the hospital to send the Transition Record/Discharge Summary to Molina on the day of the member's discharge. Upon receipt and review, Molina then faxes the record to the PCP or Health Care professional notifying them of the transition. • For further efficiency, Molina has requested access to the hospital electronic medical record system where Molina has a high concentration of Molina MMP members to obtain and send the Transition Record immediately upon notification of the discharge. • Additionally, Molina obtained an attestation from one of the largest hospital systems that the transition record is automatically sent via their electronic system to the members PCP on record. This will be verified through audit to ensure accuracy. • Molina Healthcare of Michigan partnered with the Molina Corporate Compliance department to improve our internal processes for collecting and submitting the ISCAT. Molina implemented a proactive approach by establishing frequent meetings with the various Functional Areas (FAs) to ensure responses and requested documentation were updated appropriately and reviewed and approved by FA leadership. • Regarding the subcontractors involved in the processes related to the measures under the scope of the validation, Molina collaborated with our Delegation Oversight team to ensure all pertinent details regarding subcontractors (i.e., PIHPs) were complete, accurate, and included with the initial submission of the ISCAT. • Molina improved the Quality Assurance process by implementing additional quality checks throughout the collection process to ensure complete and accurate information is provided with the initial submission of the ISCAT. • Molina conducted a root cause analysis to determine why some adults 66 years of age and older are missing advanced care planning and functional status assessments. The analysis included the review of the medical records to identify issues with documentation and conversations with the providers and staff to determine if there were processes in place to review advanced care planning and functional status with the patients annually. Additionally, Molina conducted education with providers and staff which included written tips that covered proper documentation in the medical record and the appropriate codes to submit the information electronically.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
• The COVID 19 PHE prevented some members from following through with office visits. Providers were encouraged to use telehealth visits to complete these services and were provided the appropriate telephone visit and online assessment codes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina has been able to audit and verify that the transition records were sent as attested to the PCP or Healthcare Provider timely. • The RY2022 rate for COA—Care for Older Adults—Advance Care Planning was reported at 44.53% which is 2.44 percentage points above the RY2020 rate of 42.09%. • The RY2022 rate for Functional Status Assessment was reported at 53.04% which is 2.43 percentage points above the RY2020 rate of 50.61%.
c. Identify any barriers to implementing initiatives: • Though Molina notifies the hospital to send the Transition Record to Molina on the day of discharge, the hospitals often do not send it timely or may not send it at all. Molina may not be notified of the member's discharge until 1-2 days after the discharge and Molina may need to make multiple attempts requesting the information. • Many hospitals' security precautions make it difficult to obtain permission and access to their electronic systems.
HSAG Assessment: HSAG has determined that **Molina** partially addressed the prior year's recommendations. **Molina** addressed the prior year's recommendation to 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. **Molina** improved upon its internal processes for collecting and submitting the ISCAT and implemented additional quality checks throughout the collection process to ensure complete and accurate information. Additionally, HSAG did not identify any issues with the ISCAT or supporting documentation during the SFY 2022 PMV activity. **Molina** put forth effort to address the prior year's recommendation for MI2.6 data element C to implement a process for checking the timeliness requirement. **Molina** updated the process, requested access to a hospital electronic medical record system with a high concentration of members, and obtained attestation from one of the largest hospital systems that the transition records were being automatically sent. However, during the SFY 2022 PMV activity, corrected member-level detail file submissions were required for MI2.6 due to HSAG's identification of several cases that were either listed as compliant for data element C that had transition record transmission dates outside of two days after discharge or listed as noncompliant for data element C that had incorrect transition record transmission dates listed. As such, although **Molina** noted future implementation of additional quality checks as a result of HSAG's findings for MI2.6, HSAG recommends that **Molina** ensure these quality checks are implemented in a timely manner and that they include reviewing the member-level data to ensure alignment with the reporting requirements, especially in relation to time frame parameters required by the specifications for the performance measure. **Molina** demonstrated improved performance for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators, as its rates increased by over 2 percentage points from MY 2020 to MY 2021. Additionally, **Molina** has put forth effort to further improve performance for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators by conducting a root cause analysis and identifying factors that led to the low MY 2020 rate, and conducting education with providers.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
Molina demonstrated improved performance for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators, as its rates increased by over 5 percentage points from MY 2020 to MY 2021. Additionally, **Molina** has put forth effort to further improve performance for the *COA—Care for Older Adults—Advance Care Planning* and *Functional Status Assessment* measure indicators by conducting a root cause analysis and identifying factors that led to the low MY 2020 rate, distributing education to providers, focusing on the PIP currently in place for the *Advance Care Planning* measure indicator, and planning to implement a new PIP for the *Functional Status Assessment* measure indicator.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **Molina** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 has evaluated it processes regarding MDHHS-set coverage and authorization of service standards and has implemented an operational dashboard that is utilized on a daily basis to ensure compliance. Additional staff reference tools have been developed to maintain compliance. • Molina has evaluated it processes regarding credentialing and has implemented the following: o Multi-department team meetings to include Quality Improvement to determine how to incorporate provider utilization management details into the recredentialing processes. • Molina has evaluated it processes and procedures for Appeals and Grievances and has implemented the following: o Acknowledgement letters – a new system was implemented 10/2021 and a new team was created for in-take appeals and grievances. This team has been tasked with creating the acknowledgement letters upon receipt rather than waiting until the case is assigned.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
○ Grammar/Spelling issues – the new system that has been implemented has a built-in spell check. Additional resources are being reviewed for grammar as well as ability to create/utilized standard paragraphs in the letter writing module. ○ Grade Levels – Additional training has been provided along with tools to help staff meet this requirement. Additional resources are being reviewed for grade level as well as ability to create/utilized standard paragraphs in the letter writing module.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina's coverage and authorization process turn around compliance has increased to 98% for expedited authorizations and 99% for standard requests. • Upon review of recommendations for individual practitioner and organizational credentialing Molina has implemented the Disclosure of Ownership (DOO) form upon initial credentialing of applications effective 8/1/21. The Molina quality review process includes the DOO form as each file is reviewed for participation criteria. In addition, during the organizational credentialing process, Molina will continue to verify accreditation and complete site visits when necessary. The Molina Network team will verify Medicaid enrollment through CHAMPS [Community Health Automated Medicaid Processing System], submit DOO forms for new applicants and ensure there is a form on file for existing groups when submitting applications for participation into the network. • For Appeals and Grievances, the update for the system and the change in the process has resulted in a significantly higher compliance rate in all areas. Additionally, there has been a significant decrease in spelling/grammar and miss identified grade-levels issues due to the system changes being made as well as manual review of outbound letters. The manual review has allowed the leadership to work with specific team members to increase their performance.
c. Identify any barriers to implementing initiatives: • There were no barriers identified for the coverage and authorization process. • Molina is receiving some abrasion from Practitioners and Organizational Providers who are already in the network, or who are Medicaid enrolled on the need to submit the DOO form. • No significant barriers have been identified for the initiatives related to Appeals and Grievances.
HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations based on the ICO's narrative and the SFY 2021 compliance review remediation plan. The SFY 2022 compliance review activity also confirmed **Molina** successfully remediated one of the two authorization services findings as the ICO did not receive a deficiency specifically related to the content/language included in the IDNs. However, the SFY 2022 compliance review activity confirmed that **Molina**'s dental delegate was using an outdated version of the IDN, which was also a finding during the SFY 2021 compliance review activity for the ICO's pharmacy team. **Molina** remediated the 2021 review findings but appears to not have implemented a process to ensure its departments/delegates are timely provided with updated letter templates on an ongoing basis. As such, HSAG recommends that **Molina** develop oversight processes to address this continued finding. Additionally, HSAG was unable to confirm if **Molina** successfully remediated findings related to credentialing, grievances, and appeals as these areas were not included in the scope of the SFY 2022 compliance review activity and will be reviewed during the future SFY 2023 activity.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Molina** 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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 continually monitors its LTSS provider network through solicitation of new providers and ongoing meetings with the Health Care Services team to identify any specific service needs. For the Medicaid providers in the program, including hospitals, physicians, and ancillary providers, Molina utilizes geographical software of provider locations against member locations. Provider data accuracy is verified through direct conversation with providers during ongoing service contacts, general calls to validate the Provider Online Directory, and "secret shopper" calls by Molina to verify information.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • At this time, the Molina LTSS and provider networks meet all standards and are robust.
c. Identify any barriers to implementing initiatives: • Molina is constantly challenged with receiving accurate and timely provider demographic information.
HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations. The SFY 2022 NAV activity confirmed **Molina** met the minimum network requirements for all provider types in Region 7 and Region 9.

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
HSAG recommended the following: • **Molina** 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. Additionally, as MDHHS required **Molina** to submit a CAP, the ICO should fully implement its remediation plans and continue to monitor for provider-related data concerns. • **Molina** should work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. Further, **Molina** should consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 has implemented a monthly secret shopper survey of its provider Network to ensure Molina has the most current and up to date information. Several Network staff are randomly assigned 20-40 providers to contact each month and submit updates as applicable. Additionally, Molina has also

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
implemented a roster reconciliation project where Molina outreaches and requests a full roster from each of its Network and Delegated providers in order to reconcile against Molina's provider data. • Molina also utilizes provider attested data from Council for Affordable Quality Healthcare (CAQH) system to update provider data on an ongoing quarterly basis. • Molina conducts an annual appointment availability survey of providers to assure compliance with required standards. The results of the survey are reviewed and addressed with any provider out of compliance, including a formal Corrective Action Plan, if necessary. Molina partners to discuss operational efficiencies and best practices with providers for improved member communication about appointment access as needed or requested.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During Molina's numerous touchpoints, provider education has increased regarding the importance of receiving up to date information. We have increased our outreach to the providers and added additional logic to the roster reconciliation process to ensure Molina's provider data is as accurate as possible.
c. Identify any barriers to implementing initiatives: • Molina is constantly challenged with receiving accurate and timely provider demographic information.
HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations. However, since the SFY 2022 survey did not evaluate the same provider types, HSAG could not evaluate whether the initiatives were successful or effective.

Upper Peninsula Health Plan MI Health Link

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

1. Prior Year Recommendation from the EQR Technical Report for Validation of Quality Improvement Projects
HSAG recommended the following: • **UPHP** should 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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 identified a new topic for the Performance Improvement Project in FY2022. Data analysis was performed to identify a statistically significant racial disparity, and a cause-and-effect analysis was performed to identify and prioritize barriers to completion of care for the target population. The final baseline report for this PIP was submitted in September 2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A – it is too soon to assess for performance improvement.
c. Identify any barriers to implementing initiatives: • No barriers to implementing initiatives noted at this time.
HSAG Assessment: HSAG has determined that **UPHP** did not address the prior year's recommendations. Although the ICO identified and initiated a new QIP topic during SFY 2022 for submission to HSAG, the ICO should continue to initiate and evaluate efforts to improve the performance of the concluded QIP topic, *Follow-Up After Hospitalization for Mental Illness*.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **UPHP** should 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 **UPHP** can ensure it is able to appropriately identify members discharged to the community, further assuring the accuracy of data element B. Further, **UPHP** should 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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 was able to identify and correct logic in Element A's code so that it is only including paid claims to identify Institutional Facility Admissions. Element B's logic was adjusted to reflect the usage of both paid and denied claims in Step 3's exclusion criteria that excludes the discharge to home if the member had an inpatient admit or an institutional facility admit within 60 days of discharge. UPHP also found that Element C was being calculated by applying the expected discharge probability equation to only those institutional facility admissions that resulted in discharge to the community, rather than all of the IFA's present in Element A.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • After adjusting the logic as stated above, Element A's aggregate stayed predominantly the same, while we saw a significant change in Element B because a few dozen discharges to the community were excluded due to readmission within 60 days. Element C's total changed significantly, also, after the correction was put in place that applied the expected discharge probability calculation to all identified IFA's in element A.
c. Identify any barriers to implementing initiatives: • The only barriers to implementing the initiatives were related to our interpretation of the Core 9.3 measure guidelines. After our 2022 ISCAT PMV audit, some back and forth between UPHP and HSAG with the source code approval process, and finally a phone call to insure we were on the same page as the measure stewards, we were able to overcome these barriers.
HSAG Assessment: HSAG has determined that **UPHP** partially addressed the prior year's recommendation. **UPHP** put forth effort to address the prior year's recommendation for Core Measure 9.3 to implement more stringent validation checks prior to data submission. **UPHP** corrected its programming logic for all data elements to further align with the reporting requirements. However, during the SFY 2022 PMV activity, HSAG identified that **UPHP**'s source code did not align with the Core Measure 9.3 Core Reporting Requirements, as it was not limiting identification of data element A to only paid claims. As such, HSAG recommends that **UPHP** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements to confirm that its programming logic fully aligns with the reporting requirements and guidance. **UPHP** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **UPHP** 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. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **UPHP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set grievance standards. • In addition to developing a CAP to mitigate the gaps within its processes and documentation, **UPHP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to MDHHS-set appeal standards.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• In addition to developing a CAP to mitigate the gaps within its processes and documentation, **UPHP** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to delegation standards.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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)***: • For coverage and authorization of services standards, UPHP reviews its Utilization Management (UM) policies and procedures at least yearly. UPHP is utilizing the correct version of the Integrated Denial Notice (IDN) and is receiving notification when new templates are developed to ensure the correct notice is being used. UPHP continues to review and create denial templates for services that are commonly denied that are in plain language for members to understand. UPHP also worked with Michigan Department of Health and Human Resources (MDHHS) to identify the correct citation to use in the Integrated Denial Notices when a member no longer wants services that were approved by UPHP. • For grievance standards, UPHP reviews grievance policies and procedures at least annually. When updates are required, UPHP obtains MDHHS approval before policy changes become effective. UPHP performs monthly quality analysis on all grievances to ensure standards are being met. • For appeal standards, UPHP reviews its appeal policies at least yearly. The UPHP Clinical Appeals team received education in sending out the appeal acknowledgement letter within 5 calendar days of receipt. • For Delegation Standards: UPHP conducted an audit of Jensen Case Management, Audit Period: March 1, 2019, to March 31, 2020. UPHP termed contract with Jensen Case Management in January of 2022. Findings included: o 23 different pieces of documentation were requested. o 4 related to Downstream Entities ended up being not applicable, as Jensen Case Management does not have any downstream entities. o 4 items received satisfied the request: Evidence of Insurance Coverage, demonstrating scheduling and scheduling attempts were completed during the audit period for a sample of members, and Providing proof of licensure for all employees who completed assessments during the audit period The remaining 16 requested items were unable to be accounted for by Jensen Case Management. Items not produced include: A Business Continuity Plan, when to notify UPHP of any suspected fraud, waste, or abuse, evidence of OIG screenings for employees, evidence of security where member information is accessible, mechanisms used to disseminate compliance messages to staff. o Recommendations to Jensen were to create a business continuity plan and create required policies and procedures. UPHP did not develop a corrective action plan because the contract was terminated. • UPHP executed an amendment to Delta Dental's contract that outlines specific reporting requirements. • Report names are: Encounter Data (monthly), First Call Resolution (monthly), Applicable ODAG Universe Files (annually), Provider Directory (monthly), Patient Access API [application programming interface] (837 or flat file) (daily), Provider Directory API (monthly).

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • UPHP is utilizing the correct version of the IDN. All IDN's issued when a member no longer wants services include a citation citing their right to decline services. • UPHP has a compliance rate of 95% (39/41) in sending out the appeal acknowledgement letter within 5 calendar days of receipt (April 6,2021-August 26, 2022) • For Delegation Standards: With increased reporting requirement from our delegated entities, it allows UPHP to monitor contractual requirements more timely and discover discrepancies sooner thus allowing these discrepancies to be corrected sooner.
c. Identify any barriers to implementing initiatives: • No barriers to implementing initiatives noted at this time.
HSAG Assessment: HSAG has determined that **UPHP** addressed the prior year's recommendations based on the ICO's narrative and the SFY 2021 compliance review remediation plan. The SFY 2022 compliance review activity also confirmed **UPHP** successfully remediated the authorization services findings as the ICO did not receive a deficiency specifically related to the reading-grade level or version of the IDNs. However, HSAG was unable to confirm if **UPHP** successfully remediated findings related to grievances, appeals, and delegation as these areas were not included in the scope of the SFY 2022 compliance review activity and will be reviewed during the future SFY 2023 activity.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **UPHP** 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.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 receives outreach from LTSS providers requesting network participation. UPHP will notify UPCAP [Upper Peninsula Commission for Area Progress] of the request, and UPCAP will work with the service for contracting. UPHP receives outreach from Dental providers requesting network participation as well, and UPHP will notify Delta Dental to contract with the provider. UPHP is working on implementing an internal data verification process to identify and contract with new service providers as they become available within the region.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Any inquiries received from LTSS or Dental providers requesting network participation are passed along immediately to UPCAP and Delta Dental for contracting. This has helped to expand the network within the region that adequacy was limited.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
c. Identify any barriers to implementing initiatives: • Due to the rural nature of the Upper Peninsula, this has prevented a lack of provider opportunities to expand within the region. UPHP will continue to pass along LTSS and Dental Providers as they become aware of the availability.
HSAG Assessment: HSAG has determined that **UPHP** addressed the prior year's recommendations. The SFY 2022 NAV activity confirmed **UPHP** met the minimum network requirements for the Assistive Technology—Van Lifts and Tie Downs provider type in Region 1. While **UPHP** did not meet the minimum network requirements for the Adult Day Program, Dental, Hearing Examinations, Hearing Aids, and MIHP Agency provider types in Region 1 during SFY 2022, the ICO was granted an exception from MDHHS.

5. Prior Year Recommendation from the EQR Technical Report for Secret Shopper Survey
HSAG recommended the following: • **UPHP** 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. Additionally, as MDHHS required **UPHP** to submit a CAP, the ICO should fully implement its remediation plans and continue to monitor for provider-related data concerns. • **UPHP** should work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. Further, **UPHP** should consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE 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 continuously audits and monitors the provider network. Any data deficiencies are addressed with the provider offices and updated in UPHP's internal system. UPHP has implemented a secret shopper outreach to provider offices to audit and monitor provider appointment availability. UPHP will provide education to the provider offices regarding any deficiencies found through this outreach.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • UPHP has implemented a secret shopper outreach to verify provider wait times and provider availability. UPHP also has a quarterly verification process to verify provider availability within each contracted provider office.
c. Identify any barriers to implementing initiatives: • Provider office staff turnover continues to be a barrier of correct information being relayed to members. The quarterly verification process provides the opportunity for provider offices to keep the form on file for staff when a UPHP member calls to schedule an appointment.
HSAG Assessment: HSAG has determined that **UPHP** addressed the prior year's recommendations. However, since the SFY 2022 survey did not evaluate the same provider types, HSAG could not evaluate whether the initiatives were successful or effective.

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 and optional EQR activities across the ICOs.

Validation of Quality Improvement Projects

For the SFY 2022 validation, the ICOs submitted baseline data for their ICO-specific QIP topic. HSAG's validation evaluated the technical methods of the ICO's QIPs (i.e., the QIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of each ICO's QIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 5-1 provides a comparison of the overall QIP validation statuses and the scores for the QIP Design (Steps 1 through 6) and Implementation (Steps 7 and 8) stages, by ICO.

Table 5-1—Comparison of Validation Statuses and Scores by ICO

Overall QIP Validation Status, by ICO			Design and Implementation Scores		
			Met	Partially Met	Not Met
AET	*Comprehensive Diabetes Care—HbA1c Test: Decreasing the Disparity Between White and African American Members*	*Partially Met*	78%	22%	0%
AMI	*Transitions of Care, Medication Reconciliation Post-Discharge*	*Partially Met*	88%	12%	0%
HAP	*Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members*	*Met*	100%	0%	0%
MER	*Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes*	*Met*	100%	0%	0%

Overall QIP Validation Status, by ICO			Design and Implementation Scores		
			Met	Partially Met	Not Met
MOL	*Addressing Disparities in Controlling Blood Pressure*	*Met*	89%	11%	0%
UPHP	*Annual Dental Care*	*Met*	100%	0%	0%

Performance Measure Validation

The SFY 2022 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 all six ICOs[5-1] 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.

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)*	*REPORTABLE (R)*	*REPORTABLE (R)*
MOL	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*
UPHP	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*	*REPORTABLE (R)*

[5-1] While **Michigan Complete Health** calculated and reported all performance measures for CY 2021, **Michigan Complete Health** merged with **Meridian** effective January 1, 2022. Therefore, results for **Michigan Complete Health** are not included within the SFY 2022 EQR technical report.

Performance Measure Rates

Table 5-3 provides an ICO-to-ICO comparison with the statewide average for HEDIS MY 2021 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 2020 and HEDIS MY 2021 statewide averages. Statewide averages in **bold** font and shaded in orange indicate the HEDIS MY 2021 statewide average demonstrated better performance than the HEDIS MY 2020 statewide average.

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

HEDIS Measure	HEDIS MY 2020 Statewide Average (%)	HEDIS MY 2021						
		Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MOL (%)	UPHP (%)
Prevention and Screening								
BCS—Breast Cancer Screening	56.31	52.74	47.16	46.82	56.87	52.53	54.67	62.90
COL—Colorectal Cancer Screening	56.77	56.03	50.12	49.15	63.04	56.45	60.34	65.94
COA—Care for Older Adults—Advance Care Planning	42.46	41.07	29.93	30.41	55.28	27.74	44.53	78.35
COA—Care for Older Adults—Medication Review	66.63	**74.85**	58.64	85.89	59.21	77.13	77.62	92.46
COA—Care for Older Adults—Functional Status Assessment	53.52	**58.42**	78.10	60.83	63.88	28.47	53.04	84.43
COA—Care for Older Adults—Pain Assessment	67.04	**75.25**	81.75	74.45	75.18	74.21	78.10	92.21
Respiratory Conditions								
SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD	24.27	22.93	21.37	17.24	25.26	22.22	27.60	19.59
PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	71.84	68.65	78.43	55.10	61.62	42.67	71.31	87.80
PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	90.73	89.67	88.73	91.84	88.89	87.33	91.64	91.87
Cardiovascular Conditions								
CBP—Controlling High Blood Pressure	56.89	**60.52**	54.99	60.83	61.31	66.18	57.91	84.91
PBH—Persistence of Beta-Blocker Treatment After a Heart Attack	89.59	**95.25**	100	100	91.67	100	97.06	88.89
SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy	80.63	**82.00**	78.85	84.92	79.40	79.74	81.96	89.86

HEDIS Measure	HEDIS MY 2020 Statewide Average (%)	HEDIS MY 2021						
		Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MOL (%)	UPHP (%)
SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%	80.11	84.22	76.02	85.05	82.28	77.35	95.35	84.21
Diabetes								
CDC—Comprehensive Diabetes Care—HbA1c Testing	84.70	87.50	84.43	87.10	84.18	91.73	89.05	93.67
*CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)**	44.54	43.53	44.77	38.44	50.36	37.23	43.55	25.79
CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)	47.38	49.06	48.42	54.26	44.28	54.26	47.93	65.21
CDC—Comprehensive Diabetes Care—Eye Exam	55.61	57.33	52.80	52.55	60.34	61.07	58.64	69.83
CDC—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	91.69	90.01	88.56	90.51	90.75	89.83	90.51	92.46
CDC—Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	56.67	60.82	52.80	54.50	60.58	66.18	62.29	85.16
SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy	76.52	76.83	74.37	78.52	79.48	80.70	76.56	73.60
SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%	81.68	82.46	75.89	72.17	81.86	80.39	90.83	81.07
Musculoskeletal Conditions								
OMW—Osteoporosis Management in Women Who Had a Fracture	6.97	16.12	5.88	40.00	14.29	0.00	26.09	23.08
Behavioral Health								
AMM—Antidepressant Medication Management—Effective Acute Phase Treatment	70.43	75.06	69.19	79.17	70.54	72.46	84.70	67.62
AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment	55.06	60.75	52.53	59.72	56.25	53.89	75.14	53.33
FUH—Follow-Up After Hospitalization for Mental Illness—7 Days	29.65	26.13	20.95	17.07	16.25	26.32	28.85	39.39
FUH—Follow-Up After Hospitalization for Mental Illness—30 Days	57.00	50.22	47.97	31.71	37.50	42.11	59.13	65.15

HEDIS Measure	HEDIS MY 2020 Statewide Average (%)	HEDIS MY 2021						
		Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MOL (%)	UPHP (%)
FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days	31.68	33.87	43.93	22.22	12.90	47.62	28.89	48.78
FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days	49.24	51.71	58.88	40.74	38.71	65.48	43.56	65.85
Medication Management and Care Coordination								
TRC—Transitions of Care—Notification of Inpatient Admission	11.77	13.11	0.49	2.19	16.55	29.68	6.57	48.66
TRC—Transitions of Care—Receipt of Discharge Information	11.34	12.77	2.19	2.68	14.84	29.93	7.06	42.09
TRC—Transitions of Care—Patient Engagement After Inpatient Discharge	75.36	74.60	74.70	74.70	75.67	84.67	66.67	89.54
TRC—Transitions of Care—Medication Reconciliation Post-Discharge	30.96	43.96	38.69	64.48	39.17	62.29	28.71	79.56
Overuse/Appropriateness								
*PSA—Non-Recommended PSA-Based Screening of Older Men**	21.36	24.68	18.27	18.82	24.60	20.74	31.93	23.10
*DDE—Potentially Harmful Drug-Disease Interactions in Older Adults**	32.83	31.94	34.83	27.68	31.53	30.70	30.17	41.28
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid**	18.05	17.81	17.05	11.54	22.16	18.55	19.63	20.42
*DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis**	5.37	5.50	5.93	4.05	5.03	5.92	4.22	9.77
*DAE—Use of High-Risk Medications in Older Adults—Total**	21.46	21.56	21.39	14.55	25.41	22.53	22.28	26.99
Access/Availability of Care								
AAP—Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	82.27	84.27	81.40	78.63	84.65	84.73	87.86	89.32
AAP—Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	92.90	93.49	92.50	90.58	93.23	93.65	95.36	95.86
AAP—Adults' Access to Preventive/Ambulatory Health Services—65 and Older	89.79	91.45	90.19	87.28	89.48	93.26	93.07	95.76

HEDIS Measure	HEDIS MY 2020 Statewide Average (%)	HEDIS MY 2021						
		Statewide Average (%)	AET (%)	AMI (%)	HAP (%)	MER (%)	MOL (%)	UPHP (%)
AAP—Adults' Access to Preventive/Ambulatory Health Services—Total	89.49	**90.77**	89.13	86.75	89.80	91.62	92.98	94.69
IET—Initiation of Alcohol and Other Drug Dependence Treatment	37.65	**48.59**	34.72	40.41	53.59	81.79	44.19	22.40
IET—Engagement of Alcohol and Other Drug Dependence Treatment	6.59	6.53	6.94	4.11	7.18	11.43	3.95	3.20
Risk-Adjusted Utilization								
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)**	1.20	**1.17**	1.24	1.80	1.02	1.27	0.98	1.10
*PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)**	1.15	1.20	1.40	1.44	1.11	1.31	1.14	0.93

* 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 2020 and HEDIS MY 2021 are comparable, statewide averages in **bold** font and shaded in orange indicate the HEDIS MY 2021 statewide average demonstrated better performance than the HEDIS MY 2020 statewide average.

Compliance Review

Table 5-4 presents the current three-year cycle of reviews (SFY 2022–SFY 2024) and the division of standards reviewed over each year. Table 5-4 also compares the MI Health Link program average compliance score in each of the seven standards with the compliance score achieved by each ICO. A review of Year Two standards will occur during the SFY 2023 compliance review activity, and the results will be included in the SFY 2023 annual EQR technical report.

Table 5-4—Summary of Combined SFY 2022 and SFY 2023 Compliance Review Results

Standard[1]	AET	AMI	HAP	MER	MOL	UPHP	MI Health Link Program
SFY 2022 (Year One)							
Standard I—Disenrollment: Requirements and Limitations[2]	100%	100%	100%	100%	100%	89%	**97%**
Standard II—Member Rights and Member Information	65%	59%	61%	70%	70%	73%	**66%**
Standard III—Emergency and Poststabilization Services[2]	100%	100%	100%	100%	100%	100%	**100%**

Standard[1]	AET	AMI	HAP	MER	MOL	UPHP	MI Health Link Program
Standard IV—Availability of Services	92%	85%	100%	100%	100%	85%	**94%**
Standard V—Assurances of Adequate Capacity and Services	100%	100%	75%	75%	100%	75%	**88%**
Standard VI—Coordination and Continuity of Care	73%	77%	80%	73%	80%	77%	**77%**
Standard VII—Coverage and Authorization of Services	89%	89%	86%	78%	85%	100%	**88%**
SFY 2022 Total Compliance Score	**83%**	**82%**	**83%**	**81%**	**85%**	**86%**	**83%**
SFY 2023 (Year Two)							
Standard VI—Confidentiality	—	—	—	—	—	—	—
Standard VII—Grievance and Appeal Systems	—	—	—	—	—	—	—
Standard VIII—Subcontractual Relationships and Delegation	—	—	—	—	—	—	—
Standard IX—Practice Guidelines	—	—	—	—	—	—	—
Standard X—Health Information Systems	—	—	—	—	—	—	—
Standard XI—Quality Assessment and Performance Improvement Program	—	—	—	—	—	—	—
SFY 2023 Total Compliance Score	—	—	—	—	—	—	—
Combined Compliance Score (SFY 2022 and SFY 2023)	—	—	—	—	—	—	—
SFY 2023 (Year Three)							
HSAG will perform a comprehensive review of the ICOs' implementation of corrective actions taken to remediate any elements that received a *Not Met* score during SFY 2022 and SFY 2023.							

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.

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

[3] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

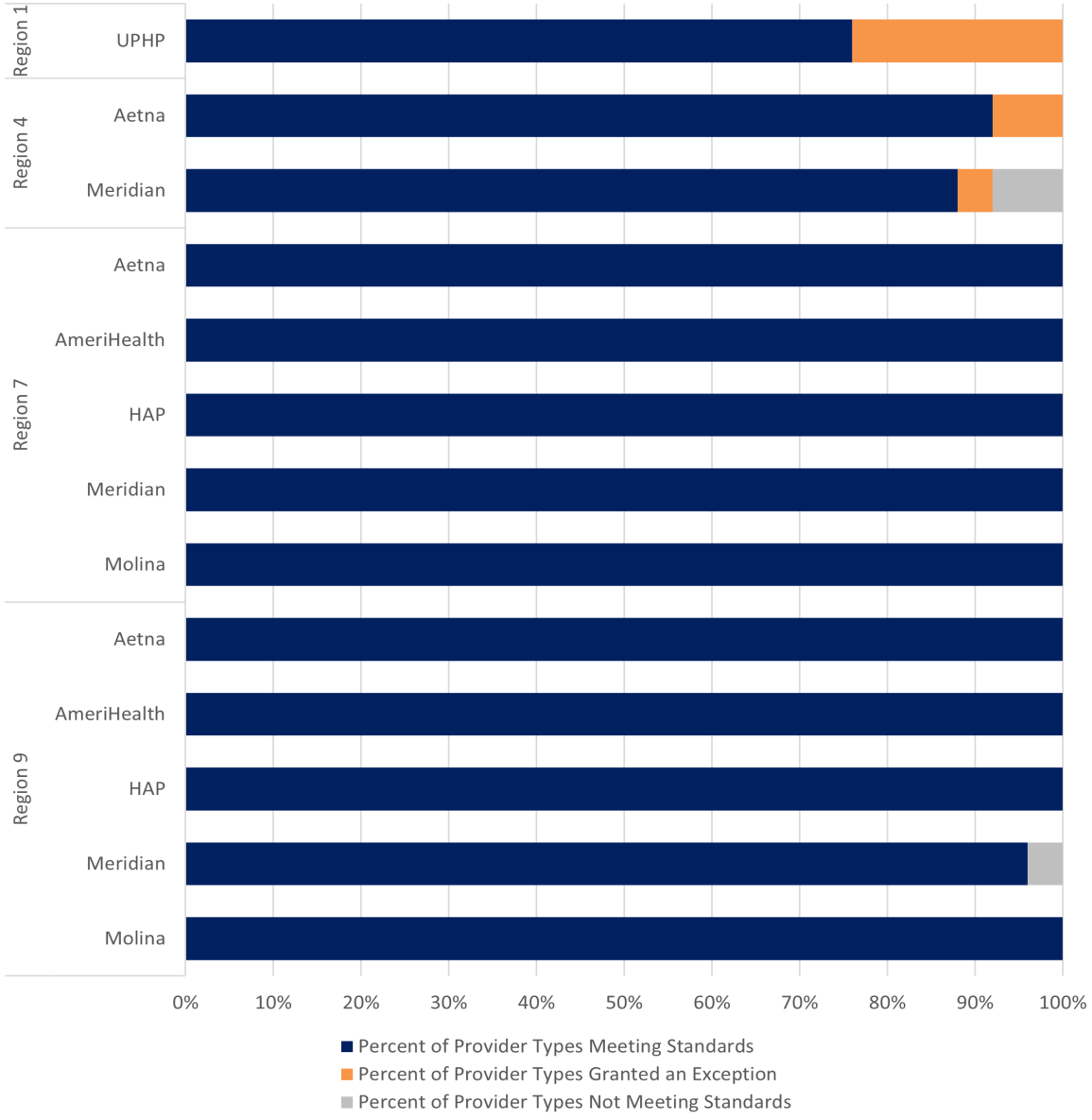
Dash (—): No scores are available. Scores will be determined following the SFY 2023 compliance review activity.

Network Adequacy Validation

Time/Distance and Provide Capacity Analysis

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, received an exception, or did not meet the minimum network requirements) using the most recent data submission and MDHHS' exception determinations.

Figure 5-1—SFY 2022 Final NAV Results by Region and ICO



Secret Shopper Survey

During March and April 2022, HSAG completed a secret shopper telephone survey of dental provider offices contracted with one or more ICOs under the MI Health Link program to collect information on the MI Health Link members' access to preventive dental care visits. Therefore, survey respondents may have given different information for each ICO-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

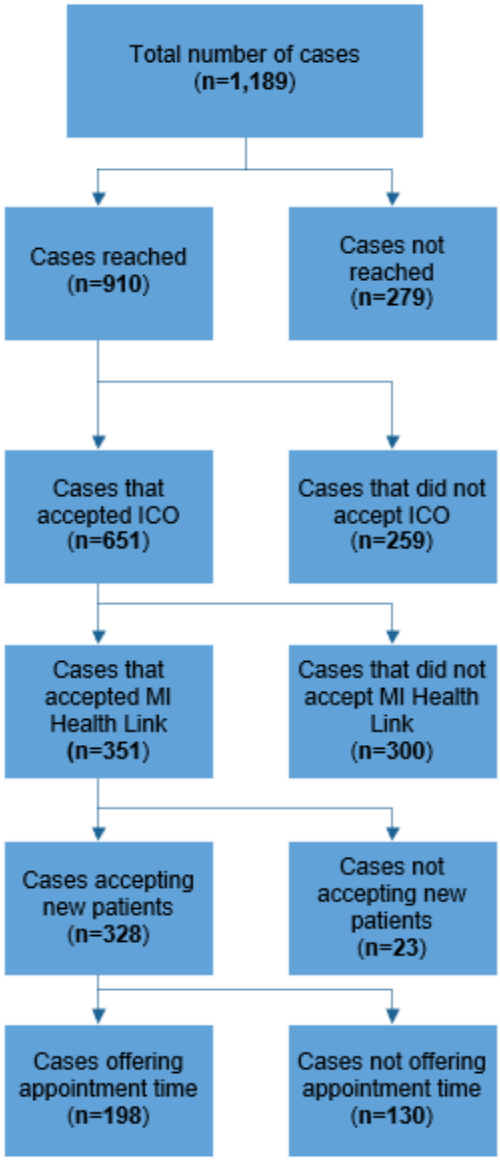


Table 5-5 summarizes the number of survey cases and outcomes by region and ICO.

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

ICO	Total Survey Cases	Cases Accepting ICO	Cases Accepting MI Health Link	Cases Accepting New Patients	Percentage of Cases Offered Appointment[1]	Median Appointment Wait Time (Calendar Days)
Region 1						
UPHP	24	18	11	10	80.0%	61
Region 1 Total	**24**	**18**	**11**	**10**	**80.0%**	**61**
Region 4						
Aetna	85	46	15	11	63.6%	93
Meridian	78	45	30	26	76.9%	66
Region 4 Total	**163**	**91**	**45**	**37**	**73.0%**	**90**
Region 7						
Aetna	161	74	31	28	32.1%	2
AmeriHealth	29	12	8	8	100%	10
HAP	159	77	40	40	47.5%	11
Meridian	162	109	64	61	96.7%	14
Molina	100	58	41	39	48.7%	14
Region 7 Total	**611**	**330**	**184**	**176**	**64.8%**	**11**
Region 9						
Aetna	85	33	14	14	14.3%	11
AmeriHealth	15	11	9	9	77.8%	18
HAP	112	47	22	22	22.7%	27
Meridian	87	60	31	30	90.0%	16
Molina	92	61	35	30	26.7%	44
Region 9 Total	**391**	**212**	**111**	**105**	**46.7%**	**18**
ICO Total[2]	**1,189**	**651**	**351**	**328**	**60.4%**	**18**

[1] The denominator includes cases responding to the survey and indicating that at least one practitioner at the location accepts the requested ICO, MI Health Link, and new patients.

[2] Total survey cases represent unique ICO and phone number/location combinations, as one location may have been sampled for more than one ICO for those providers contracted with multiple ICOs.

Table 5-6 displays the number and percentage of cases in which the survey respondent reported that the provider location offered an appointment date to new MI Health Link patients with the specified ICO for a routine dental visit. Appointments may have been offered with any practitioner at the sampled location.

Table 5-6—New Patient Appointment Wait Time in Calendar Days for Routine Dental Services, by ICO and Region

ICO	Total Survey Cases	Cases Contacted and Accepting New Patients	Cases Offered an Appointment			Appointment Wait Time (Days)			
			Number	Rate Among Cases Accepting New Patients[1] (%)	Rate Among All Surveyed Cases[2] (%)	Min	Max	Average	Median
Region 1									
UPHP	24	10	8	80.0%	33.3%	6	236	99	61
Region 1 Total	**24**	**10**	**8**	**80.0%**	**33.3%**	**6**	**236**	**99**	**61**
Region 4									
Aetna	85	11	7	63.6%	8.2%	4	183	85	93
Meridian	78	26	20	76.9%	25.6%	15	273	95	66
Region 4 Total	**163**	**37**	**27**	**73.0%**	**16.6%**	**4**	**273**	**92**	**90**
Region 7									
Aetna	161	28	9	32.1%	5.6%	0	158	30	2
AmeriHealth	29	8	8	100%	27.6%	4	41	13	10
HAP	159	40	19	47.5%	11.9%	0	88	22	11
Meridian	162	61	59	96.7%	36.4%	0	118	22	14
Molina	100	39	19	48.7%	19.0%	1	71	21	14
Region 7 Total	**611**	**176**	**114**	**64.8%**	**18.7%**	**0**	**158**	**22**	**11**
Region 9									
Aetna	85	14	2	14.3%	2.4%	0	22	11	11
AmeriHealth	15	9	7	77.8%	46.7%	1	112	28	18
HAP	112	22	5	22.7%	4.5%	1	102	39	27
Meridian	87	30	27	90.0%	31.0%	1	209	26	16
Molina	92	30	8	26.7%	8.7%	0	132	46	44
Region 9 Total	**391**	**105**	**49**	**46.7%**	**12.5%**	**0**	**209**	**30**	**18**
ICO Total	**1,189**	**328**	**198**	**60.4%**	**16.7%**	**0**	**273**	**37**	**18**

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

[2] The denominator includes all cases included in the sample.

Among all surveyed cases, the overall appointment rate was 16.7 percent. Appointment availability was reported for 60.4 percent of all cases in which the survey respondent reported that the provider location accepted the ICO, the MI Health Link program, and new patients.

Consumer Assessment of Healthcare Providers and Systems Analysis

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in all six 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 5-7 presents the 2020, 2021, and 2022 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 5-7—Summary of HCBS CAHPS Survey Mean Scores for the MI Health Link Program

	2020 Mean Score	2021 Mean Score	2022 Mean Score
Global Ratings			
Rating of Personal Assistance and Behavioral Health Staff	95.9	96.3	95.3
Rating of Homemaker	95.5*	96.8	91.9*
Rating of Case Manager	96.1	95.6	96.2
Composite Measures			
Reliable and Helpful Staff	90.0	92.4 ▲	88.5
Staff Listen and Communicate Well	92.7	92.6	90.7*
Helpful Case Manager	96.5	94.4	92.5*
Choosing the Services that Matter to You	93.4	92.4	91.1
Transportation to Medical Appointments	87.3	89.2	88.1
Personal Safety and Respect	94.7	96.6	94.6
Planning Your Time and Activities	73.9	73.8	73.5
Recommendation Measures			
Recommend Personal Assistance/Behavioral Health Staff	95.9	96.1	92.7
Recommend Homemaker	90.9*	95.3	89.7*
Recommend Case Manager	92.2	93.8	92.9
Unmet Need Measures			
No Unmet Need in Dressing/Bathing	S	S	S
No Unmet Need in Meal Preparation/Eating	S	S	S

	2020 Mean Score	2021 Mean Score	2022 Mean Score
No Unmet Need in Medication Administration	S	84.2*	S
No Unmet Need in Toileting	100* ▲	100 ▲	93.7*
No Unmet Need with Household Tasks	S	S	S
Physical Safety Measure			
Not Hit or Hurt by Staff	100	100	99.0

* 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 score is statistically significantly higher than the 2022 score.
▼ Indicates the score is statistically significantly lower than the 2022 score.
If no statistically significant differences were found, no indicator (▲ or ▼) is shown.

6. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the ICOs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the MI Health Link program to identify programwide conclusions. The programwide conclusions are not intended to be inclusive of all EQR activity results; rather, only those results that had a substantial impact on a CQS goal. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the Michigan CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members.

Table 6-1—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1—Ensure high quality and high levels of access to care	**Conclusions:** The results of the PMV activity confirmed that MDHHS and the MI Health Link program are making improvement in achieving Goal #1 of the CQS in the following areas: • Preventive and Screening domain: – Three of the four indicator rates for the *COA—Care for Older Adults* measure demonstrated an improvement in performance from the previous year. The indicator rates improved between 4.9 and 8.22 percentage points. • Cardiovascular Conditions domain: – All four indicator rates for the *CBP—Controlling High Blood Pressure*, *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack*, and *SPC—Statin Therapy for Patients With Cardiovascular Disease* measures demonstrated an improvement in performance from the previous year. The indicator rates improved between 1.37 and 5.66 percentage points. • Diabetes domain: – Five of the six indicator rates for the *CDC—Comprehensive Diabetes Care* measure demonstrated an improvement in performance from the prior year. The indicator rates improved between 1.01[6-1] and 4.15 percentage points. – Both indicator rates for the *SPD—Statin Therapy for Patients With Diabetes* measure demonstrated a slight improvement in	☒ Quality ☒ Timeliness ☒ Access

[6-1] The indicator rate for the *CDC—Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)* measure decreased by 1.01 percentage points, which demonstrates better performance.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	performance from the previous year. The indicator rates improved between 0.31 and 0.78 percentage points. • Musculoskeletal domain: – The indicator rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure demonstrated an improvement in performance from the previous year. The indicator rate improved by 9.15 percentage points. • Behavioral Health domain: – Both indicator rates for the *AMM—Antidepressant Medication Management* measure demonstrated an improvement in performance from the previous year. The indicator rates improved between 4.63 and 5.69 percentage points. – Both indicator rates for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness* measure demonstrated an improvement in performance from the previous year. The indicator rates improved between 2.19 and 2.47 percentage points. • Access/Availability of Care domain: – All four indicator rates for the *AAP—Adults' Access to Preventive/Ambulatory Health Services* measure demonstrated an improvement in performance from the previous year. The indicator rates improved between 0.59 and 2 percentage points. – The indicator rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure demonstrated an improvement in performance from the previous year. The indicator rate improved by 10.94 percentage points. Additionally, the network requirements analysis of the NAV activity demonstrated that, overall, the MI Health Link program had a sufficient network of LTSS providers, with most MDHHS-established minimum network requirements being met. However, the results of the analysis also suggest some members may not have reasonable access to some provider types as three ICOs failed to meet all minimum network requirements for provider capacity and time/distance. These provider types included Adult Day Program, Assistive Technology—Van Lifts and Tie Downs, Dental, Hearing Aids, Hearing Examinations, MIHP Agency, and NEMT. While, in most cases, the ICOs contracted with all available providers in their region(s), the lack of available providers may prevent members from accessing care and services. The results of the secret shopper survey also suggested that members may be experiencing barriers in accessing dental services. Overall, a high volume of dental providers reported not accepting an ICO, the MI	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Health Link program, and/or new patients. Many of the ICOs delegate the delivery of dental services to a dental subcontractor, which is likely a contributing factor to why dental providers reported they are not accepting the ICO or the MI Health Link program. Additionally, of the dental providers who reported accepting an ICO, the MI Health Link program, and new patients, only 60.4 percent of callers were offered an appointment. Considering all surveyed providers, only 16.7 percent resulted in an offered appointment. While the average appointment wait time was 37 days, in many instances, the maximum wait time was significantly above MDHHS' appointment time standard of eight weeks for initial dental appointments. These results indicate opportunities to mitigate barriers to ensure dental services are accessible and available. However, MDHHS required all ICOs to implement a CAP to remediate the deficiencies identified through the survey. Further, the PMV activity results also demonstrated continued opportunities to enhance access to quality care as several HEDIS measures declined in performance from the previous year. Within the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, and Access/Availability of Care domains, 10 indicator rates declined in performance from the previous year. The measures with the greatest percentage point decline (i.e., greater than 3 percentage points) included *BCS—Breast Cancer Screening*, *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*, and *FUH—Follow-Up After Hospitalization for Mental Illness*. **Recommendations:** The current secret shopper survey activity reports on the minimum, maximum, average, and median appointment wait times. However, MDHHS' contract with the ICOs has defined appointment wait time standards according to the type of requested services or care (e.g., urgent, routine, specialty). In future secret shopper activities, MDHHS could consider including in the methodology an evaluation of each ICO's compliance in adherence to the corresponding appointment time standard. Additionally, MDHHS required each ICO to develop a CAP to address the findings of the dental provider secret shopper survey activity. As MDHHS has elected to conduct another dental provider secret shopper survey activity in SFY 2023, MDHHS could consider additional penalties if improvement in performance is not realized. Further, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #1.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** MDHHS requires the ICOs to develop person-centered care plans referred to as IICSPs. The IICSP must be developed by the member, the member's ICO care coordinator, and the member's ICT and incorporate the following elements: assessment results; summary of the member's health; the member's preferences for care, supports, and services; the member's prioritized list of concerns, goals and objectives, and strengths; specific services including amount, scope and duration, providers, and benefits; the plan for addressing concerns or goals; the person(s) responsible for specific interventions, monitoring, and reassessment; and the due date for the intervention and reassessment. The ICOs' adherence to IICSP requirements and the person-centered planning process was evaluated through the compliance review activity. However, all ICOs were cited for deficiencies for not developing IICSPs that captured all required components. IICSPs must be developed through the person-centered planning process and include the necessary information to assist the member in achieving personally defined outcomes in the most integrated settings, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.[6-2] Additionally, MDHHS requested that the HCBS CAHPS Survey be conducted, which gathers direct feedback from members receiving HCBS about their experiences and the quality of LTSS they receive. Eleven of the 15 reportable measures had median scores above 90 (using a scale of 0 to 100), with three of those measures above 95, indicating many members reported having positive experiences. The measures with the highest scores included *Rating of Personal Assistance and Behavioral Health Staff*, *Rating of Case Manager*, and *Not Hit or Hurt by Staff*. However, the *Reliable and Helpful Staff* measure experienced a statistically significant decline in the median score compared to the previous year's results. Further, the lowest performing measure was *Planning Your Time and Activities* with a score of 73.5, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.	☒ Quality ☐ Timeliness ☒ Access

[6-2] Centers for Medicare & Medicaid Services. System-Wide Person Centered Planning. Available at: https://www.medicaid.gov/sites/default/files/2019-12/system-wide-person-centered-planning.pdf. Accessed on: Feb 24, 2023.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Recommendations: While HCBS CAHPS Survey scores could be reported for the MI Health Link program, ICO-specific scores were unable to be presented due to the low number of respondents to the survey. MDHHS should continue to work with HSAG to develop innovative approaches to increase the number of members participating in the survey during the 2023 HCBS CAHPS Survey activity. Additionally, while MDHHS requires IICSPs include the member's preferences in social activities, in an effort to increase positive member experiences in *Planning Your Time and Activities*, MDHHS could consider adding more specificity in its contract with the ICOs detailing the information that should be included in the IICSP related to social activities and community inclusion. The person-centered planning process could also include the development of a calendar, when appropriate, that outlines routines, activities of daily living, and social activities chosen by the member to be used as tool for the member and care manager to identify opportunities to increase engagement in meaningful activities of daily living, including social activities. Further, the compliance review activity identified continued opportunities for improvement in the development of IICSPs during the current three-year cycle and the previous three-year cycle of reviews. Given this continued trend, MDHHS could consider developing a standard IICSP template in which all ICOs are required to use. This template could be developed in partnership with the ICOs with the intent to increase adherence to MDHHS' IICSP content requirements. Lastly, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #2.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)	**Conclusions:** MDHHS requires each ICO to employ a care coordination platform supported by web-based technology that manages communication and information flow regarding referrals, care transitions, and care delivery; facilitates timely and thorough coordination and communication among the member, ICO, PIHP, PCP, LTSS supports coordinators, and other providers; provides prior authorization information for services; and houses the Integrated Care Bridge Record (individualized member health record). The care coordination platform also allows ICO care coordinators, supports coordinators, and providers to post key updates and notify ICT members. Each ICO must also have a mechanism to alert ICT members of ED use or inpatient admissions using the electronic care coordination platform or other methods such as telephonic notification.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Effective care coordination and communication among managed care programs, members, and providers should positively impact the health outcomes for all Medicaid populations, including MI Health Link members. Additionally, MDHHS is able to monitor care coordination and communication of care through the PMV and compliance review activities. For example, one performance indicator included as part of the PMV activity measured the number of members for whom a transition record was transmitted timely to a PCP or other sites of care when a member was discharged from an inpatient facility. Another performance indicator measured the number of members who had a medication review conducted by a prescribing practitioner or a clinical pharmacist. All ICOs were compliant with State and federal specifications when reporting data for these measures. Further, transition from an inpatient setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication, and follow-up needs.[6-3] However, the results of the PMV activity confirm several opportunities to improve transition of care processes. While three measure indicator rates, *TRC—Transitions of Care—Notification of Inpatient Admission*, *TRC—Transitions of Care—Receipt of Discharge Information*, and *TRC—Transitions of Care—Medication Reconciliation Post-Discharge*, improved in performance from the previous year, the rates remained relatively low (13.11, 12.77, and 43.96, respectively). Additionally, while the indicator rate for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure declined slightly in performance from the previous year, it had the highest rate (74.60) among the indicator rates for the *TRC—Transitions of Care* measure. Lastly, through the compliance review, MDHHS is able to monitor whether the ICOs have processes to ensure care coordinators have access to and are informed of all ABDs to service authorization requests. However, four ICOs did not have mechanisms in place to ensure care coordinators received communication of ABDs rendered by a delegate. Communication of timely service authorization denials is necessary for care coordinators to effectively coordinate care and ensure a member's service needs are being met.	

[6-3] National Committee for Quality Assurance. Transitions of Care (TRC). Available at: https://www.ncqa.org/hedis/measures/transitions-of-care/. Accessed on: Feb 24, 2023.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Recommendations: Currently, ICOs contract with PIHPs to deliver Medicare behavioral health services; however, Medicaid-covered behavioral health services are carved out of the ICO benefit package and instead are delivered by the PIHPs through contracts directly with MDHHS. As such, the service delivery of the MI Health Link program is not fully integrated, and ICOs may not be fully aware of their members' service utilization. MDHHS could consider possible options to fully integrate all behavioral health services under the ICO benefit package or develop standardized mechanisms to ensure Medicaid behavioral health service utilization is communicated to the ICOs to assist in coordinating care and services for members. Additionally, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #3.	
Goal 4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** For SFY 2022, the ICOs were responsible for initiating a new QIP to address healthcare disparities within their population. While MDHHS did not mandate a statewide topic, the ICOs were instructed to identify existing racial or ethnic disparities within the regions and populations served and determine plan-specific topics and performance indicators. Four of the six ICOs received an overall validation of *Met*, indicating those ICOs designed methodologically sound QIPs. The remaining two ICOs had opportunities for improvement related to their sampling method and/or conducting accurate statistical testing for comparison between the two population subgroups. Through the QIP activity, the ICOs' implemented interventions are aimed at eliminating those racial and ethnic disparities. Additionally, MDHHS requires each ICO's quality program to include a process for identifying and addressing health disparities in access to healthcare and health outcomes experienced by different member populations. Each ICO's QIP and other activities or initiatives targeting populations experiencing health disparities should be reported through the annual quality program evaluation. The ICOs' quality programs will be reviewed during the future SFY 2023 compliance review activity. Further, MDHHS has partnered with MPHI to develop an annual Expanding Equity in MI Health Link report. The ICOs submitted performance data on a select list of measures and the aggregated statewide rates are presented for all racial/ethnic populations enrolled in the MI Health Link program. The goal of the project is to continue to improve quality in the MI Health Link program while decreasing overall disparities that may be present.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Recommendations: MDHHS has required QIPs to support the reduction in racial and ethnic disparities. As the QIPs progress and the ICOs identify or change interventions, MDHHS should continue to review the planned interventions to confirm that these interventions specifically target the disparate populations and have the likelihood of removing the barriers that prevent members' access to needed services. Additionally, MDHHS could consider how EQR activity results could be stratified by race/ethnicity. For example, stratifying the results of the NAV activity to determine if members with different races/ethnicities have equal access to Medicaid providers. Further, MDHHS should continue to leverage the information gleaned from the annual Expanding Equity in MI Health Link report to implement statewide initiatives focused on national and Michigan-specific priorities. Lastly, HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #4.	
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** MDHHS has implemented a quality withhold policy in which CMS and MDHHS withhold a percentage of their respective components of the capitations payment. The withheld amounts are then repaid subject to each ICO's performance consistent with the established quality thresholds. MDHHS' contract with the ICOs identify the quality withhold measures for each year of the demonstration and include a combination of CMS/state-defined measures, HEDIS, CAHPS, and CMS data. In SFY 2022, which relied on MY 2021 data, all ICOs received a portion of their withheld funds. **Aetna**, **HAP**, **Molina**, and **UPHP** received 75 percent of withheld funds, while **AmeriHealth** and **Meridian** received 50 percent. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics MDHHS will use to evaluate progress toward achieving Goal #5, which may include the quality withhold measures and benchmarks.	☒ Quality ☐ Timeliness ☐ Access

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 involve:

- 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, an ICO'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 the ICO executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably 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 2022 validation, the ICOs submitted baseline data for their plan-specific QIP topics. HSAG conducted validation of the QIP Design (Steps 1 through 6) and Implementation (Steps 7 and 8) stages of the selected QIP topic for each ICO. The QIP topics chosen by the ICOs addressed CMS' requirements related to quality outcomes—specifically, quality and access to care and services. MDHHS requested that the ICOs implement QIPs that focus on eliminating disparities within their populations, when applicable.

Technical Methods of Data Collection and Analysis

In its QIP evaluation and validation, HSAG used the CMS EQR Protocol 1. Using this protocol, HSAG, in collaboration with MDHHS, developed the QIP Submission Form, which each ICO completed and submitted to HSAG for review and evaluation. The QIP Submission Form standardized the process for submitting information regarding QIPs and ensured all CMS EQR Protocol 1 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 1. The HSAG QIP review team consisted of, at a minimum, an analyst with expertise in statistics and QIP design and a clinician with expertise in QI processes. The CMS EQR Protocol 1 identifies nine steps that should be validated for each QIP. For the SFY 2022 submissions, the ICOs reported baseline data and were validated for Steps 1 through 8 in the QIP Validation Tool.

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

1. Review the Selected QIP Topic
2. Review the QIP Aim Statement
3. Review the Identified QIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of QIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

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 2022, the ICOs submitted baseline data for their QIP topic. The performance indicator measurement period dates for the QIP are listed in Table A-1.

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

ICO	Data Obtained	Measurement Period	Period to Which the Data Applied
AET	Hybrid	Baseline	SFY 2022 (CY 2021)
AMI	Hybrid		
HAP	Hybrid		
MER	Administrative		
MOL	Administrative		
UPHP	Administrative		

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG validated the QIPs to ensure they used a sound methodology in their design and QIP implementation. 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., performance indicator results compared to baseline and QIP goals) and qualitative results (e.g., technical design of the QIP) 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 2021 (i.e., January 1, 2021, through December 31, 2021), along with the performance measure number. The performance measures are numbered as they appear in the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements*[A-2] and the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements: Michigan-Specific Reporting Requirements*[A-3] technical specification manuals.

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*

Technical Methods of Data Collection and Analysis

HSAG developed the PMV protocol for ICOs in accordance with the CMS EQR Protocols. The CMS MMP Core Reporting Requirements (issued November 2, 2020, and effective as of January 1, 2021) and Michigan-Specific Reporting Requirements (issued February 28, 2022) 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 IS; 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

[A-2] 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: Mar 2, 2023.

[A-3] 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/mireportingrequirements02282022.pdf-0. Accessed on: Mar 2, 2023.

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 the 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 2021 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 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 IS, 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)*, or *Not Applicable (NA)* 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.

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, 2021–March 31, 2021 Quarter 2: April 1, 2021–June 30, 2021 Quarter 3: July 1, 2021–September 30, 2021 Quarter 4: October 1, 2021–December 31, 2021
Core Measure 9.3	CY 2021
MI2.6	CY 2021
MI5.6	CY 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 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-4] for 2021, as provided by MDHHS, for the SFY 2022 EQR.

Technical Methods of Data Collection and Analysis

MDHHS and CMS required each ICO to contract with an organization licensed by NCQA to conduct HEDIS Compliance Audits and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS MY 2021 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 2021 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*

[A-4] HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Rate, or *Un-Audited*. HSAG further analyzed the results of the ICO's HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to HEDIS MY 2020 performance levels and MY 2021 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 post-stabilization 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 six ICOs contracted with MDHHS to deliver services to MI Health Link members.

The SFY 2022 compliance review commenced a new three-year cycle of compliance reviews. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable State contract requirements. The compliance reviews for the MI Health Link program consist of 14 standards. MDHHS requested that HSAG conduct a review of the first seven standards in Year One (SFY 2022). The remaining seven standards will be reviewed in Year Two (SFY 2023). Table A-5 outlines the division of standards reviewed in Year One and Year Two.

Table A-5—Current Three-Year Cycle (SFY 2022–SFY 2024)

Standard	Associated Federal Citations[1]	Year One (SFY 2022)	Year Two (SFY 2023)	Year Three (SFY 2024)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of ICOs' implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		

Standard	Associated Federal Citations[1]	Year One (SFY 2022)	Year Two (SFY 2023)	Year Three (SFY 2024)
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal systems standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).
[2] The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the Three-Way Contract agreement among CMS, the State of Michigan, and the ICOs as they related to the scope of the review. The review processes used by HSAG to evaluate the ICOs' compliance were consistent with the CMS EQR Protocol 3.

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

Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the ICO a detailed timeline, description of the compliance review process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the ICO.
- Hosted a pre-site review preparation session with all ICOs.
- Generated a sample of cases for care management and service authorization denials for case file reviews.
- Conducted a desk review of supporting documentation the ICO submitted to HSAG.
- Followed up with the ICO, as needed, based on the results of HSAG's preliminary desk review.

- Developed an agenda for the site review interview sessions and provided the agenda to the ICO to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed ICO key program staff members.
- Conducted a review of care management and service authorization denial records.
- Conducted an IS review of the data systems that the ICO used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the ICO.
- Documented findings and assigned each element a score (*Met*, *Not Met*, or *NA* as described in the below Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an ICO-specific report and CAP template for the ICO to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the ICO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an ICO during the period covered by HSAG's review. This scoring methodology, displayed in Table A-6, is consistent with the CMS EQR Protocol 3.

Table A-6—Scoring Methodology

Compliance Score	Point Value	Definition
Met	Value = 1 point	• *Met* indicates "full compliance" defined as *all* of the following: • All documentation listed under a regulatory provision, or component thereof, is present. • Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation. • Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.
Not Met	Value = 0 points	• *Not Met* indicates "noncompliance" defined as *one or more* of the following:

Compliance Score	Point Value	Definition
		• There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews. • Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice. • Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement. • No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The requirement does not apply to the ICO line of business during the review period.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements not applicable to the ICO were scored *N A* and were not included in the denominator of the total score.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

For the member handbook, provider directory, member rights, and appointment standards, HSAG developed checklists to support compliance with the associated regulatory provisions. Findings from the checklist reviews were documented within the corresponding standard and element in the compliance review tool.

HSAG conducted file reviews of the ICO's records for care management and service authorization denials to verify that the ICO had put into practice what the ICO had documented in its policies. HSAG selected 10 records each for care management and service authorization denials from the full universe of records provided by the ICO. The file reviews were not intended to be a statistically significant representation of all the ICO's files. Rather, the file reviews highlighted instances in which practices

described in policy were not followed by ICO staff members. Based on the results of the file reviews, the ICO must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the ICO provided to members, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the ICO's progress in achieving compliance with State and federal requirements.
- Scores assigned to the ICO's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Corrective Action Plan Process:

HSAG created a CAP template that contained the findings and required actions for each element scored *Not Met*. When submitting its CAP to MDHHS and HSAG, the ICOs must use this template to propose its plan to bring all elements scored as *Not Met* into compliance with the applicable standard(s). The CAP process included the following activities:

- ICOs completed the CAP template describing the action plans to be implemented to remediate each deficient element.
- HSAG and MDHHS reviewed the ICOs' action plans for each deficient element and assigned each element a designation of *Accepted*, *Accepted With Recommendations*, or *Not Accepted*.
- For any deficient element that received a designation of *Not Accepted*, the ICOs were required to revise the CAP until HSAG and MDHHS determined the action plan is sufficient to ensure compliance with the requirements of the element.
- ICOs were required to submit periodic progress updates to report the status of each action plan to HSAG and MDHHS.

Description of Data Obtained and Related Time Period

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for care management and service authorization denials.
- Online member handbook and provider directory.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the ICO's key staff members. Table A-7 lists the major data sources HSAG used to determine the ICO's performance in complying with requirements and the time period to which the data applied.

Table A-7—Description of ICO Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	October 1, 2021–January 23, 2022
Information obtained through interviews	April 8, 2022
Information obtained from a review of a sample of service authorization denial records	Listing of all denials (excluding concurrent reviews) between October 1, 2021–January 23, 2022
Information obtained from a review of a sample of care management records	January 1, 2021–February 28, 2022

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 achieved 100 percent compliance.[A-5]
- Weakness—Any program area that received more than three *Not Met* elements.

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

Time/Distance and Provider Capacity Analysis

Activity Objectives

HSAG's SFY 2022 NAV validated the ICOs' Medicaid and LTSS networks, which included providers under contract and members currently in the program as of August 1, 2022, using time/distance and provider capacity analyses for the 25 Medicaid and LTSS provider types listed below. HSAG used the MI Health Link member data supplied by each ICO when calculating time/distance results. Member data were limited to only those individuals residing in a county covered by the ICO's MI Health Link region. To assess the network requirement of a minimum of 90 percent of members within 30 miles or 30 minutes of a given provider type, HSAG calculated travel times and distances from residential addresses for each ICO's region-specific members to the service addresses for the ICO's network data for each of the following provider types:

- Adult Day Program
- Dental (preventive and restorative)
- Eye Examinations

[A-5] For Standard I—Disenrollment: Requirements and Limitations and Standard III—Emergency and Poststabilization Services, there were noted opportunities for all ICOs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the ICOs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR, and the ICOs' progress in implementing HSAG's recommendations in this program area will be further assessed for continued compliance in future reviews.

- Eye Wear (providers dispensing eyeglasses and contact lenses)
- Hearing Aids
- Hearing Examinations
- MIHP Agency

HSAG considered an ICO's region to have a network deficiency for these provider types when fewer than 90 percent of the members residing in the region were within 30 miles of driving distance or 30 minutes from the nearest two providers.

For the below provider types with no time/distance requirements but where the providers still need to be within a reasonable traveling distance from members, HSAG identified providers outside of the 30-mile distance from the region borders or provider records listing PO boxes in lieu of physical addresses for MDHHS' information and applied exclusions on a case-by-case basis according to MDHHS' discretion. HSAG proceeded with the NAV analyses and assessed the ICOs' network adequacy in each region according to the established minimum network capacity standards (at least two providers located in each region for each ICO).

- Chore Services
- Environmental Modifications
- ECLS
- NEMT
- Non-Medical Transportation (waiver services only)
- Personal Care Services
- Preventive Nursing Services
- Private Duty Nursing
- Respite
- Skilled Nursing Home

For each of the following provider types, services can be rendered from any location or can be delivered to the member from any location. Therefore, while ICOs are required to have at least two providers contracted to deliver services to MI Health Link members in each region, the contracted providers are not required to have a physical address within the region or within the 30-mile minimum travel distance from the region borders. HSAG proceeded with the NAV analyses, regardless of provider location, and assessed the ICOs' network adequacy in each region according to the established minimum network adequacy capacity standards (at least two providers contracted to serve members in each region for each ICO).

- Adaptive Medical Equipment and Supplies
- Assistive Technology—Devices
- Assistive Technology—Van Lifts and Tie Downs

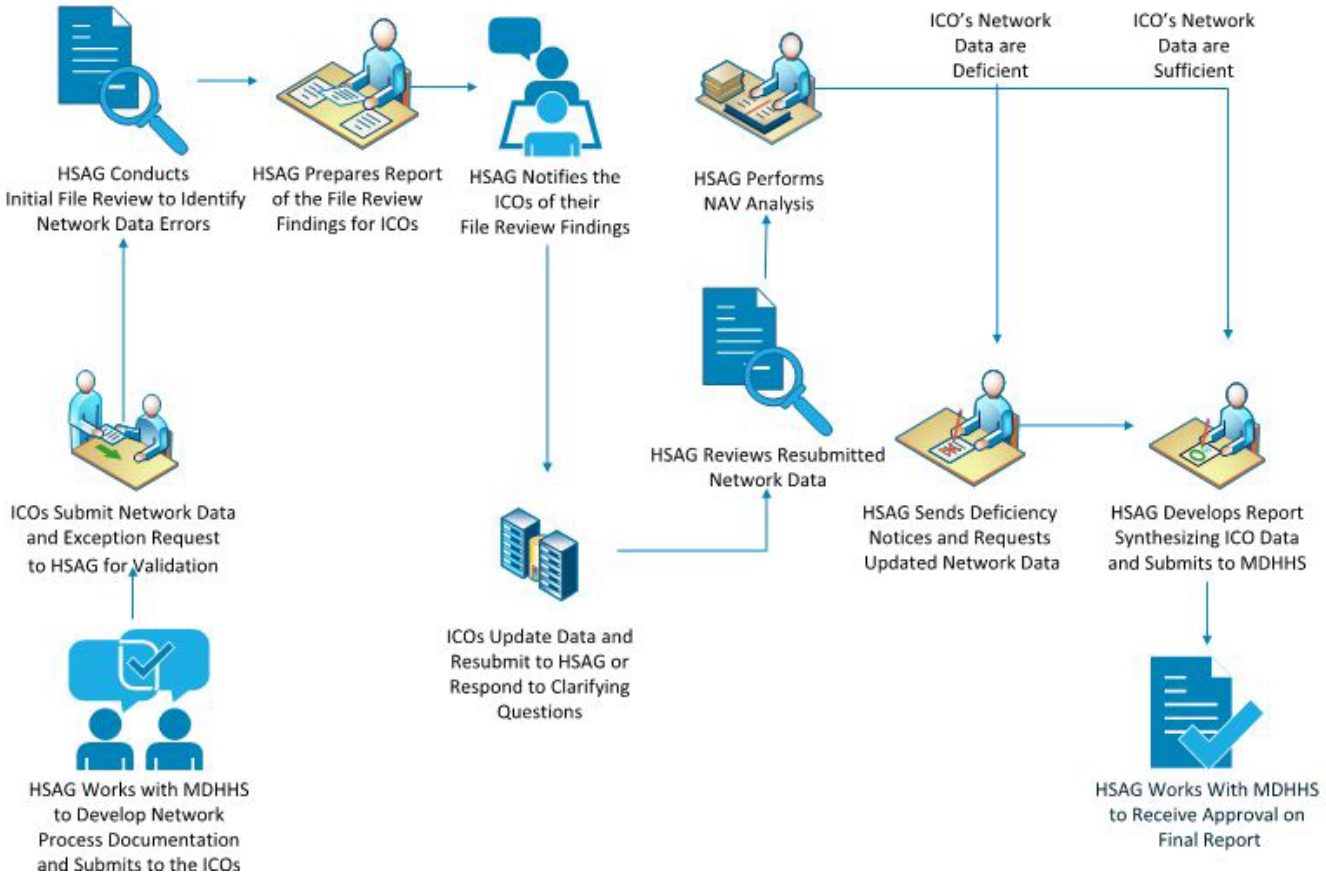
- Community Transition Services
- Fiscal Intermediary
- Home Delivered Meals
- Medical Supplies
- Personal Emergency Response System

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 2022 NAV process.

Figure A-1—SFY 2022 NAV Process



To initiate the NAV activity, each ICO submitted member and network provider data files and exception requests to HSAG in September 2022, followed by an initial data file review. Following the initial data file review, HSAG requested that applicable ICOs submit updated data files and/or exception[A-6] requests during October 2022 to address potential data quality and validity concerns prior to completing the NAV analyses. Based on the NAV findings, MDHHS requested an additional data resubmission of the network data files and exception requests from both **Aetna** and **Meridian** in December 2022.

After final 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/distance requirements), HSAG considered an ICO's region to have a network deficiency for these provider types when fewer than 90 percent of the members residing in the region were within 30 miles of driving distance or 30 minutes from the nearest two providers.[A-7]
- For the 10 provider types with no time/distance requirements but still needed to be within a reasonable traveling distance from members, HSAG identified providers outside of the 30-mile distance from the region borders or provider records listing PO boxes in lieu of physical addresses for MDHHS' information and applied exclusions on a case-by-case basis according to MDHHS' discretion. HSAG proceeded with the NAV analyses and assessed the ICOs' network adequacy in each region according to the established minimum network capacity standards (at least two providers located in each region for each ICO).
- For the eight provider types where services can be rendered from any location or can be delivered to the member from any location, the ICOs were required to have at least two providers contracted to deliver services to MI Health Link members in each region. Therefore, it was not required that the contracted providers have a physical address within the region or within the 30-mile minimum travel distance from the region borders. HSAG proceeded with the NAV analysis, regardless of provider location, and assessed the ICO's network adequacy in each region according to the established minimum network capacity standards (at least two providers located in each region for each ICO).

Upon receipt of the ICOs' Excel template files, HSAG reviewed the data to ensure that all worksheets were populated as requested. HSAG collaborated with MDHHS to identify the data validation checks that HSAG would apply to assess the ICOs' fidelity to the data submission instructions and identify potential data anomalies (e.g., invalid NPI or provider taxonomy code values).

[A-6] MDHHS allowed the ICOs to request exceptions to the minimum network requirements for any provider types for which there are known network access gaps. 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.

[A-7] If a region did not contain an adequate number of providers to meet the travel time/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/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.

Following these data validation checks, HSAG communicated via email with each ICO to address any questions regarding the data file that may have affected the NAV calculations (e.g., use of an incorrect data template, missing provider types, or unexpected data values) and to request a resubmission of data to meet the needs of the NAV activity, if needed.

MDHHS Follow-Up Process—To address any network adequacy-related concerns, MDHHS requested the ICOs provide information to ensure the ICOs maintained accountability and were addressing any areas of the network with noted gaps. MDHHS specifically required the ICOs to provide follow-up on any provider type for which the ICO was found to be noncompliant with minimum provider network requirements or for which the ICO received an exception during the NAV activity. The ICOs had to provide responses to the following questions for noncompliant providers:

- What is your ICO doing to close this provider type network gap?
- When does your ICO anticipate the gap to be closed?
- What is your ICO doing to ensure members are able to easily and timely access these services before the coverage gap is closed?

The ICOs had to provide responses to the following questions for providers with exceptions:

- What does your ICO do to increase the number of contracted providers?
- How does your ICO ensure you are contracted with all available providers?
- What does your ICO do to ensure there are no gaps in access to care/access to services for this provider type?
- How does your ICO assist members in timely access to care/services for this provider type?
- How does your ICO track any issues members might experience trying to access these services?
- How does your ICO address these issues?

Description of Data Obtained and Related Time Period

During September 2022, the ICOs supplied HSAG and MDHHS with the following data:

- Member data reflecting all members assigned to the ICO as of August 1, 2022.
- 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 August 1, 2022, through at least September 1, 2022.

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 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 2022 secret shopper survey was to collect appointment availability information for preventive dental 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 dental care. Specific survey objectives included the following:

- Determine whether dental service locations accept patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligns with the ICOs' provider data.
- Determine whether dental service locations accepting MI Health Link for the requested ICO accept new patients and the degree to which new patient acceptance aligns with the ICOs' provider data.
- Determine appointment availability with the sampled dental service locations for preventive dental care.

Technical Methods of Data Collection and Analysis

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

Each ICO submitted dental provider data to HSAG, reflecting individual practitioners[A-8] actively enrolled with the ICO to serve members in the MI Health Link program as of January 15, 2022. Out-of-state dental practitioners located in Indiana, Ohio, or Wisconsin were included in the study if they were adjacent to the demonstration region and located within a reasonable distance. Dental practitioners specializing in endodontics, orthodontics, periodontics, or prosthodontics were excluded from the study. HSAG randomly selected survey cases by ICO from a de-duplicated list of unique provider locations.[A-9]

[A-8] HSAG identified dental practitioners from the ICOs' data based on provider type, specialty, and taxonomy code. Provider types and specialties indicating that the provider was a general dentist, pediatric dentist, or hygienist were included unless the corresponding taxonomy code was that of a student or dental specialist.

[A-9] In order to minimize the number of repeat phone calls to providers, HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple regions or addresses within a plan, HSAG randomly assigned the number to a single region and standardized address. Phone numbers could still be associated with more than one plan, but sampled phone numbers could only be called once per plan.

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 eight weeks following HSAG's 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. ICOs may contract the provision of dental services for its MI Health Link members with a dental benefits administrator (DBA), a vendor that maintains the dental provider network, processes payments, and provides member support. The ICOs are responsible for the oversight of vendors such as DBAs. Actions by an ICO's DBA may impact the timeliness and quality of dental provider data, and the ICOs' adherence to MDHHS' network standards. HSAG continued the survey if the location confirmed acceptance of the ICO or DBA.
3. Time to the first available appointment is based on appointments requested with the sampled provider location. Cases were counted as being unable to offer an appointment if the case offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which MI Health Link members are willing to travel to an alternate location.
4. Survey findings were compiled from self-reported responses supplied to HSAG's callers by the providers' office personnel. Therefore, survey responses may vary from information obtained at other times or using other data sources (e.g., the ICO's online provider directory, MDHHS' encounter data files).
5. To maintain the secret nature of the survey, callers posed as members who were not existing patients at the sampled provider locations. As such, survey results may not represent appointment timeliness among members who are existing patients with these provider locations.

MDHHS CAP Requirements—Based on the survey's findings, the ICOs were required to develop and implement remediations for all identified deficiencies that included cases in which HSAG was unable to reach the provider, no appointment date was offered, or the offered appointment's wait time exceeded the timely access to care standards. At a minimum, the remediation plan was expected to include the following:

- The ICOs were required to address provider data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers, incorrect address, listing non-medical facility or medical facility that does not provide dental services).
- Based on the comparison of SFY 2020 and SFY 2022 results, the ICOs were required to evaluate the effectiveness of the SFY 2020 remediations and make appropriate modifications to interventions in 2022. The interventions should have been based on an evaluation of potential root causes for each type of indicated deficiency.
- The ICOs were required to provide MDHHS with evidence of training offered to dental providers' offices regarding the ICO plan names, MI Health Link program, and benefit coverage. Evidence should have demonstrated that all office staff member responsible for scheduling appointments were

educated on the ICO names and benefit coverage and the offices had a plan in place for educating new staff in the event of staff turnover.

- Some offices indicated the requested ICO only provided the callers' medical benefits and was not the insurance used for dental benefits. These offices informed the caller that they would need coverage through the ICOs' DBA to be seen at the location. The ICOs had to address how members would know who the ICO's DBA was?
- In some cases, in which HSAG was able to reach the provider and an appointment was offered, the ICOs were required to evaluate the appointment wait time to assure timely access to services.
- The ICOs were required to investigate how dental offices used the limitation "schedule/calendar not available" as this may have indicated extended wait times which might be noncompliant with the appointment and timely access to care standards.

The CAP implementation and reporting consisted of two steps:

1. The Remediation Report was due by October 6, 2022. In this step, the ICOs were required to complete the Root Cause & Remediation and Responsible Party sections of the Analytic Dataset + CAP Template Tab. The Root Cause & Remediation column was required to include an analysis of potential root causes for the deficiencies and gaps identified within the template, and the description of the steps the ICOs planned to take to address the deficiencies and gaps. The Responsible Party section was to include the name, title, and organization of the individual responsible for the implementation of the described remediations. If the responsible individual was a staff member at an ICO's dental vendor, the ICO had to include the name and title of the ICO staff member responsible for the oversight.
2. The Completion and Evidence Report was due by December 8, 2022. In this step, the ICOs were required to complete the Date Completed and Evidence sections of the Analytic Dataset + CAP Template Tab. The ICOs were required to provide the evidence of remediations being completed.

The ICOs were also expected to extend all training and oversight activities implemented for the purpose of the CAP to dental providers not included in the survey's sample. The ICOs were required to provide evidence of including all MI Health Link dental provider networks in the CAP remediation activities.

Description of Data Obtained and Related Time Period

HSAG completed the survey calls during March and April 2022. 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 dental 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 dental 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 dental service locations for preventive dental visits.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

The goal of the HCBS CAHPS Survey is to gather direct feedback from MI Health Link 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 computer-assisted telephone interviewing (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 March 31, 2022, and were continuously enrolled in a plan during the three-month measurement period (January 1, 2022, to March 31, 2022), 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 2022.

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 and 2021 to review and evaluate any statistically significant differences. A higher mean score indicates a positive response (e.g., no unmet need), and a lower mean score indicates a negative response.