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State Fiscal Year 2021 External Quality Review Technical Report for the MI Choice Waiver Program

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality, timeliness, and accessibility of 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.

MI Choice is a Section 1915(c) waiver used to deliver home- and community-based services (HCBS) to elderly and disabled individuals meeting Michigan's nursing facility level of care (NFLOC) who, but for the provision of such services, would require services provided in a nursing facility. The goal of the waiver is to provide HCBS and supports to members using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life. The waiver is administered by the Bureau of Aging and Community Living Supports[1-1] within MDHHS. MDHHS exercises administrative discretion in the administration and supervision of the waiver, as well as all related policies, rules, and regulations. The MI Choice Waiver Program is a Medicaid managed care program, and its members receive services from entities classified as prepaid ambulatory health plans (PAHPs), otherwise referred to as "waiver agencies." MDHHS contracts with waiver agencies to carry out its waiver obligations, and each waiver agency must sign a provider agreement with MDHHS assuring that it meets all program requirements. The waiver agencies contracted with MDHHS during state fiscal year (SFY) 2021 are displayed in Table 1-1.

Table 1-1—PAHP Waiver Agencies in Michigan

Waiver Agency Name
A&D Home Health Care
Agency on Aging of Northwest Michigan
Area Agency on Aging 1B
Area Agency on Aging of Western Michigan
Detroit Area Agency on Aging
Milestone Senior Services

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

Waiver Agency Name
MORC Home Care
Northern Healthcare Management
Region 2 Area Agency on Aging
Region 3B Area Agency on Aging
Region IV Area Agency on Aging
Region VII Area Agency on Aging
Region 9 Area Agency on Aging
Reliance Community Care Partners
Senior Resources
The Information Center
The Senior Alliance
Tri-County Office on Aging
UPCAP Care Management, Inc.
Valley Area Agency on Aging

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (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 Medicaid members. For the SFY 2021 assessment, HSAG used findings from the mandatory 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 waiver agency. Detailed information about each activity's methodology is provided in Appendix A.

[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: Sept 9, 2022.

Table 1-2—EQR Activities

Activity	Description	EQR Protocol
Validation of Performance Improvement Projects (PIPs)*	This activity verifies whether a PIP conducted by a waiver agency used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)*	This activity assesses whether the performance measures calculated by a waiver agency 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 a waiver agency complies 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
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Analysis*,[1-3]	This activity assesses member experience with a waiver agency and its providers and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

* The EQR activity was performed by MDHHS or its contracted vendor. MDHHS provided HSAG with the results of the EQR activity to include in the annual EQR.

MI Choice Waiver Program Findings and Conclusions

HSAG used MDHHS' and its contracted entities' analyses and evaluations of EQR activity findings from the SFY 2021 activities to comprehensively assess the waiver agencies' performance in providing quality, timely, and accessible healthcare services to MDHHS' waiver members. For each waiver agency reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the waiver agency's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all waiver agencies were also compared, as appropriate, and analyzed to develop overarching conclusions and recommendations for MDHHS and the MI Choice Waiver Program. Table 1-3 highlights substantive findings and actionable state-specific recommendations for MDHHS to further promote its goals and objectives in the 2020–2023 MDHHS Comprehensive Quality Strategy (MDHHS CQS). Refer to Section 6 of this report for more details.

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

Table 1-3—MI Choice Waiver Program Substantive Findings

Program Strengths
• The overarching aggregated findings from the PIP, PMV, compliance review, and CAHPS analysis activities demonstrate that MDHHS focused its quality improvement efforts on care management processes and person-centered planning to support waiver members' access to services in accordance with their individualized health needs. Through CAHPS, the waiver agencies are also assessing members' satisfaction with their healthcare and, specifically, with the quality of services being provided to them by waiver agency staff members and providers. Additionally, MDHHS and its contracted waiver agencies are focusing strategies on quality of care by implementing quality improvement initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes. Further, MDHHS mandates immediate corrective action when issues are identified that may impact a member's ability to maintain optimal function, make informed choices, preserve independence and community integration, and/or create barriers to quality care or access to timely and necessary services.
Program Weaknesses
• Although the MI Choice Waiver Program focuses on person-centered planning and members' individual needs, waiver members may not be engaging with family and friends or participating in activities within their communities as often as they would like, as the CAHPS domain, *Planning Your Time and Activities*, received the lowest score statewide. Spending time with family and friends and interacting within the communities in which they live can help promote enhanced quality of life for waiver members, including both their physical and mental health. Of note, the CAHPS survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the coronavirus disease 2019 (COVID-19) pandemic, which may have negatively impacted this domain. However, the waiver program should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic. • HSAG's assessment of the waiver agencies' quality management plans (QMPs) and annual activities and outcomes reports, the MI Choice performance measure report, and the compliance review results and succeeding corrective action plans (CAPs) indicated the MI Choice Waiver Program has opportunities to enhance its EQR-related processes for overseeing and managing its contracted waiver agencies and subsequently assisting them to improve their performance with respect to quality, timeliness, and access to care, which should support an improvement in the MI Choice Waiver Program's overall performance in these performance domains. Additionally, although the quality and accessibility of waiver services were being evaluated through the MI Choice Waiver Program activities, there appeared to be minimal mechanisms used to evaluate for the timeliness of waiver services. • HSAG's assessment identified that the weaknesses within the MI Choice Waiver Program were primarily related to the gaps in MDHHS' processes for conducting EQR-related activities, as there were noted discrepancies within the data reviewed or the data were not available as expected. The discrepant and incomplete data created challenges in evaluating each waiver agency's performance in the domains of quality, timeliness, and access to care as it relates to member outcomes.
Program Recommendations
Associated Quality Strategy Goal and/or Objective
In consideration of the goals of the MDHHS CQS and the assessment of all activities related to quality, timely, and accessible care and services, HSAG recommends the following quality improvement initiatives, which focus on the EQR-related processes designed to provide a sound understanding of the strengths and weaknesses of the waiver agencies' performance related to the quality, timeliness, and accessibility of care, and primarily target

Program Recommendations
goals 1, 2, 3, and/or 4 and the associated objectives within the MDHHS CQS to support improvement within the MI Choice Waiver Program in the areas identified through the EQR. • **Goal 1**: Ensure high quality and high levels of access to care. • **Goal 2**: Strengthen person and family-centered approaches. • **Goal 3**: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external). • **Goal 4**: Reduce racial and ethnic disparities in healthcare and health outcomes.
HSAG Recommendations
• Implementation of EQR-related activities in accordance with 42 CFR §438.358 and in alignment with the CMS EQR Protocols will improve MDHHS' ability to oversee and manage the waiver agencies, and should lead to more comprehensive, accurate, and reliable data to assess the MI Choice Waiver Program's performance related to the quality, timeliness, and accessibility of care. As such, HSAG recommends MDHHS conduct its EQR-related activities following the Medicaid and CHIP Managed Care Final Rule and the CMS EQR Protocols. • In accordance with 42 CFR §438.330(d), MDHHS must require through its contracts that each waiver agency establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members. HSAG recommends MDHHS and its contracted waiver agencies continue to enhance the QMPs and the annual QMP evaluation through the existing State-initiated work group. • To promote optimal health and well-being for waiver members, HSAG recommends MDHHS focus efforts on improving members' satisfaction with their ability to get together with family and friends, participate in community and social events, and having the autonomy to make decisions about their day-to-day activities. To support these efforts, MDHHS should implement a statewide PIP that focuses on improving member satisfaction rates for the *Planning Your Time and Activities* component of the CAHPS activity and to improve waiver members' overall quality of life and integration into the community. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agencies should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.

2. Overview of the MI Choice Waiver Agencies

Managed Care in Michigan

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

Table 2-1—Michigan Medicaid Managed Care Programs

Medicaid Managed Care Program	MCEs	MDHHS Administration
Comprehensive Health Care Program (CHCP), including: • CHIP—MIChild • Children's Special Health Care Services Program • Healthy Michigan Plan (Medicaid Expansion) • Flint Medicaid Expansion Waiver	Medicaid Health Plans (MHPs)	MSA
Managed LTSS, including: • MI Health Link Demonstration • MI Choice Waiver Program • Program of All-Inclusive Care for the Elderly	Integrated Care Organizations (ICOs) Prepaid Inpatient Health Plans (PIHPs) PAHPs	MSA

[2-1] While MSA was responsible for the MI Choice Waiver Program during the time period of this annual EQR, the HASA was created under Executive Order 2021-14, combining the Aging and Adult Services Agency and the MSA under one umbrella within MDHHS effective December 14, 2021. The Executive Order can be accessed at: https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-573368--,00.html. MDHHS also announced that HASA became BPHASA effective March 21, 2022. The BHDDA, the division responsible of the Behavioral Health Managed Care Program, became part of BPHASA to demonstrate equal prominence of behavioral and physical health. The program changes will be reflected in future EQR technical reports.

Medicaid Managed Care Program	MCEs	MDHHS Administration
Dental Managed Care Programs, including: • Healthy Kids Dental • Pregnant Women Dental • Healthy Michigan Plan Dental	PAHPs	MSA
Behavioral Health Managed Care	PIHPs	BHDDA

MI Choice Waiver Program

MI Choice is a waiver program to deliver HCBS to elderly persons and other adults with physical disabilities who meet the Michigan NFLOC criteria. The waiver is approved by CMS under sections 1915(b) and 1915(c) of the Social Security Act. The MI Choice Waiver Program began in 1992 as the Home and Community Based Services for the Elderly and Disabled (HCBS/ED) waiver program, which became available in all Michigan counties effective October 1, 1998. The program allows individuals to live independently while receiving LTSS in their home or a community-based setting. MI Choice is limited to serving older adults (age 65 and over) and persons with disabilities (age 18 and older). The goal of MI Choice is to provide HCBS to members using a person-centered planning process that allows them to maintain or improve their health, welfare, and quality of life.

Overview of Waiver Agencies

During the SFY 2021 review period, MDHHS contracted with 20 waiver agencies. These waiver agencies are responsible for the provision of waiver services to MI Choice Waiver Program members within designated regions within the State of Michigan. Table 2-2 provides a profile for each waiver agency, including the region(s) of the state where services are provided and whether the waiver agency maintained case management accreditation through the National Committee for Quality Assurance (NCQA) or the Commission on Accreditation of Rehabilitation Facilities (CARF) during the time period under review.

Table 2-2—Waiver Agency Profiles[2-2]

Agency	Covered Services	Service Area/ Regions Served	Accreditation Status/Accrediting Body
A&D Home Health Care	• Adult day health (adult day care) • Chore services • Community health worker	Region 7	Accredited—NCQA
Agency on Aging of Northwest Michigan		Region 10	Accredited—NCQA
Area Agency on Aging 1B		Region 1B	Accredited—NCQA

[2-2] Michigan Department of Health and Human Services. MI Choice Waiver Program. 2021. Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_4857-16263--,00.html#list. Accessed on: Sept 13, 2022.

Agency	Covered Services	Service Area/ Regions Served	Accreditation Status/Accrediting Body
Area Agency on Aging of Western Michigan	• Community living supports • Community transportation • Counseling • Environmental accessibility adaptations • Fiscal intermediary • Goods and services • Home delivered meals • Nursing services • Personal emergency response systems (PERS) • Private duty nursing/respiratory care • Respite services • Specialized medical equipment and supplies • Training in a variety of independent living skills	Region 8	Accredited—CARF
Detroit Area Agency on Aging		Region 1A	Accredited—NCQA
Milestone Senior Services		Region 3	Not Accredited
MORC Home Care		Region 1B	Accredited—NCQA
Northern Healthcare Management		Region 10	Accredited—NCQA
Region 2 Area Agency on Aging		Region 2	Accredited—NCQA
Region 3B Area Agency on Aging		Regions 3 and 4	Not Accredited
Region IV Area Agency on Aging		Region 4	Not Accredited
Region VII Area Agency on Aging		Region 7	Accredited—NCQA
Region 9 Area Agency on Aging		Region 9	Accredited—NCQA
Reliance Community Care Partners		Regions 8 and 14	Accredited—NCQA
Senior Resources		Region 14	Accredited—CARF
The Information Center		Region 1C	Accredited—NCQA
The Senior Alliance		Region 1C	Accredited—NCQA
Tri-County Office on Aging		Region 6	Accredited—NCQA
UPCAP Care Management, Inc.		Region 11	Not Accredited
Valley Area Agency on Aging		Region 5	Accredited—NCQA

Quality Strategy

The 2020–2023 MDHHS CQS[2-3] provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by all MDHHS Medicaid managed care programs, including MI Choice. The MDHHS CQS document is intended to meet the required Medicaid and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 MDHHS CQS, MDHHS strived 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 MDHHS CQS also aligns with CMS' Quality Strategy and the U.S. Department of Health and Human Services (HHS) National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health

[2-3] 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: Sept 13, 2022.

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 the 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 were specifically designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

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

MDHHS CQS Medicaid 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.
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.

[2-4] Ibid.

MDHHS CQS Medicaid Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
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.
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.

MDHHS CQS Medicaid Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
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 MDHHS CQS also includes a common set of performance measures to address the required Medicaid 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 the MDHHS 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 MDHHS CQS.

Quality Initiatives and Interventions

To accomplish its objectives, MDHHS, through the MI Choice Waiver Program, has implemented several initiatives and interventions that focus on quality improvement. Examples of these initiatives and interventions include:

- **Quality Structure/Committee**—The Quality Management Committee (QMC) advises and provides insight into the development and review of MI Choice quality management activities and initiatives. Through the QMC, members, waiver agencies, program directors, advocates, and providers review quality outcomes, identify barriers and improvement opportunities, and develop service delivery

remediation strategies. Members and advocates also contribute their valuable perspectives during the implementation of care options such as person-centered planning and self-determination.

- **MI Choice Quality Improvement Strategy (QIS)**—The QIS describes how the program assesses and improves the quality of services and supports managed by the waiver agencies. The QIS outlines the methods used to gather data and measure individual and system performance including: the MDHHS QMP, waiver agency-specific QMPs, Clinical Quality Assurance Review (CQAR), Administrative Quality Assurance Review (AQAR) and Critical Incident Reporting System. Waiver agencies are required to develop their own QMP every other year to address CMS and MDHHS quality requirements. MDHHS reviews and analyzes the QMPs and associated yearly reports, and complies and compares individual waiver agency quality indicator data and statewide averages to monitor agency performance, as indicated.
- **Performance Monitoring**—MDHHS monitors the waiver agencies using multiple methods including established performance measures in six waiver assurances and requirements in the areas of service adequacy, access, provider network training, care plans, satisfaction and quality of life, and critical incidents. Quality indicator selection, measurement, reporting and improvement activities also assess member health status outcomes in the following domains: nutrition, incontinence, skin ulcers, physical and cognitive function, pain, and safety/environment. Quarterly reports are generated and shared with MDHHS for review and analysis. The QMC selects five indicators for focused quality improvement efforts over a minimum two-year period and regularly meets with local consumer advisory teams to collaborate on related activities.
- **Performance Bonus**—MDHHS withholds a portion of the approved capitation payment from each MI Choice waiver agency, which are used for the agency's annual performance bonus incentive. The incentives are distributed to the agencies after the end of the year according to rankings based on criteria and standards established annually by MDHHS. Waiver agency rankings are calculated based on CQAR/AQAR performance indicators, encounter data, significant support participant, acuity, critical incidents reporting, waiver agency reports, and supports coordinator per member.

3. Assessment of Waiver Agency Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2021 review period to comprehensively evaluate the performance of the waiver agencies on providing quality, timely, and accessible healthcare services to MI Choice Waiver Program members. Quality, as it pertains to EQR, means the degree to which the waiver agency 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 waiver agencies 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 waiver agency.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for each waiver agency to identify strengths and weaknesses that may pertain to the domains of quality, timeliness, and access to services furnished by the waiver agency 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 waiver agency.
- **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 waiver agency.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2021 to provide context for the resulting findings of each EQR activity. As HSAG does not conduct the EQR-related activities for the MI Choice waiver agencies, MDHHS provided the data and the information sources necessary for HSAG to complete the annual EQR. 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 Performance Improvement Projects

For SFY 2021, the waiver agencies continued implementing the five PIPs, referred to as quality improvement projects (QIPs) for the MI Choice Waiver Program, that were initiated in SFY 2020. Each waiver agency develops a QMP biennially that addresses CMS and MDHHS quality requirements, including the MDHHS required QIPs. MDHHS also requires each waiver agency to compile an annual

report, called the MI Choice Summary of Quality Management Plan Activities & Outcomes Report (actual name of the report varies across waiver agencies), which provides a description of each waiver agency's quality management activities and outcomes. Throughout this report, the QMP and the annual report are collectively referred to as "QMP reports." Every two years, or at MDHHS' discretion, the QMC members vote on five PIPs and the associated quality indicators, goals, and strategies. Waiver agency progress of each QIP and the associated quality indicators are reported annually to MDHHS through the MI Choice Summary of Quality Management Plan Activities & Outcomes Report. Table 3-1 outlines the five QIP indicators for the waiver agencies for the SFY 2020 and SFY 2021 review years, and the MDHHS-defined statewide goals for each QIP indicator. Of note, a lower percentage indicates better performance.

Table 3-1—QIP Indicators and Goals

QIP Indicators	MDHHS Statewide Goals
1. *Prevalence of Neglect/Abuse*	3%
2. *Prevalence of Pain With Inadequate Pain Control*	20%
3. *Prevalence of Falls*	23%
4. *Prevalence of Any Injuries*	3%
5. *Prevalence of Dehydration*	1.5%

Performance Measure Validation

The PMV activity comprised information derived from the CQAR, in which reviewers from the Michigan Public Health Institute (MPHI) evaluated a sample of records from each waiver agency to validate information included in the Form CMS-372(S) Annual Report on Home- and Community-Based Services (HCBS) Waivers and Supporting Regulations (CMS-372 report) complied with the requirements of the MI Choice Waiver Program. MDHHS also used internal systems and reports to evaluate financial information, critical incident data, claims data, and other performance measure data. The performance measure domains included Administrative Authority, Evaluation/Reevaluation of Level of Care, Participant Services, Participant-Centered Planning and Service Delivery, Participant Safeguards, and Financial Accountability. Of note, for all measures submitted as part of the CMS-372 report, the performance measure percentage rate was calculated at the statewide rate, and not for each individual waiver agency. While MDHHS maintained the numerators and denominators for each waiver agency for several performance measures and the individual scores for each standard included as part of the CQAR, MDHHS did not calculate an individual waiver agency performance measure rate. Additionally, for statewide reporting, MDHHS maintained the CQAR tool for each waiver agency for those performance measures that rely on the CQAR as the data source. These performance measures are highlighted in blue in Table 3-2, and these performance measures were used by HSAG to evaluate individual waiver agency performance, as the CQAR findings that determined the performance measure rates within the CMS-372 report were available to HSAG for review. For other data sources, MDHHS had the capability of analyzing data available in the performance measure's associated data base (i.e.,

critical incident data base for Participant Safeguards measures). Table 3-2 lists the performance measures reported by MDHHS to CMS in compliance with waiver requirements. Table 3-2 also includes the data source(s) and sampling approach used to calculate the performance measure results as specified in the CMS-approved Section 1915(c) waiver application for the MI Choice Waiver Program.

Table 3-2—Performance Measures and Source Data

	Performance Measures	Source Data	Sampling Approach
	Administrative Authority		
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.*	CQAR	Representative sample
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.*	CQAR	Representative sample
3	*Number and percent of waiver agencies who submit annual Quality Management Plan (QMP) activity and outcome reports that illustrate they are adhering to their QMP.*	Reports	100% review
4	*Number and percent of appropriate level of care determinations (LOCDs) found after MDHHS review.*	CQAR	Representative sample
5	*Number and percent of corrective action plans that were provided by waiver agencies according to requirements set by the Michigan Department of Health and Human Services (MDHHS) or the External Quality Review Organization (EQRO).*	Reports	100% review
	Evaluation/Reevaluation of Level of Care		
6	*Number and percent of new MI Choice waiver participants who meet the NFLOC criteria prior to waiver enrollment.*	Online database	100% review
7	*Number and percent of LOCDs made by a qualified evaluator.*	CQAR	Representative sample
8	*Number and percent of participants who had initial LOCDs where the NFLOC criteria were accurately applied.*	CQAR	Representative sample
9	*Number and percent of MI Choice disenrollments based upon no longer meeting NFLOC criteria that were determined correctly.*	Online database	Not reviewed*
10	*Number and percent of providers continuing to meet applicable licensure & certification standards in accordance with state law following initial enrollment.*	Record reviews	100% review

	Performance Measures	Source Data	Sampling Approach
11	*Number and percent of new waiver service provider applications that meet initial licensure/certification standards in accordance with state law prior to the provision of waiver services.*	Record reviews	100% review
12	*Number and percent of non-licensed or non-certified waiver providers that initially met provider qualifications.*	Record reviews	100% review
13	*Number and percent of non-licensed or non-certified waiver providers that continue to meet provider qualifications.*	Record reviews	100% review
14	*Number and percent of providers who meet provider training requirements.*	Record reviews	100% review
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.*	CQAR	Representative sample
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.*	CQAR	Representative sample
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.*	CQAR	Representative sample
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.*	CQAR	Representative sample
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.*	CQAR	Representative sample
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.*	CQAR	Representative sample
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.*	CQAR	Representative sample
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.*	CQAR	Representative sample
	Participant Safeguards		
23	*Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.*	Critical events and incident reports	100% review

	Performance Measures	Source Data	Sampling Approach
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.*	CQAR	Representative sample
25	*Number and percent of critical incidents due to unexplained death reported within two business days of notification that the incident occurred.*	Critical incident reporting database	100% review
26	*Number and percent of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred.*	Critical incident reporting database	100% review
27	*Number and percent of waiver agencies that utilize the critical incident database to track incidents through effective resolution.*	Critical incident reporting database	100% review
28	*Number and percent of waiver agencies with staff who have completed required training to prevent incidents.*	Record reviews	100% review
29	*Number and percent of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident.*	Critical incident reporting database	100% review
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of caregiver).*	CQAR	Representative sample
31	*Number and percent of participant suicide attempts that resulted in follow up by the waiver agency.*	Critical incident reporting database	100% review
32	*Number and percent of participants requiring emergency medical treatment or hospitalization due to medication error.*	Critical incident reporting database	100% review
33	*Number and percent of critical incidents reporting hospitalization or emergency room visit within 30 days of the previous hospitalization due to neglect or abuse.*	Critical incident reporting database	100% review
34	*Number and percent of properly reported suicide attempts in the critical incident database.*	Critical events and incident reports	100% review
	Financial Accountability Performance Measures		
35	*Number and percent of encounters submitted to MDHHS with all required data elements.*	Online database	100% review
36	*Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility.*	Online database	100% review
37	*Number and percent of encounters submitted to MDHHS within required timeframes.*	Online database	100% review

	Performance Measures	Source Data	Sampling Approach
38	*Number and percent of service plans that supported paid services.*	CQAR	Representative sample
39	*Number and percent of capitation payments that have been paid at rates approved by the Actuary.*	Online database	100% review

*MDHHS was unable to calculate the rate for this performance measure due to data limitations. MDHHS indicated it will need to revise the performance measure specifications to appropriately calculate this performance measure's rate.

Indicates the performance measures that rely on the CQAR as the data source for reporting and used by HSAG to assess individual waiver agency performance as part of this EQR.

Compliance Review

MPHI, on behalf of MDHHS, completes a CQAR for every waiver agency each state fiscal year that consists of a record review and home interview. During the CQAR, reviewers examine case records and other information to gauge the level of compliance with program standards and to assess the quality of waiver agency service to each member. The CQAR includes a review of whether person-centered service plans (PCSPs) and service delivery are in compliance with State and federal requirements. Each review element is assigned a value of *Evident* (compliant), *Non-Evident* (non-compliant), or *NA*. A percentage of *Evident* for each focus area is derived from the total number of elements assigned a value of *Evident* divided by the number of total applicable elements. Each standard is then assigned an overall compliance determination based on a compliance level determination matrix. The SFY 2021 CQAR consisted of 17 standards (focus areas) identified in Table 3-3. Table 3-3 also identifies the standards included as part of the record review and the home interview.

Table 3-3—CQAR Standards

Standards		Record Review	Home Interview
Focus 1	Level of Care Determination	✓	✓
Focus 2	Freedom of Choice	✓	
Focus 3	Release of Information	✓	
Focus 4	Status	✓	
Focus 5	Pre-Planning	✓	✓
Focus 6	Assessment	✓	✓
Focus 7	Medication Record	✓	✓
Focus 8	Person-Centered Service Planning	✓	✓
Focus 9	MI Choice Services	✓	✓
Focus 10	Linking and Coordinating	✓	✓
Focus 11	Follow-Up and Monitoring	✓	✓
Focus 12	Service Provider	✓	
Focus 13	Contingency Plan	✓	✓

Standards		Record Review	Home Interview
Focus 14	Critical Incidents	✓	✓
Focus 15	Adverse Benefit Determination	✓	
Focus 16	Complaints and Grievances	✓	
Focus 17	Home and Community Based		✓

Consumer Assessment of Healthcare Providers and Systems Survey

The CAHPS HCBS survey asks waiver members to report on and evaluate their experiences with healthcare and, specifically, about the services and supports received through the MI Choice Waiver Program and the individuals who are paid for the waiver services. This survey covers topics that are important to waiver members, such as the communication skills of, and the treatment received from, providers. The Institute for Health Policy (IHP), a unit within the College of Human Medicine (CHM) of Michigan State University, administered the CAHPS surveys on behalf of the waiver agencies. Survey results were standardized to a 100-point scale with mean scores calculated. HSAG presents the percentage of members who responded to the survey with positive experiences in a particular aspect of their healthcare. Table 3-4 depicts the domains and questions analyzed by the IHP.

Table 3-4—CAHPS Domains and Questions

Domain	Question
Global Ratings Measures	Global rating of personal assistance and behavioral health staff
	Global rating of homemakers
	Global rating of case manager
Recommendation Measures	Recommendation of personal assistance and behavioral health staff
	Recommendation of homemakers
	Recommendation of case manager
Staff are Reliable and Helpful	Staff come to work on time
	Staff work as long as they are supposed to
	Someone tells you if the staff cannot come
	Staff make sure you have enough privacy for [getting] dressed, [taking a] shower, bathing
	Homemakers come to work on time
	Homemakers work as long as they are supposed to

Domain	Question
Staff Listen and Communicate Well	Staff treat you with courtesy and respect
	Staff explanations are easy to understand
	Staff treat you the way you want them to
	Staff explain things in a way that is easy to understand
	Staff listen carefully to you
	Staff know what kind of help you need with everyday activities
	Homemakers treat you with courtesy and respect
	Homemaker explanations are easy to understand
	Homemakers treat you the way you want them to
	Homemakers listen carefully
	Homemakers know what kind of help you need
Case Manager is Helpful	Able to contact this case manager when needed
	Case manager helped when asked for help with getting or fixing equipment
	Case manager helped when asked for help with getting other changes to services
Choosing the Services that Matter to You	Person-centered service plan included all of the things that are important
	Staff knows what's on the service plan, including the things that are important
Transportation to Medical Appointments	Have a way to get to your medical appointments
	Able to get in and out of this ride easily
	Ride arrives on time to pick you up
Personal Safety and Respect	Have someone to talk to if someone hurts you or does something you that you don't like
	None of the staff take money or things without asking
	None of the staff yell, swear, or curse

Domain	Question
Planning Your Time and Activities	Can get together with nearby family
	Can get together with nearby friends
	Can do things in the community
	Needs more help to do things in the community
	Takes part in deciding what to do with their time
	Takes part in deciding when they do things each day
Met Need	Met need in dressing/bathing
	Met need in meal preparation/eating
	Met need in medication administration
	Met need in toileting
	Met need in household tasks
Physical Safety Measure	No physical safety concerns; staff does not hit or hurt

EQR Activity Results

A&D Home Health Care

Validation of Performance Improvement Projects

Performance Results

Table 3-5 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **A&D Home Health Care** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **A&D Home Health Care** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **A&D Home Health Care**'s QMP reports are also provided in Table 3-5. The results in Table 3-5 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-5—QIP Results

QIP Topic	Goal*	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Reduce the number of participants identifying the prevalence of neglect/abuse to be at or under the identified statewide percentage of 3.0%	SFY 2019 = 2.9% SFY 2020 = 3.10% SFY 2021 = 0.44% ☑
Actions/Activities/Interventions: According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks: • Quarterly review the iHC [InterRAI Home Care Assessment] QI [quality improvement] Summary and Detailed Reports for tracking and trending of members identifying the prevalence of neglect/abuse at the Management Team meeting the following month of the quarter. • When trends are discovered, additional education will be provided to waiver staff to ensure the members remain safe and free from neglect/abuse. • Continue to report critical incidents involving neglect/abuse via the critical incident portal within the contract designated time frames. • Provide annual training to all supports coordinators about abuse, neglect, and exploitation. The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • **A&D Home Health Care** management team complete audits of each member to determine the prevalence of neglect/abuse. The issue appeared to be documentation related [inaccurate documentation and reported information from previous assessments led to increased prevalence rates for some QIPs]. As the Compass system does not complete a "hard reset," the question [assessing the occurrence of neglect/abuse] would get overlooked during re-assessments. The bubbles [yes/no options] would then remain clicked until someone		

QIP Topic	Goal*	Measurement and Outcome
changed the response. Following the Quarter 2 reviews, the quality assurance team would enter the next assessment and clear out the bubble to indicate "No Selection." This in turn alerted staff to re-assess the information at the following assessment. • With the process change of the quality assurance team clearing out the bubbles, documentation appeared to improve, a more thorough review occurred, and the agency percentage decreased to a more accurate range. • **A&D Home Health Care** continues to provide yearly education on abuse, neglect, and exploitation to all staff members and vendors. All education is focused on what appears to be abuse, neglect, and exploitation and the ways to report suspected abuse. All staff and vendors are encouraged to contact Adult Protective Services (APS) anytime there is a suspicion of abuse or neglect.		
2. *Prevalence of Pain With Inadequate Pain Control*	Reduce the prevalence of pain with inadequate pain control to below the statewide average of 20.0%	SFY 2019 = 22.8% SFY 2020 = 20.85% SFY 2021 = 20.40% ☒

Actions/Activities/Interventions:

According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks:

- Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of members with prevalence of pain with inadequate pain control at the management team meeting the following month of the quarter.
- When trends are discovered, additional education will be provided to waiver staff to ensure the members will indicate satisfactory pain control.
- The clinical educator will be completing training for nurses and social workers regarding pain and alternative pain control techniques.
- Training will be provided to supports coordinators to assist members in communicating with their physicians when the current pain regimen is not effective and alternative techniques have been utilized.

The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following:

- The barriers in completing regular/routine audits on the prevalence of pain with inadequate pain control have been summed up into the following:
  - The members who trigger are noted as stating that they experience pain and experience any of the following:
    - inadequate pain control on regimen
    - breakthrough pain
    - sometimes severe or excruciatingly intense pain
  - The Compass system does not have a location to indicate the member's tolerance of pain levels or pain acceptance levels.
  - The assessment does not include questions to indicate if the member is under the care of a medical pain specialist.

QIP Topic	Goal*	Measurement and Outcome
• In addition to reviews of the iHC QI data, **A&D Home Health Care** reviewed all data with staff members to ensure knowledge and understanding of members who may not meet the identified criteria for the prevalence of pain with inadequate pain control. • Education was provided to all staff to increase understanding of the documentation and reporting mechanisms. A best practices handout was created to identify where the information was obtained which populated the iHC Quality Report. • **A&D Home Health Care** completed training with all staff members on how to identify pain and educate on non-pharmaceutical options for pain control for waiver members. • The clinical educator utilized the non-pharmaceutical options for pain control to educate on pain control and discussed options the members can speak with the physician about during the local consumer quality council meeting. Options presented to the group included: speaking with their physician about a review of medical conditions, medication reviews, and the possibility of a referral to a pain specialist. • Management observed that with the understanding and implementation of the education a decrease in the numerator occurred. • Final conclusions show that **A&D Home Health Care** is reducing the prevalence of pain with inadequate pain control. Current processes are working and will be improved upon to ensure this standard is at or below the statewide goal of 20.0%.		
3. *Prevalence of Falls*	Reduce the prevalence of falls to be at or below the statewide goal of 23.0%	SFY 2019 = 25.6% SFY 2020 = 23.16% SFY 2021 = 20.89% ☑
Actions/Activities/Interventions: According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks: • Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of members identifying the prevalence of falls at the management team meeting the following month of the quarter. • When trends are discovered, additional education will be provided to waiver staff on fall prevention and in home safety. • The clinical educator will be utilizing the contracted occupational therapist to request she speak at an upcoming local consumer quality council meeting about safe transfers and fall prevention. • All supports coordinators have completed the Model of Care certification and will utilize the resources obtained from the program as individuals with fall risks are identified. The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • **A&D Home Health Care** management team conducted audits of each member regarding the prevalence of falls, and a common theme was found. The theme appeared to be a documentation issue [inaccurate documentation and reported information from previous assessments led to increased prevalence rates for some QIPs]. As the Compass system does not complete a "hard reset," the question [assessing the occurrence of falls] would get overlooked during re-assessments. The bubbles [yes/no options] would then remain clicked until someone changed the response. Following the Quarter 2 reviews, the quality assurance team		

QIP Topic	Goal*	Measurement and Outcome
would enter the next assessment and clear out the bubble to indicate "No Selection." This in turn alerted staff to re-assess the information at the following assessment. • Due to the process change of the quality assurance team clearing out the bubbles, documentation appeared to improve, a more thorough review occurred, and the agency percentage decreased to a more accurate range. The improvement is noted in the Quarter 3 & 4 waiver agency percentage, indicating that final fall data is below the statewide goal. • The clinical educator utilized the contracted occupational therapist to educate on safe transfers and discuss options for fall prevention during the local consumer quality council meeting.		
4. *Prevalence of Any Injuries*	Reduce the prevalence of any injury to be at or below the statewide goal of 3.0%	SFY 2019 = 6.9% SFY 2020 = 8.23% SFY 2021 = 1.65% ☑
Actions/Activities/Interventions: According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks: • Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of members identifying the prevalence of any injury at the management team meeting the following month of the quarter. • The quality assurance team will complete a 5-10% randomized audit on the individual members reporting injuries to identify trends and possible solutions to decrease the prevalence of any injury. All results will be presented to the management team at the month following the quarter. • When trends are discovered, additional education will be provided to waiver staff on the prevalence of injuries. The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • **A&D Home Health Care** management team began doing audits of each member indicating an injury and found a common theme. The theme appeared to be a documentation issue [inaccurate documentation and reported information from previous assessments led to increased prevalence rates for some QIPs]. As the Compass system does not complete a "hard reset," the question [assessing the occurrence of any injuries] would get overlooked during re-assessments. The bubbles [yes/no options] would then remain clicked until someone changed the response. Following the Quarter 2 reviews, the quality assurance team would enter the next assessment and clear out the bubble to indicate "No Selection." This in turn alerted staff to re-assess the information at the following assessment. • Due to the process change of the quality assurance team changing the bubbles to ensure a more thorough review, the waiver agency percentage decreased to a more accurate range. • In addition to quarterly and monthly reviews of the iHC QI data, **A&D Home Health Care** reviewed all data with staff members to ensure knowledge and understanding of members who may not meet the identified criteria for the prevalence of any injuries. • Education was provided to all staff to increase understanding of the documentation and reporting mechanisms. A best practices handout was created to identify where the information was obtained which populated the report.		

QIP Topic	Goal*	Measurement and Outcome
• Management observed that with the understanding and implementation of the education a decrease in the numerator occurred.		
5. *Prevalence of Dehydration*	Reduce the risk of dehydration to be at or below the statewide goal of 1.5%	SFY 2019 = 2.1% SFY 2020 = 1.97% SFY 2021 = 0.61% ☑

Actions/Activities/Interventions:

According to **A&D Home Health Care**'s MI Choice Quality Management Report FY 2020–2021 dated January 13, 2020, **A&D Home Health Care** planned to complete the following tasks:

- Quarterly review the iHC QI Summary and Detailed Reports for tracking and trending of members identifying the prevalence of dehydration at the management team meeting the following month of the quarter.
- When trends are discovered, additional education will be provided to waiver staff on the prevalence of dehydration.
- The clinical educator will be doing a quarterly audit of the identified members, per the iHC QI Detailed report, to ensure identified member's fluid needs are within their normal, medically prescribed limits.
- Additionally, for NCQA Accreditation, **A&D Home Health Care** will be completing several presentations on dehydration and the effect it has on members. The focus of the education is to decrease the prevalence of dehydration.

The **A&D Home Health Care** MI Choice Quality Management Report Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following:

- Further review of the data indicates that many of the members notating insufficient fluid intake are currently receiving dialysis services and are on a medically required fluid restriction.
- Additional education was provided to staff regarding the Compass system identifying questions for dehydration and how to respond when the individual is under a medical fluid restriction. Education focused on the members should not be noted as dehydrated, rather that they are following their physician's orders. In addition, education was provided regarding all dialysis patients and where the individuals' specific fluid restriction should be noted in the system.

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Goals in the QMP differed from the goals in the annual report. As the goals identified in the annual report were more stringent, HSAG used these goals to determine performance.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: A&D Home Health Care met its established goals for the *Prevalence of Dehydration* QIP, suggesting that **A&D Home Health Care** implemented interventions that had a positive effect on the prevalence rate, and members experienced fewer incidents of dehydration than the baseline year. Additionally, this rate demonstrated improvement from SFY 2020. **A&D Home Health Care** also met its established goals for the *Prevalence of Neglect/Abuse*, *Prevalence of Falls*, and *Prevalence of Any Injuries* QIPs. The reduction in prevalence rates for these QIPs was primarily attributed to corrections in documentation processes. Refer to **Strength #2** for additional details. [**Quality**]

Strength #2: A&D Home Health Care identified issues within its care management database where member responses from previously conducted assessments remained in the system and no prompts existed for staff members to reassess the information and ask questions about more recent situations pertaining to neglect/abuse, falls, and injuries. Since the system was not being updated with current information, this falsely led to higher prevalence rates for some QIPs. Upon identification of this documentation issue, **A&D Home Health Care** manually removed historical responses and updated the assessment question to "No Selection," prompting the supports coordinator to reassess the information pertaining to neglect/abuse, falls, and injuries during the next assessment, which supported a decrease in prevalence rates. [**Quality**]

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care's SFY 2020–2021 QMP and SFY 2021 annual report included conflicting goals, which made it difficult to determine the actual goal established by **A&D Home Health Care** when initiating the QIPs. This was also identified as a weakness in the SFY 2020 EQR technical report. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each quality indicator needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: A&D Home Health Care's SFY 2020–2021 QMP identified different goals for each QIP than the SFY 2021 annual report. The SFY 2021 goal within the annual report aligned with MDHHS' established statewide goals; however, the goals identified in the SFY 2020–2021 QMP were listed under a heading titled "FY 2021 Quality Improvement Projects,

Goals, Strategies, and Results" (e.g., the QMP indicated the percentage goal for the *Prevalence of Neglect/Abuse* QIP as 4.95 percent; however, the annual report indicated the goal for this QIP as 3 percent).

Recommendation: HSAG recommends that **A&D Home Health Care** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports and should not change through the measurement period of the QIP unless documentation is provided to support the rationale for the change. Additionally, **A&D Home Health Care** should ensure that its annual report includes additional strategies it will implement in the following year to eliminate identified barriers.

Weakness #2: The interventions implemented by **A&D Home Health Care** did not appear to be effective in improving outcomes as the prevalence rate remained consistent with the previous year's rate for the *Prevalence of Pain With Inadequate Pain Control* QIP and **A&D Home Health Care** did not reach its goal. **A&D Home Health Care**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIP. [**Quality**]

Why the weakness exists: **A&D Home Health Care**'s SFY 2020–2021 QMP listed planned activities and the SFY 2021 annual report documented that the activities were conducted. However, the SFY 2021 annual report did not support that a causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers. Additionally, the interventions only included supports coordinator educational activities, which do not appear to demonstrate performance improvement on their own.

Recommendation: HSAG recommends that **A&D Home Health Care** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **A&D Home Health Care** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **A&D Home Health Care** should analyze and interpret results at multiple points in time and test for statistical significance. **A&D Home Health Care** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **A&D Home Health Care**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process,

analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and the methodology followed by **A&D Home Health Care** when implementing its QIPs.

Recommendation: HSAG recommends that **A&D Home Health Care** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **A&D Home Health Care** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-6. Table 3-6 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **A&D Home Health Care**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **A&D Home Health Care**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-6—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**93.16%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**96.18%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**97.64%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**98.39%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**95.16%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**92.41%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**93.75%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**85.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**96.77%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**80.00%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**93.55%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: A&D Home Health Care received a 100 percent performance rating for Performance Measures 4, 8, 22, and 24, indicating that appropriate LOCDs were made; level of care (LOC) criteria were accurately applied on initial determinations; waiver provider choice was offered to members; and members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents. [**Quality]**

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care performed substantially worse than other waiver agencies on Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan,* as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that services provided were not always consistent with the PCSP. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: A&D Home Health Care's performance rate for Performance Measure 20 fell 8.18 percentage points below the statewide rate. Through the CQAR, of the 31 records reviewed, MPHI determined that four of the nine applicable records did not demonstrate evidence that the supports coordinator contacted newly enrolled members to ensure service delivery in accordance with MDHHS policy and contract requirements; and two of the 19 applicable records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with the member's backup plan or an out-of-network provider.

Recommendation: MDHHS required **A&D Home Health Care** to submit a CAP to remediate the deficiencies associated with Performance Measure 20. **A&D Home Health Care**'s CAP included, but was not limited to, updates to its policies and processes; individual education for each supports coordinator out of compliance; education for all staff members on policy and process changes; and a review of 12 records per month by the management team. However, **A&D Home Health Care** also indicated that once standards show compliance of 90 percent, no further reporting will be required. Therefore, HSAG recommends that **A&D Home Health Care** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: A&D Home Health Care performed substantially worse than other waiver agencies on Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies,* as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always ensure members had an individualized contingency plan for emergencies. [**Quality** and **Access**]

Why the weakness exists: A&D Home Health Care's performance rate for Performance Measure 30 fell 10.29 percentage points below the statewide rate. Through the CQAR, of the 31 records reviewed, MPHI determined that 13 of the 31 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan.

Recommendation: MDHHS required **A&D Home Health Care** to submit a CAP to remediate the deficiencies associated with Performance Measure 30. **A&D Home Health Care**'s CAP included, but was not limited to, individual education and training for each supports coordinator out of compliance and a review of 12 records per month by the management team. However, **A&D Home Health Care** also indicated that once standards show compliance of 80 percent, no further reporting will be required. Therefore, HSAG recommends that **A&D Home Health Care** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is

important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: A&D Home Health Care performed substantially worse than other waiver agencies on Performance Measure 38, *number and percent of service plans that supported paid services,* as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always ensure service plans supported paid services. [**Quality** and **Access**]

Why the weakness exists: A&D Home Health Care's performance rate for Performance Measure 38 fell 5.93 percentage points below the statewide rate. Through the CQAR, of the 31 records reviewed, MPHI determined that two of the 31 applicable records did not demonstrate evidence that the member received at least one MI Choice Waiver Program service on a continual basis or the supports coordinator made an effort to secure the services.

Recommendation: Although MDHHS did not require **A&D Home Health Care** to submit a CAP for these deficiencies, HSAG recommends that **A&D Home Health Care** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-7 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-7 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-7—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	96.77%		**4.00**
Focus 3	Release of Information	100.00%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 4	Status	94.90%		**4.00**
Focus 5	Pre-Planning	97.47%	100.00%	**4.00**
Focus 6	Assessment	94.27%	100.00%	**4.00**
Focus 7	Medication Record	92.31%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	89.67%	100.00%	**4.00**
Focus 9	MI Choice Services	97.67%	100.00%	**4.00**
Focus 10	Linking and Coordinating	98.78%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	80.28%	100.00%	**3.34**
Focus 12	Service Provider	88.24%		**4.00**
Focus 13	Contingency Plan	82.19%	100.00%	**4.00**
Focus 14	Critical Incidents	83.33%	100.00%	**2.68**
Focus 15	Adverse Benefit Determination	97.22%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**93.29%**	**100.00%**	**3.91**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Sixteen home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their PCSPs and preferences and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the area of Critical Incidents as the overall rating for this program area was less than full compliance. [**Quality**, **Timeliness**, and **Access**]

Strength #2: A&D Home Health Care achieved a substantial compliance rating in 16 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**]

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **A&D Home Health Care** received less than a substantial compliance rating in one program standard, indicating there are opportunities for improvement related to Critical Incidents. MDHHS required a CAP for the noted areas of deficiency. **A&D Home Health Care**'s CAP included, but was not limited to, updates to its policies and processes; individual education for each supports coordinator out of compliance; education for all staff members on policy and process changes; and a review of four records per quarter per supports coordinator by the management team. However, **A&D Home Health Care** also indicated that once standards show compliance of 90 percent, no further reporting will be required. Therefore, HSAG recommends that **A&D Home**

Health Care continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated percentage of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-8 presents **A&D Home Health Care**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-8—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	**86.0%**	91.5%
Recommendation Measures	90.6%	92.6%
Staff are Reliable and Helpful	89.8%	91.9%
Staff Listen and Communicate Well	**88.3%**	95.0%
Case Manager is Helpful	91.7%	95.2%
Choosing the Services that Matter to You	91.8%	92.7%
Transportation to Medical Appointments	89.2%	92.5%
Personal Safety and Respect	95.0%	97.2%
Planning Your Time and Activities	75.6%	75.4%
Met Need	91.7%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: A&D Home Health Care achieved a higher score than the statewide results on two of the domains: *Planning Your Time and Activities* and *Physical Safety Measure*, indicating that **A&D Home Health Care** provides services in a manner that meets or exceeds members' expectations in some domains. It should be noted that while **A&D Home Health Care** achieved a higher score than the statewide results for *Planning Your Time and Activities*, this domain received the lowest statewide score across all domains. [**Quality**]

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care scored more than 5 percentage points below the statewide average on the *Global Ratings Measures* domain at 86.0 percent compared with the statewide rate of 91.5 percent. [**Quality**]

Why the weakness exists: The *Global Ratings Measures* domain included *global rating of personal assistance and behavioral health staff*, *global rating of homemakers*, and *global rating of case manager*. While **A&D Home Health Care** scored above the statewide rate for *global rating of case manager*, *global rating of personal assistance and behavioral health staff* was below the statewide rate, and the denominator was too small to calculate for *global rating of homemakers*.

Recommendation: HSAG recommends that **A&D Home Health Care** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Global Ratings Measures* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Global Ratings Measures* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

Weakness #2: A&D Home Health Care scored more than 5 percentage points below the statewide rate on the *Staff Listen and Communicate Well* domain at 88.3 percent compared with the statewide rate of 95.0 percent. [**Quality**]

Why the weakness exists: Of the 11 questions within the *Staff Listen and Communicate Well* domain, five questions had denominators that were too small to calculate a percentage. Additionally, **A&D Home Health Care** scored below the statewide rate for one question, *Staff listen carefully to you*.

Recommendation: HSAG recommends that **A&D Home Health Care** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Staff Listen and Communicate Well* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Staff Listen and Communicate Well* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **A&D Home Health Care**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **A&D Home Health Care** across all EQR activities. The overarching aggregated findings showed that **A&D Home Health Care**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **A&D Home Health Care** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **A&D Home Health Care** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **A&D Home Health Care** should focus its efforts on improving members' experiences with waiver agency staff and providers, as members reported lower satisfaction in the *Global Ratings Measures* and *Staff Listen and Communicate Well* domains. HSAG's assessment of **A&D Home Health Care** also identified continued opportunities for **A&D Home Health Care** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **A&D Home Health Care** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **A&D Home Health Care** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **A&D Home Health Care**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Agency on Aging of Northwest Michigan

Validation of Performance Improvement Projects

Performance Results

Table 3-9 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Agency on Aging of Northwest Michigan** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Agency on Aging of Northwest Michigan** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Agency on Aging of Northwest Michigan**'s QMP reports are also provided in Table 3-9. The results in Table 3-9 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-9—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Reduce the prevalence of abuse and neglect to below the state average [5.1%]	SFY 2019 = 5.5% SFY 2020* = 3.6% SFY 2021† = 4.3% ☒
Actions/Activities/Interventions: According to **Agency on Aging of Northwest Michigan**'s MI Choice Summary of Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; while the goal is to reduce the prevalence of abuse and neglect to below the statewide average, the unintended consequence of underreporting is at the forefront throughout the quality improvement process. Supports Coordination staff are skilled in identifying exploitation, abuse, and neglect. Supports coordinators are also able to offer intervention or alternative options to reduce the participant's risk. **Agency on Aging of Northwest Michigan** staff are required to complete annual training on identifying and reporting abuse. According to **Agency on Aging of Northwest Michigan**'s MI Choice Summary of Quality Management Plan Activities and Outcomes Report FY 2021 dated January 15, 2022, **Agency on Aging of Northwest Michigan** completed the following activities: • **Agency on Aging of Northwest Michigan** supports coordinators have increased the frequency in which monitoring calls are made to participants, due to decrease in home visits and increase in telehealth services. During these monitoring contacts, supports coordinators have been assessing for any signs of abuse or neglect. Given the inability to see many of the members (during the pandemic) and the decrease of in-home services, this assessment is vital to the safety of all members. If any signs of abuse/neglect are identified, critical incident reporting is done per policy and necessary interventions put in place for the safety of the member. Additionally, care providers, caregivers and family have been educated and informed on how to report suspected abuse or neglect. Provider agencies are audited and policies reviewed to ensure abuse and neglect policies are in place.		

QIP Topic	Goal	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Reduce the prevalence of pain with inadequate pain control to below 20%	SFY 2019 = 22% SFY 2020* = 23.8% SFY 2021† = 21.9% ☒

Actions/Activities/Interventions:

According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; supports coordinators are trained to assess for pain and document accordingly. However, in an effort to promote quality, the supports coordinators will complete at least one training on adequate pain control and assessing for pain. Pain will also be a topic of focus for ongoing peer reviews.

According to **Agency on Aging of Northwest Michigan**'s MI Choice Summary of Quality Management Plan Activities and Outcomes Report FY 2021 dated January 15, 2022, **Agency on Aging of Northwest Michigan** completed the following activities:

- **Agency on Aging of Northwest Michigan** integrated efforts from the Consumer Quality Collaborative towards interventions aimed to improve the rate of pain with inadequate pain control for **Agency on Aging of Northwest Michigan** MI Choice members. Interventions included research of pain clinics in the region, support services in the region, and recommended nonpharmacological interventions for pain. Additional resources for statewide and nationwide pain support resources were updated. **Agency on Aging of Northwest Michigan** supports coordinators were educated on available resources and resources shared with families and members who are identified as potentially benefiting from the updated local resources for continued coordination and support.

3. *Prevalence of Falls*	Reduce the prevalence of falls to less than 25%	SFY 2019 = 27.9% SFY 2020* = 29.6% SFY 2021† = 28.0% ☒

Actions/Activities/Interventions:

According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; with the implementation of the MiCapable Model of care, supports coordinators will be able to ensure members are in an appropriate environment and using the most appropriate equipment to promote independence. Safety is and will remain a priority of **Agency on Aging of Northwest Michigan**'s staff and by utilizing the MiCapable Model, safety and independence will impact the rate in which members fall.

According to **Agency on Aging of Northwest Michigan**'s MI Choice Summary of Quality Management Plan Activities and Outcomes Report FY 2021 dated January 15, 2022, **Agency on Aging of Northwest Michigan** completed the following activities:

- **Agency on Aging of Northwest Michigan** incorporated the STEADI [Stopping Early Accidents, Deaths & Injuries] program information and resources to be used with members and family caregivers to aid in the reduction of falls. Home safety checklists were provided to all members at enrollment, which includes tips to reduce safety hazards within the home. Additionally, **Agency on Aging of Northwest Michigan** has provided staff and the Consumer Quality Collaborative education from the local fire department on safety strategies within the home. Fall reduction strategies and resources are available for staff to reference routinely

QIP Topic	Goal	Measurement and Outcome
when communicating with members and/or families and can readily access reliable resources for supporting members and families.		
4. *Prevalence of Any Injuries*	Reduce the prevalence of any injuries to 5% or less	SFY 2019 = 5.8% SFY 2020* = 3.9% SFY 2021† = 6.7% ☒
Actions/Activities/Interventions: According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; implementing the MiCapable model of care could impact the number of factures due to falls or improper equipment. In addition to providing ongoing education to supports coordinators regarding skin integrity and falls, **Agency on Aging of Northwest Michigan**'s Consumer Quality Collaborative will have a guest speaker providing similar education to those in attendance. According to **Agency on Aging of Northwest Michigan**'s MI Choice Summary of Quality Management Plan Activities and Outcomes Report FY 2021 dated January 15, 2022, **Agency on Aging of Northwest Michigan** completed the following activities: • **Agency on Aging of Northwest Michigan** incorporated the STEADI program information and resources to be used with members and family caregivers to aid in the reduction of injuries. Home safety checklists are provided to all members at enrollment, which includes tips to reduce safety hazards within the home. • Additionally, **Agency on Aging of Northwest Michigan** has provided staff and the Consumer Quality Collaborative education from the local fire department on safety strategies within the home. **Agency on Aging of Northwest Michigan** supports coordinators collaborate with skilled care providers, PCPs [primary care providers], and others within the member's health team to implement interventions for members with major skin issues, as well as collaborative efforts to identify and reduce risks of injuries. SFY 2021 identified an increase in rate, potentially related to impacts from the COVID-19 pandemic in regards to social isolation, decrease in care providers, reduction in social gatherings, movement, etc. related to pandemic practices to mitigate spread of disease through increase social interactions outside of the home.		
5. *Prevalence of Dehydration*	Below the state average [2.6%] and the agency's plan is to maintain the current average	SFY 2019 = 1.7% SFY 2020* = 2.5% SFY 2021† = 2.0% ☑
Actions/Activities/Interventions: According to **Agency on Aging of Northwest Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–FY 2021 dated January 15, 2020; quarterly review of quality indicator reports will provide **Agency on Aging of Northwest Michigan** a list of members that will be monitored by the primary supports coordinator. This allows **Agency on Aging of Northwest Michigan**'s supports coordinators to provide those identified members with the support or intervention needed to improve fluid intake and nutrition. According to **Agency on Aging of Northwest Michigan**'s MI Choice Summary of Quality Management Plan Activities and Outcomes Report FY 2021 dated January 15, 2022, **Agency on Aging of Northwest Michigan** completed the following activities:		

QIP Topic	Goal	Measurement and Outcome
• **Agency on Aging of Northwest Michigan** supports coordinators collaborate with skilled care providers, PCPs, and others within the member's health team to implement interventions for members with poor fluid intake.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Performance rate was based off data obtained from April 2020 through September 2020 only.
†Performance rate based off data obtained from April 2021 through September 2021 only.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Agency on Aging of Northwest Michigan met its established goals for the *Prevalence of Dehydration* QIP and reduced the prevalence rate from SFY 2020, suggesting that members experienced less dehydration than the prior year. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Agency on Aging of Northwest Michigan did not clearly identify its goal for two QIPs, *Prevalence of Neglect/Abuse* and *Prevalence of Dehydration*. While the goal was to reduce prevalence to below the statewide average, the statewide average was not provided by **Agency on Aging of Northwest Michigan** in the QMP reports. HSAG's assumption is that the references to the statewide average refer to the SFY 2019 baseline statewide average, which HSAG used to determine if **Agency on Aging of Northwest Michigan** met or did not meet its goals. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: Agency on Aging of Northwest Michigan's goals as identified in the SFY 2020–2021 QMP did not align with the statewide goals established by MDHHS for four of the five QIPs. Additionally, two QIP goals were related to the statewide average; however, **Agency on Aging of Northwest Michigan** did not identify the actual statewide rate. Further, **Agency on Aging of Northwest Michigan**'s SFY 2021 annual report did not include a thorough analysis as to whether it met its established goals.

Recommendation: HSAG recommends that **Agency on Aging of Northwest Michigan** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Agency on Aging of Northwest Michigan** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: Agency on Aging of Northwest Michigan's QIP performance results reported in the SFY 2021 annual report were not comparable to the prevalence rates reported by other waiver agencies. [**Quality**]

Why the weakness exists: The performance rates, numerators, and denominators in the SFY 2021 annual report identified a data time frame of April 2021 to September 2021 for all QIPs. It is unknown why the **Agency on Aging of Northwest Michigan** only reported data for a six-month period for the SFY 2021 annual results.

Recommendation: HSAG recommends that **Agency on Aging of Northwest Michigan**'s annual report include an evaluation of the full year's performance results for each QIP quality indicator.

Weakness #3: The interventions implemented by **Agency on Aging of Northwest Michigan** did not appear to be appropriate, active interventions as prevalence rates for four QIPs did not meet the goals: *Prevalence of Neglect/Abuse*, *Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Falls*, and *Prevalence of Any Injuries*. **Agency on Aging of Northwest Michigan**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP provided a brief summary of planned interventions and the SFY 2021 annual report briefly summarized activities that occurred during SFY 2021. However, the annual report did not support that a causal/barrier analysis was conducted, or an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Agency on Aging of Northwest Michigan** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Agency on Aging of Northwest Michigan** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address the identified barriers to improve outcomes. **Agency on Aging of Northwest Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Agency on Aging of Northwest Michigan** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #4: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Agency on Aging of Northwest Michigan**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and the methodology followed by **Agency on Aging of Northwest Michigan** when implementing its QIPs.

Recommendation: HSAG recommends that **Agency on Aging of Northwest Michigan** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Agency on Aging of Northwest Michigan** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-10. Table 3-10 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Agency on Aging of Northwest Michigan**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Agency on Aging of Northwest Michigan**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-10—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**80.95%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**97.50%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**97.73%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**72.73%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**91.55%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**72.22%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**86.67%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**96.00%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Agency on Aging of Northwest Michigan received a 100 percent performance rating for Performance Measures 4, 8, 16, 21, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included strategies to address health and safety risks; waiver service choice was offered to members; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Agency on Aging of Northwest Michigan performed substantially worse than other waiver agencies on Performance Measure 1, *number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always comply with the service plan completion time frames. [**Quality** and **Timeliness**]

Why the weakness exists: Agency on Aging of Northwest Michigan's performance rate for Performance Measure 1 fell 7.5 percentage points below the statewide rate. Through the CQAR, of the 11 records reviewed, MPHI determined that four of the 11 applicable records did not demonstrate evidence that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements; six of the 11 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member; two of the 11 applicable records did not demonstrate that the PCSP included the provider, type, amount, frequency, and duration of services and supports; three of the 11 applicable records did not demonstrate that the PCSP included outcome evaluations for each goal; and one of the seven applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements or provided the member/guardian with appropriate alternatives.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 1. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff and a review of 15 records. However, **Agency on Aging of Northwest Michigan** also indicated that its compliance goal was 90 percent and that individual staff mentoring and monitoring may result based

on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Agency on Aging of Northwest Michigan performed substantially worse than other waiver agencies on Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always include the goals and preferences desired by the member in the PCSP. [**Quality**]

Why the weakness exists: Agency on Aging of Northwest Michigan's performance rate for Performance Measure 17 fell 18.61 percentage points below the statewide rate. Through the CQAR, of the 11 records reviewed, MPHI determined that six of the 11 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 17. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff and a review of 15 records. However, **Agency on Aging of Northwest Michigan** also indicated that its compliance goal was 90 percent and that individual staff mentoring and monitoring may result based on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: Agency on Aging of Northwest Michigan performed substantially worse than other waiver agencies on Performance Measure 19, *number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always update the PCSP according to MDHHS requirements. [**Quality**]

Why the weakness exists: Agency on Aging of Northwest Michigan's performance rate for Performance Measure 19 fell 16.23 percentage points below the statewide rate. Through the CQAR, of the 11 records reviewed, MPHI determined that four of the 11 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and one of the seven applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff and a review of 15 records. However, **Agency on Aging of Northwest Michigan** also indicated that its compliance goal was 90 percent and that individual staff mentoring and monitoring may result based on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #4: Agency on Aging of Northwest Michigan performed substantially worse than other waiver agencies on Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that services provided were not always consistent with the PCSP. [**Quality** and **Access**]

Why the weakness exists: Agency on Aging of Northwest Michigan's performance rate for Performance Measure 20 fell 6.51 percentage points below the statewide rate. Through the CQAR, of the 11 records reviewed, MPHI determined that two of the four applicable records did not demonstrate evidence that the supports coordinator contacted newly enrolled members to ensure service delivery in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 20. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff and a review of 15 records. However, **Agency on Aging of Northwest Michigan** also indicated that its compliance goal was 90 percent and that individual staff mentoring and monitoring may result based on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-11 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-11 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-11—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	81.82%		**2.00**
Focus 3	Release of Information	81.82%		**3.00**
Focus 4	Status	100.00%		**4.00**
Focus 5	Pre-Planning	97.94%	98.48%	**4.00**
Focus 6	Assessment	93.94%	100.00%	**4.00**
Focus 7	Medication Record	70.00%	100.00%	**2.06**
Focus 8	Person-Centered Service Planning	87.12%	100.00%	**4.00**
Focus 9	MI Choice Services	96.77%	100.00%	**4.00**
Focus 10	Linking and Coordinating	90.00%	94.44%	**4.00**
Focus 11	Follow-Up and Monitoring	76.92%	95.83%	**2.71**
Focus 12	Service Provider	50.00%		**1.00**
Focus 13	Contingency Plan	96.55%	88.89%	**4.00**
Focus 14	Critical Incidents	25.00%	100.00%	**2.06**
Focus 15	Adverse Benefit Determination	71.43%		**2.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**89.49%**	**98.75%**	**3.62**

	Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Agency on Aging of Northwest Michigan achieved a substantial compliance rating in 10 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Agency on Aging of Northwest Michigan did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid Freedom of Choice (FOC) form is on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the 11 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff and a review of 15 records. However, **Agency on Aging of Northwest Michigan** also indicated that its compliance goal was 90 percent and that individual staff mentoring and monitoring may result based on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated percentage of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Agency on Aging of Northwest Michigan did not consistently follow all Medication Record requirements—specifically, ensuring the medication record included all prescribed medications; ensuring that the medication record included the name, prescribing physician name, purpose, strength/dose, frequency, and route for all medications; ensuring that the record identified the pharmacy/pharmacies the member used; and ensuring that the medication record identified the member's known pharmaceutical, environmental, and food allergies or indicated that the member had no known allergies. If a member's medication record does not include all prescribed medications and information related to medication and the member's allergies, medication errors can occur, such as adverse drug-to-drug interactions or allergic reactions. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that five of the 11 applicable medication records did not include all prescribed medications; four of the11 medication records did not include the prescribing physician name, purpose, strength/dose, frequency, and route for all medications; one of the 11 applicable medication records did not identify the pharmacy/pharmacies the member used; and eight of the 11 applicable medication records did not include the member's known allergies.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff and a review of 15 records. However, **Agency on Aging of Northwest Michigan** also indicated that its compliance goal was 90 percent and that individual staff mentoring and monitoring may result based on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: Agency on Aging of Northwest Michigan did not consistently follow all Service Provider requirements; specifically, ensuring that if the member experienced a health and welfare issue, the service provider contacted the waiver agent and/or supports coordinator to inform them of the issue. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the four applicable records did not demonstrate evidence that the service provider contacted the waiver agent or the supports coordinator to inform them of a member's health and welfare issue.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff and a review of 15 records. However, **Agency on Aging of Northwest Michigan** also indicated that its compliance goal was 90 percent and that individual staff mentoring and monitoring may result based on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #4: Agency on Aging of Northwest Michigan did not consistently follow all Critical Incidents requirements—specifically, addressing the incident(s) with the member/guardian; taking appropriate action and discussing methods to prevent further occurrence with the member/guardian; and entering, reporting, and providing updates to the critical incident portal in accordance with MDHHS policy and contract requirements. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that the one applicable record did not demonstrate evidence that the service coordinator addressed the incident with the member/guardian; took appropriate action and discussed methods to prevent further occurrence with the member/guardian; or entered, reported, and provided updates to the critical incident portal in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff and a review of 15 records. However, **Agency on Aging of Northwest Michigan** also indicated that its compliance goal was 90 percent and that individual staff mentoring and monitoring may result based on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #5: Agency on Aging of Northwest Michigan did not consistently follow all Adverse Benefit Determination requirements; specifically, providing the member/guardian with the required Adverse Action Notice (AAN)/Adverse Benefit Determination (ABD) in accordance with MDHHS policy and contract requirements, and ensuring that the AAN/ABD was complete and accurate. Complete and accurate ABD notices are important to ensure members understand their appeal rights and the process to request an appeal. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the four applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD and one of the three applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate.

Recommendation: MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, education and training for all staff, a review of 15 records, and internal monitoring until compliance of 80 percent or more is achieved. However, **Agency on Aging of Northwest Michigan** also indicated that individual staff mentoring and monitoring may result based on the review findings. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **Agency on Aging of Northwest Michigan** ensure mechanisms are in place that verify timely completion of the PCSP as required.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-12 presents **Agency on Aging of Northwest Michigan**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-12—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	95.9%	91.5%
Recommendation Measures	96.4%	92.6%
Staff are Reliable and Helpful	95.3%	91.9%
Staff Listen and Communicate Well	96.6%	95.0%
Case Manager is Helpful	91.0%	95.2%
Choosing the Services that Matter to You	93.0%	92.7%
Transportation to Medical Appointments	95.0%	92.5%
Personal Safety and Respect	99.1%	97.2%
Planning Your Time and Activities	74.4%	75.4%
Met Need	95.7%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Agency on Aging of Northwest Michigan achieved scores higher than the statewide results in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Met Need*, and *Physical Safety Measure* domains, indicating that **Agency on Aging of Northwest Michigan** provides services in a manner that meets or exceeds members' expectations in many domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Agency on Aging of Northwest Michigan did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **Agency on Aging of Northwest Michigan** scored below the statewide average on the *Case Manager is Helpful* and *Planning Your Time and Activities* domains; therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction scores within these domains, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Case Manager is Helpful* and *Planning Your Time and Activities* domains, evaluate the effectiveness of the interventions regularly, and make changes as necessary. It should be noted that the *Planning Your Time and Activities* domain received the lowest statewide score across all domains. The CAHPS survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. However, the waiver agency should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agency should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.

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

To identify strengths and weaknesses and draw conclusions for **Agency on Aging of Northwest Michigan**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Agency on Aging of Northwest Michigan** across all EQR activities. The overarching aggregated findings showed that **Agency on Aging of Northwest Michigan**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Agency on Aging of Northwest Michigan** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Agency on Aging of Northwest Michigan** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Agency on Aging of Northwest Michigan** should focus its efforts on improving members' experiences with waiver agency staff and case manager effectiveness, as members reported lower satisfaction in the *Case Manager is Helpful* and *Planning Your Time and Activities* domains. HSAG's assessment of **Agency on Aging of Northwest Michigan** also identified continued opportunities for **Agency on Aging of Northwest Michigan** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Agency on Aging of Northwest Michigan** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Agency on Aging of Northwest Michigan** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Agency on Aging of Northwest Michigan**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Area Agency on Aging 1B

Validation of Performance Improvement Projects

Performance Results

Table 3-13 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Area Agency on Aging 1B** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Area Agency on Aging 1B** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Area Agency on Aging 1B**'s QMP reports are also provided in Table 3-13. The results in Table 3-13 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-13—QIP Results

QIP Topic	Goal*	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Decrease the percentage of participants reporting being neglected/abused, have poor hygiene, are fearful of family member, or have been restrained to be equal to or below the statewide goal of 3.0%	SFY 2019 = 24.75% SFY 2020 = 28.49% SFY 2021 = 30.16% ☒

Actions/Activities/Interventions:

According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation.

According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcome Report Fiscal Year 2021 dated January 14, 2022, **Area Agency on Aging 1B** has taken the following actions:

- Monitors a separate WellSky (Harmony) report that identifies members reporting neglect/abuse, poor hygiene, are fearful of a family member, or have been restrained. The report can be sorted by the iHC question(s) that triggered the individual to the report and provides a more streamlined process for root cause analysis.
- Identified the need for additional training to ensure alternatives are being offered and tried prior to more restrictive measures.
- Conducted peer reviews at least bi-annually with supports coordinators and new enrollments are thoroughly audited (based on a tiered schedule) by the quality department to ensure any members reporting neglect/abuse, poor hygiene, are fearful of a family member, or have been restrained receive appropriate follow-up and person-centered care planning to address identified issues.
- At least 10% of enrolled members are audited, annually. At least 13 charts are audited per month utilizing the full or targeted CQAR Record Review protocol (based on SFY 2020 CQAR Corrective Action Plan) and added to the CQAR portal for review.

QIP Topic	Goal*	Measurement and Outcome
• In the development phase of adding additional questions to the iHC assessment to ensure sufficient information is collected regarding restraints, including, type restraint, if the restraint is prescribed and the member's choice, education, and alternatives provided. This will assist the supports coordinator with suggesting the most appropriate interventions for the member to address safety concerns related to restraints. • Training/discussions with all clinical staff surrounding CCIRs [Critical Complaints and Incident Reports]; neglect, abuse, exploitation; residential settings; person-centered planning; and the iHC (with a specific focus on restraints). Training completed in quarter 1, 2, 3, and 4 of FY21. • Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching with supports coordinators. • The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics. • Consumer Advisory Team [CAT] meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals.		
2. *Prevalence of Pain With Inadequate Pain Control*	Decrease the percentage of participants that report pain with inadequate pain control to be equal to or below the statewide goal of 20%	SFY 2019 = 30.75% SFY 2020 = 29.96% SFY 2021 = 30.35% ☒
Actions/Activities/Interventions: According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation. According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcome Report Fiscal Year 2021 dated January 14, 2022, **Area Agency on Aging 1B** has taken the following actions: • Monitors a separate WellSky (Harmony) report that identifies members in pain with inadequate pain control and breaks down the reason why the individual pulled to the report. • Identified need for additional training to improve accuracy in coding of the iHC. Training completed with all program staff in quarter 1 of SFY 2021. • Conducted peer reviews at least bi-annually with supports coordinators and new enrollments are thoroughly audited (based on a tiered schedule) by the quality department to ensure pain issues receive appropriate follow-up and person-centered care planning to address, if necessary. • At least 10% of enrolled members are audited, annually. At least 13 charts are audited per month utilizing the full or targeted CQAR Record Review protocol (based on SFY 2020 CQAR Corrective Action Plan) and added to the CQAR portal for review. • In the development phase of adding additional questions to the iHC assessment to ensure sufficient information is collected regarding pain, including, baseline pain, description of pain, location, physician involvement (regarding unaddressed and breakthrough pain), current pain control methods. This will assist the supports coordinator with suggesting the most appropriate interventions for the member to address their pain.		

QIP Topic	Goal*	Measurement and Outcome
• Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching with supports coordinators. • The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics. • CAT meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals.		
3. *Prevalence of Falls*	Decrease the percentage of participants that report a fall within the last 90 days, post initial assessment to be at or below the statewide goal of 23%	SFY 2019 = 26.7% SFY 2020 = 18.16% SFY 2021 = 16.90% ☑

Actions/Activities/Interventions:

According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation.

According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcome Report Fiscal Year 2021 dated January 14, 2022, **Area Agency on Aging 1B** has taken the following actions:

- Identified need for additional training to improve accuracy in coding of the iHC. Training completed with all program staff in quarter 1 of SFY 2021.
- Peer Reviews are conducted at least bi-annually with supports coordinators and new enrollments are thoroughly audited (based on a tiered schedule) by the quality department to ensure injury issues receive appropriate follow-up and person-centered care planning to address, if necessary.
- At least 10% of enrolled members are audited, annually. At least 13 charts are audited per month utilizing the full or targeted CQAR Record Review protocol (based on SFY 2020 CQAR Corrective Action Plan) and added to the CQAR portal for review.
- In the development phase of adding additional questions to the iHC assessment to ensure sufficient information is collected regarding all falls; including, reason for fall, support provided (education, referrals, community resources) and interventions (DME [durable medical equipment], MI Choice Services, etc.). This will assist the supports coordinator with suggesting the most appropriate interventions for the member to address their fall risk.
- In the development phase of a fall risk report, that will identify members at high risk for falls based on data extrapolated from the iHC.
- Upon the recommendation of the CAT, [the waiver agency] has added the National Council on Aging (NCOA) Falls Prevention Fact Sheet to all enrollment folders and provide a copy to existing members at least annually.
- Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching with supports coordinators.
- The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics.

QIP Topic	Goal*	Measurement and Outcome
• CAT meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals. During our April 2021 CAT meeting, the members received a presentation regarding fall prevention and all members were provided the handouts from the May QMC [Quality Management Committee] meeting that also had a fall prevention training.		
4. *Prevalence of Any Injuries*	Decrease the percentage of participants that report an injury to be at or below the statewide goal of 3%	SFY 2019 = 5.9% SFY 2020 = 2.20% SFY 2021 = 2.92% ☑

Actions/Activities/Interventions:

According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation.

According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcome Report Fiscal Year 2021 dated January 14, 2022, **Area Agency on Aging 1B** has taken the following actions:

- Monitors a separate WellSky report that identifies members with fractures or major skin problems, excluding current pressure or stasis ulcers.
- Identified need for additional training to improve accuracy in coding on iHC.
- Conducted peer reviews at least bi-annually with supports coordinators and new enrollments are thoroughly audited (based on a tiered schedule) by the quality department to ensure injury issues receive appropriate follow-up and person-centered care planning to address, if necessary.
- At least 10% of enrolled members are audited, annually. At least 13 charts are audited per month utilizing the full or targeted CQAR Record Review protocol (based on SFY 2020 CQAR Corrective Action Plan) and added to the CQAR portal for review.
- In the development phase of adding additional questions to the iHC assessment to ensure sufficient information is collected regarding all fractures; including, location of fracture and how the injury was sustained. This will assist the supports coordinator with suggesting the most appropriate interventions for the member.
- In quarter 1, training/discussions surrounding injuries and appropriate coding of the iHC, with a special focus on coding of major skin problems vs. [versus] pressure sores and clear documentation of the issue within the summary section was completed.
- Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching provided to supports coordinators.
- The Quality Indicator workgroup and the MI Choice Quality Assurance Team reviews quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics.
- CAT meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals.

QIP Topic	Goal*	Measurement and Outcome
5. *Prevalence of Dehydration*	Decrease the percentage of participants that report dehydration to be at or below the statewide goal of 1.5%	SFY 2019 = 5% SFY 2020 = 2.64% SFY 2021 = 2.60% ☒

Actions/Activities/Interventions:

According to **Area Agency on Aging 1B**'s MI Choice Quality Management Plan Fiscal Years 2020–2021 dated January 6, 2020; **Area Agency on Aging 1B**'s Clinical and Quality departments work together to determine improvement project strategies which are communicated to staff through training and implementation.

According to **Area Agency on Aging 1B**'s MI Choice Summary of Quality Management Plan (QMP) Activities and Outcome Report Fiscal Year 2021 dated January 14, 2022, **Area Agency on Aging 1B** has taken the following actions:

- Utilizes a separate WellSky (Harmony) report that monitors limited fluid intake and members currently receiving dialysis, to assist with root cause analysis.
- In quarters 1, 3 and 4, additional training was provided to all supports coordinators related to dehydration, resulted in 83.78% (31/37) of the unique members at risk for dehydration had received additional education and the issue addressed on their PCSP. Compared to SFY 2020 (41.94% (13/31)), this is an improvement in addressing dehydration risk by 99.80%.
- Conducted peer reviews at least bi-annually with supports coordinators and new enrollments are thoroughly audited (based on a tiered schedule) by the quality department to ensure dehydration issues receive appropriate follow-up and person-centered care planning to address, if necessary.
- At least 10% of enrolled members are audited, annually. At least 13 charts are audited per month utilizing the full or targeted CQAR Record Review protocol (based on SFY 2020 CQAR Corrective Action Plan) and added to the CQAR portal for review.
- In the development phase of adding additional questions to the iHC assessment to ensure sufficient information is collected regarding dehydration and educational materials are available to be reviewed/provided to the member/ally in real-time.
- Training/discussions surrounding internal and external audit findings and monthly one-on-one coaching with supports coordinators is provided.
- The Quality Indicator workgroup and the MI Choice Quality Assurance Team review quality indicator findings and focus on process improvement activities that concentrate on state-wide quality goals and internal metrics.
- CAT meets at least quarterly to discuss quality metrics and ways to address state-wide quality goals.

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Goals in the QMP differed from the goals in the annual report. As the goals identified in the annual report aligned with the statewide goals, HSAG used these goals to determine performance.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Area Agency on Aging 1B met its established goal for the *Prevalence of Falls* QIP, suggesting that **Area Agency on Aging 1B** implemented interventions that had a positive effect on prevalence rates, and members experienced fewer falls than the prior year. Of note, although **Area Agency on Aging 1B** also met its established goal for the *Prevalence of Any Injuries* QIP, there was a higher prevalence of injuries from the prior year. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1B's SFY 2020–2021 QMP and SFY 2021 annual report included conflicting goals, which made it difficult to determine the actual goal established by **Area Agency on Aging 1B** when initiating the QIPs. This was also identified as a weakness in the SFY 2020 EQR technical report. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: Area Agency on Aging 1B's SFY 2020–2021 QMP identified different goals for each QIP than the SFY 2021 annual report (e.g., the QMP indicated the percentage goal for the *Prevalence of Neglect/Abuse* QIP as 4.6 percent; however, the annual report indicated the goal for this QIP as 3 percent). The SFY 2021 goal within the annual report aligned with MDHHS' established statewide goal. However, the goals identified in the SFY 2020–2021 QMP were to reduce the quality indicators to at or below the statewide average as opposed to MDHHS' established statewide goal.

Recommendation: HSAG recommends that **Area Agency on Aging 1B** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Area Agency on Aging 1B** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: The interventions implemented by **Area Agency on Aging 1B** did not appear to be appropriate, active interventions as **Area Agency on Aging 1B** did not meet its goals for the *Prevalence of Neglect/Abuse*, *Prevalence of Pain With Inadequate Pain Control*, and *Prevalence of Dehydration* QIPs, and the prevalence rates increased for the *Prevalence of Neglect/Abuse, Prevalence of Pain With Inadequate Pain Control, and Prevalence of Any Injuries* QIPs. **Area Agency on Aging 1B**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. Additionally, a review of prevalence rates for neglect/abuse for all waiver agencies demonstrated **Area Agency on Aging 1B** as an outlier with prevalence significantly higher than all other waiver agencies, suggesting that **Area Agency on Aging 1B**'s members are experiencing more incidents of abuse and neglect or the prevalence rate is not being appropriately calculated by **Area Agency on Aging 1B**. [**Quality**]

Why the weakness exists: While the SFY 2021 annual report included an assessment of the data, identified the data to support the QIPs, actions taken by **Area Agency on Aging 1B**, and any significant trends of findings, the root cause analysis appeared to be primarily focused on whether assessments were coded correctly and not a causal/barrier analysis or evaluation for each intervention to determine its effectiveness and ensure each intervention is logically linked to any identified barriers.

Recommendation: HSAG recommends that **Area Agency on Aging 1B** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Area Agency on Aging 1B** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Area Agency on Aging 1B** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging 1B** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: While more robust than reported by most other waiver agencies, details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were limited. **Area Agency on Aging 1B**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included minimal details on the design developed and methodology followed by **Area Agency on Aging 1B** when implementing its QIPs.

Recommendation: HSAG recommends that **Area Agency on Aging 1B** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Area Agency on Aging 1B** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-14. Table 3-14 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Area Agency on Aging 1B**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Area Agency on Aging 1B**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-14—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**92.63%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**97.19%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**98.23%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**96.43%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**97.39%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**77.55%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**94.87%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**89.29%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**93.06%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Area Agency on Aging 1B received a 100 percent performance rating for Performance Measures 4, 8, 16, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included strategies to address health and safety risks; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1B performed substantially worse than other waiver agencies on Performance Measure 19, *number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always update the PCSP according to MDHHS requirements. [**Quality** and **Access**]

Why the weakness exists: Area Agency on Aging 1B's performance rate for Performance Measure 19 fell 10.90 percentage points below the statewide rate. Through the CQAR, of the 28 records reviewed, MPHI determined that three of the 28 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and eight of the 21 applicable records did not demonstrate evidence that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements or provided the member/guardian with appropriate alternatives.

Recommendation: MDHHS required **Area Agency on Aging 1B** to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **Area Agency on Aging 1B**'s CAP included, but was not limited to, education, training, and corrective action for individual supports coordinators whose charts were reviewed and found to be non-evident during the record review; and 10 chart audits monthly. Additionally, **Area Agency on Aging 1B**'s CAP indicated that if a compliance score of 90 percent is not achieved, additional training will be provided along with progressive disciplinary action, if necessary. However, HSAG recommends that **Area Agency on Aging 1B** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Area Agency on Aging 1B performed substantially worse than other waiver agencies on Performance Measure 21, *number and percent of waiver participants whose records indicate choice was offered among waiver services*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that members were not always offered a choice among waiver services. [**Quality**]

Why the weakness exists: Area Agency on Aging 1B's performance rate for Performance Measure 21 fell 5.72 percentage points below the statewide rate. Through the CQAR, of the 28 records reviewed, MPHI determined that three of the 28 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian a choice of appropriate MI Choice Waiver Program services.

Recommendation: MDHHS required **Area Agency on Aging 1B** to submit a CAP to remediate the deficiencies associated with Performance Measure 21. **Area Agency on Aging 1B**'s CAP included, but was not limited to, education, training, and corrective action for individual staff members whose charts were reviewed and found to be non-evident during the record review; and 10 chart audits monthly. Additionally, **Area Agency on Aging 1B**'s CAP indicated that if a compliance score of 90 percent is not achieved, additional training will be provided along with progressive disciplinary

action, if necessary. However, HSAG recommends that **Area Agency on Aging 1B** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-15 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-15 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-15—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	92.86%		**4.00**
Focus 3	Release of Information	89.29%		**4.00**
Focus 4	Status	97.00%		**4.00**
Focus 5	Pre-Planning	99.21%	100.00%	**4.00**
Focus 6	Assessment	97.22%	100.00%	**4.00**
Focus 7	Medication Record	94.12%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	97.06%	100.00%	**4.00**
Focus 9	MI Choice Services	91.93%	100.00%	**4.00**
Focus 10	Linking and Coordinating	95.59%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	80.60%	100.00%	**3.33**
Focus 12	Service Provider	85.00%		**4.00**
Focus 13	Contingency Plan	93.10%	100.00%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 14	Critical Incidents	82.14%	100.00%	**2.67**
Focus 15	Adverse Benefit Determination	80.65%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**95.06%**	**100.00%**	**3.91**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Fourteen home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the area of Critical Incidents as the overall rating for this program area was less than full compliance. [**Quality**]

Strength #2: Area Agency on Aging 1B achieved a substantial compliance rating in 16 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical

record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1B did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the program areas under review, **Area Agency on Aging 1B** received less than a substantial compliance rating in one program standard, indicating there are opportunities for improvement related to Critical Incidents. MDHHS required a CAP for the noted areas of deficiency. **Area Agency on Aging 1B**'s CAP included, but was not limited to, education, training, and corrective action for individual supports coordinators whose charts were reviewed and found to be non-evident during the record review; and 10 chart audits monthly. Additionally, **Area Agency on Aging 1B**'s CAP indicated that if a compliance score of 90 percent is not achieved, additional training will be provided along with progressive disciplinary action, if necessary. However, HSAG recommends that **Area Agency on Aging 1B** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-16 presents **Area Agency on Aging 1B**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-16—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	86.6%	91.5%
Recommendation Measures	93.9%	92.6%
Staff are Reliable and Helpful	92.1%	91.9%
Staff Listen and Communicate Well	98.0%	95.0%
Case Manager is Helpful	99.0%	95.2%
Choosing the Services that Matter to You	93.8%	92.7%
Transportation to Medical Appointments	92.0%	92.5%
Personal Safety and Respect	98.3%	97.2%
Planning Your Time and Activities	78.6%	75.4%
Met Need	95.2%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Area Agency on Aging 1B achieved scores higher than the statewide results in the *Recommendation Measures*, *Staff are helpful and reliable*, *Staff Listen and Communicate Well*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Physical Safety Measure* domains, indicating that **Area Agency on Aging 1B** provides services in a manner that meets or exceeds members' expectations in many domains. It should be noted that while **Area Agency on Aging 1B** achieved a higher score than the statewide results for *Planning Your Time and Activities*, this domain received the lowest statewide score across all domains. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1B did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality** and **Access**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **Area Agency on Aging 1B** scored below the statewide average on the *Global Ratings Measures*, *Transportation to Medical Appointments*, and *Met Need* domains. Therefore, HSAG recommends that **Area Agency on Aging 1B** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Global Ratings Measures*, *Transportation to Medical Appointments*, and *Met Need* domains; conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Global Ratings Measures*, *Transportation to Medical Appointments*, and *Met Need* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Area Agency on Aging 1B**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Area Agency on Aging 1B** across all EQR activities. The overarching aggregated findings showed that **Area Agency on Aging 1B**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Area Agency on Aging 1B** is focusing strategies on **quality** of care by

implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Area Agency on Aging 1B** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Area Agency on Aging 1B** should focus its efforts on improving members' experiences with waiver agency staff, access to transportation, provider effectiveness, and some waiver services, as members reported lower satisfaction in the *Global Ratings Measures*, *Transportation to Medical Appointments*, and *Met Need* domains. HSAG's assessment of **Area Agency on Aging 1B** also identified continued opportunities for **Area Agency on Aging 1B** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Area Agency on Aging 1B** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Area Agency on Aging 1B** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Area Agency on Aging 1B**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Area Agency on Aging of Western Michigan

Validation of Performance Improvement Projects

Performance Results

Table 3-17 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Area Agency on Aging of Western Michigan** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Area Agency on Aging of Western Michigan** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Area Agency on Aging of Western Michigan**'s QMP reports are also provided in Table 3-17. The results in Table 3-17 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-17—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Review persons triggered for this QI and maintain prevalence of 2.4% by 9/30/20[1]	SFY 2019 = 2.4% SFY 2020* = 2.4% [2.26%] SFY 2021* = 0.03% [3.50%] ☒
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020; QA [quality assurance] will be examining CI's [critical incidents] attributed to neglect and abuse and look for trends. Discuss with CM [care management] Advisory Committee/staff for ideas/approaches to mitigate risk of these behaviors. Some assessment answers that potentially trigger for neglect/abuse may not be attributed to these issues at all. **Area Agency on Aging of Western Michigan**'s Outcomes and Activities Summary QM Report FY 2021 dated January 19, 2022, indicated that Q1 of SFY 2021 there were 0 Critical Incidents reported related to neglect/abuse, which likely contributed to the significant decrease in rate. QA will continue to record and identify trends within Critical Incidents attributed to neglect and abuse.		
2. *Prevalence of Pain With Inadequate Pain Control*	10% reduction in prevalence for appropriate persons, or prevalence of 22% by 9/30/20[1]	SFY 2019 = 24.7% SFY 2020* = 25% [26.47%] SFY 2021 = 22% ☑
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020; **Area Agency on Aging of Western Michigan** will look at Pain Supplement information for additional insight and ideas for approaches – and confirm correct responses for sample of 5% of triggered records to questions related to pain on the assessment to confirm accuracy of QI percentage.		

QIP Topic	Goal	Measurement and Outcome
Area Agency on Aging of Western Michigan's Outcomes and Activities Summary QM Report FY 2021 dated January 19, 2022, indicated that during SFY 2021 Care Management leadership provided training to supports coordinators regarding coding for pain. In addition, **Area Agency on Aging of Western Michigan** Ad Hoc hospitalization Committee reviews Emergency Room visits for Waiver members, often reporting pain as a primary complaint. Cases are reviewed for possible interventions or changes.		
3. *Prevalence of Falls*	10% reduction in prevalence for appropriate persons, or prevalence of 23% by 9/30/20[1]	SFY 2019 = 25.4% SFY 2020* = 30% [30.86%] SFY 2021 = 29% ☒
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020, **Area Agency on Aging of Western Michigan** is examining all assessment questions pertinent to fall risk in an attempt to pull this data and identify not just members that have fallen but may be at risk for falls. An independent fall risk tool was also reviewed, but cannot aggregate this info [information] in COMPASS [information system] to pull data. Education materials and other community resources are being identified. A protocol will be created for addressing falls and fall risk. **Area Agency on Aging of Western Michigan**'s Outcomes and Activities Summary QM Report FY 2021 dated January 19, 2022, indicated that in August 2021, supports coordinators completed Relias course training "Understanding Falls in the Home". In addition, **Area Agency on Aging of Western Michigan**\Ad Hoc hospitalization Committee reviews Emergency Room visits for Waiver members, where unplanned care transitions and trends are being reviewed.		
4. *Prevalence of Any Injuries*	10% reduction in prevalence for appropriate persons, or prevalence of 5% by 9/30/20[1]	SFY 2019 = 5.4% SFY 2020 = 6%* [4.91%] SFY 2021 = 6% ☒
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Summary of Quality Management Plan (QMP) FY 2020–2021 dated January 15, 2020, **Area Agency on Aging of Western Michigan** will assess how closely these numbers are correlated to falls–and whether interventions that address fall risk will improve prevalence of injuries. **Area Agency on Aging of Western Michigan**'s Outcomes and Activities Summary QM Report FY 2021 dated January 19, 2022, indicated that in August 2021, supports coordinators completed Relias course training "Understanding Falls in the Home". In addition, **Area Agency on Aging of Western Michigan**\Ad Hoc hospitalization Committee reviews Emergency Room visits for Waiver members, where unplanned care transitions and trends are being reviewed.		

QIP Topic	Goal	Measurement and Outcome
5. *Prevalence of Dehydration*	10% reduction in prevalence for appropriate persons, or prevalence of 2.2% by 9/30/20[1]	SFY 2019 = 2.5% SFY 2020* = 2.5% [2.83%] SFY 2021 = 3% ☒
Actions/Activities/Interventions: According to **Area Agency on Aging of Western Michigan**'s MI Choice Quality Management Plan Activities and Outcomes Report FY 2020–2021 dated January 15, 2020, **Area Agency on Aging of Western Michigan** has two handouts related to dehydration that will be added to the member handbook and reviewed individually per CM [care manager] for all appropriate members that trigger for this QI [quality indicator]. If members wish to add increasing their fluid intake to prevent the risk of dehydration to their PCSP, this issue will be added and their goal related to this issue reviewed at in-person contacts. **Area Agency on Aging of Western Michigan**'s Outcomes and Activities Summary QM Report FY 2021 dated January 19, 2022, indicated that this QI denominator does not filter out end stage persons or persons that have a physician-ordered fluid restriction. Care Management training supports coordinators in March 2021 regarding fluid intake/dehydration coding.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*The SFY 2021 annual report included a performance rate that did not align with the performance rate calculated by HSAG based on the reported numerator and denominator. The HSAG calculated performance rate (indicated in []), when applicable, was used to determine the outcome.
[1]The goal timeframe did not align with SFY 2021 (October 1, 2020, through September 30, 2021) and documentation provided for this EQR did not support new goals were developed by the waiver agency.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Area Agency on Aging of Western Michigan met its established goals for the *Prevalence of Pain With Inadequate Pain Control* QIP, suggesting that **Area Agency on Aging of Western Michigan** implemented interventions that had a positive effect on prevalence rates, and members experienced less pain than the prior year. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There was a disconnect between the QMP reports as the goals established by **Area Agency on Aging of Western Michigan** in the SFY 2020–2021 QMP were not addressed or analyzed in the SFY 2021 annual report. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: **Area Agency on Aging of Western Michigan**'s goals as identified in the SFY 2020–2021 QMP did not align with the statewide goals established by MDHHS. While two QIP goals were more stringent than the MDHHS-established goals and therefore acceptable, **Area Agency on Aging of Western Michigan** established goals that did not align with the intent of the MDHHS statewide goals for three QIPs (e.g., although the statewide goal for the *Prevalence of Dehydration* QIP was 1.5 percent, the waiver agency indicated a goal of 2.2 percent). Additionally, **Area Agency on Aging of Western Michigan**'s SFY 2021 annual report compared its SFY 2021 percentage rates against the SFY 2021 statewide percentage rates; however, it did not include an analysis of whether **Area Agency on Aging of Western Michigan** met its SFY 2021 goals as established in the SFY 2020–2021 QMP. Further, the goals identified in the SFY 2020–2021 QMP had a target date of September 30, 2020, and did not appear to apply to SFY 2021, which led to confusion.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Area Agency on Aging of Western Michigan** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: The interventions implemented by **Area Agency on Aging of Western Michigan** to meet performance goals were unclear. Additionally, the rates for the *Prevalence of Neglect/Abuse, Prevalence of Any Injuries,* and *Prevalence of Dehydration* QIPs increased from SFY 2020, indicating that the interventions implemented by **Area Agency on Aging of Western Michigan** were not appropriate, active interventions. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **Area Agency on Aging of Western Michigan**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. [**Quality**]

Why the weakness exists: **Area Agency on Aging of Western Michigan**'s SFY 2020–2021 QMP listed high-level planned activities, and the SFY 2021 annual report primarily focused on high-level activities conducted during the year and high-level activities to be conducted in the future. The SFY 2021 annual report did not clearly identify the interventions implemented during SFY 2021 for all QIPs, or support that a causal/barrier analysis was conducted and that an evaluation occurred for

each intervention to determine its effectiveness and ensure each intervention is logically linked to any identified barriers.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Area Agency on Aging of Western Michigan** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Area Agency on Aging of Western Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging of Western Michigan** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Area Agency on Aging of Western Michigan**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and methodology followed by **Area Agency on Aging of Western Michigan** when implementing its QIPs.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Area Agency on Aging of Western Michigan** in a methodologically sound manner.

Weakness #4: The results submitted to MDHHS via **Area Agency on Aging of Western Michigan**'s SFY 2021 annual report for *Prevalence of Neglect/Abuse* did not appear to be accurate, and **Area Agency on Aging of Western Michigan**'s performance appeared better than reported and indicated that the agency met the goal when it did not. [**Quality**]

Why the weakness exists: The prevalence rate provided by **Area Agency on Aging of Western Michigan** in the SFY 2021 annual report did not correlate to the identified numerators and denominators. The prevalence rate provided by **Area Agency on Aging of Western Michigan** for the *Prevalence of Neglect/Abuse* QIP was 0.03 percent; however, HSAG's calculation of the numerator and denominator (28/801) equals 3.50 percent.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** reevaluate the data reported to MDHHS in the SFY 2021 annual report. Additionally, **Area Agency**

on Aging of Western Michigan should enhance internal validation processes to ensure data reported to MDHHS are valid and accurate.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-18. Table 3-18 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Area Agency on Aging of Western Michigan**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Area Agency on Aging of Western Michigan**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-18—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**95.09%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**98.48%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**98.31%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**91.38%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**97.07%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**96.00%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**93.02%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**86.21%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**100.00%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Area Agency on Aging of Western Michigan received a 100 percent performance rating for Performance Measures 4, 8, 16, 22, 24, 30, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included strategies to address health and safety risks; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; members had an individualized contingency plan for emergencies; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging of Western Michigan performed substantially worse than other waiver agencies on Performance Measure 21, *number and percent of waiver participants whose records indicate choice was offered among waiver services*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that members were not always offered a choice among waiver services. [**Quality**]

Why the weakness exists: Area Agency on Aging of Western Michigan's performance rate for Performance Measure 21 fell 8.80 percentage points below the statewide rate. Through the CQAR, of the 29 records reviewed, MPHI determined that four of the 29 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian a choice of appropriate MI Choice Waiver Program services.

Recommendation: MDHHS required **Area Agency on Aging of Western Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 21. **Area Agency on Aging of Western Michigan**'s CAP included, but was not limited to, additional staff training and 11 chart reviews per month. However, while **Area Agency on Aging of Western Michigan** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Area Agency on Aging of Western Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-19 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-19 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-19—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	93.10%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 3	Release of Information	93.10%		**4.00**
Focus 4	Status	98.04%		**4.00**
Focus 5	Pre-Planning	98.84%	100.00%	**4.00**
Focus 6	Assessment	97.68%	100.00%	**4.00**
Focus 7	Medication Record	84.08%	98.67%	**3.34**
Focus 8	Person-Centered Service Planning	97.42%	100.00%	**4.00**
Focus 9	MI Choice Services	95.18%	100.00%	**4.00**
Focus 10	Linking and Coordinating	94.29%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	88.89%	100.00%	**4.00**
Focus 12	Service Provider	89.47%		**4.00**
Focus 13	Contingency Plan	100.00%	100.00%	**4.00**
Focus 14	Critical Incidents	50.00%	100.00%	**2.02**
Focus 15	Adverse Benefit Determination	80.56%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**95.31%**	**99.87%**	**3.86**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Area Agency on Aging of Western Michigan achieved a substantial compliance rating in 16 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging of Western Michigan did not consistently follow all Critical Incidents requirements—specifically, addressing the incident(s) with the member/guardian; taking appropriate action and discussing methods to prevent further occurrence with the member/guardian; and entering, reporting, and providing updates to the critical incident portal in accordance with MDHHS policy and contract requirements. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the two applicable records did not demonstrate evidence that the service coordinator addressed the incident with the member/guardian; one of the two applicable records did not demonstrate evidence that the service coordinator took appropriate action and discussed methods to prevent further occurrence with the member/guardian; and both of the two applicable records did not demonstrate evidence that the service coordinator entered, reported, and provided updates to the critical incident portal in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS required **Area Agency on Aging of Western Michigan** to submit a CAP to remediate the deficiencies. **Area Agency on Aging of Western Michigan**'s CAP included, but was not limited to, additional staff training and 11 chart reviews per month. However, while **Area Agency on Aging of Western Michigan** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Area Agency on Aging of Western Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-20 presents **Area Agency on Aging of Western Michigan**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-20—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	89.2%	91.5%
Recommendation Measures	**85.8%**	92.6%
Staff are Reliable and Helpful	92.4%	91.9%
Staff Listen and Communicate Well	94.0%	95.0%
Case Manager is Helpful	96.0%	95.2%
Choosing the Services that Matter to You	94.5%	92.7%
Transportation to Medical Appointments	93.3%	92.5%
Personal Safety and Respect	96.1%	97.2%
Planning Your Time and Activities	77.3%	75.4%
Met Need	95.0%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Area Agency on Aging of Western Michigan achieved scores higher than the statewide results in the *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Physical Safety Measure* domains, indicating that **Area Agency on Aging of Western Michigan** provides services in a manner that meets or exceeds members' expectations in several domains. It should be noted that while **Area Agency on Aging of Western Michigan** achieved a higher score than the statewide results for *Planning Your Time and Activities*, this domain received the lowest statewide score across all domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging of Western Michigan scored more than 5 percentage points below the statewide average on the *Recommendation Measures* domain at 85.8 percent compared to the statewide average of 92.6 percent. [**Quality**]

Why the weakness exists: The *Recommendation Measures* domain included *recommendation of personal assistance and behavioral health staff*, *recommendation of homemakers*, and *recommendation of case manager*. **Area Agency on Aging of Western Michigan** scored below the statewide average in all three of these sub-measures.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Recommendation Measures* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Recommendation Measures* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Area Agency on Aging of Western Michigan**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Area Agency on Aging of Western Michigan** across all EQR activities. The overarching aggregated findings showed that **Area Agency on Aging of Western Michigan**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Area Agency on**

Aging of Western Michigan is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Area Agency on Aging of Western Michigan** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Area Agency on Aging of Western Michigan** should focus its efforts on improving members' experiences with waiver agency staff, provider effectiveness, and some waiver services, as members reported lower satisfaction in the *Global Ratings Measures*, *Recommendation Measures*, *Staff Listen and Communicate Well*, *Personal Safety and Respect*, and *Met Need* domains. HSAG's assessment of **Area Agency on Aging of Western Michigan** also identified continued opportunities for **Area Agency on Aging of Western Michigan** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Area Agency on Aging of Western Michigan** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Area Agency on Aging of Western Michigan** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Area Agency on Aging of Western Michigan**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Detroit Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-21 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Detroit Area Agency on Aging** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Detroit Area Agency on Aging** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Detroit Area Agency on Aging**'s QMP reports are also provided in Table 3-21. The results in Table 3-21 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-21—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Potential and or actual neglect, verbal and/or physical abuse will be reduced by 1% through September 30, 2020	SFY 2019 = [No baseline data reported] SFY 2020* = [3.50%] SFY 2021* = [3.68%] ☒

Actions/Activities/Interventions:

According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 14, 2020, planned actions to achieve the goal are:

- The supports coordinator will report within 24 hours of notification of any suspected or actual abuse and/or neglect to adult protective services.
- Supports coordinator will provide education to member.
- Supports coordinator will conduct comprehensive assessment of the living environment.

According to **Detroit Area Agency on Aging**'s MI Choice Actions & Outcome 2021 dated January 15, 2022, **Detroit Area Agency on Aging** completed the following activities and achieved outcomes:

Activities:

- Provided training on elder abuse and neglect for members via the Advisory Consumer Council meeting.
- Assessed members for neglect/abuse monthly
- Signs and examples of abuse/neglect was educated on by compliance for both the advisory council and at the provider meetings.
- Any abuse/neglect allegation is investigated by compliance and discussed at the Quality Board Meeting.

Outcomes:

- The training was offered virtually twice during the SFY 2021
- All members were assessed monthly for neglect and abuse via monthly contact calls.

QIP Topic	Goal	Measurement and Outcome
• **Detroit Area Agency on Aging** is below the state level for this indicator and has seen a decrease in allegations.		
2. *Prevalence of Pain With Inadequate Pain Control*	Improve individuals' reported pain level from severe to moderate by 5% through September 2020	SFY 2019 = [No baseline data reported] SFY 2020* = [28.29%] SFY 2021* = [30.94%] ☒
Actions/Activities/Interventions: According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 14, 2020, planned actions to achieve the goal are: • Education and interventions to help reduce pain. • Engage services of Community Health Worker. • Refer to MI Choice Certification Program. According to **Detroit Area Agency on Aging**'s MI Choice Actions & Outcome 2021 dated January 15, 2022, **Detroit Area Agency on Aging** completed the following activities and achieved outcomes: *Activities:* • Supports coordinators assessed for pain at initial assessment and every subsequent assessment . • Supports coordinators educated members and referred to physician or pain clinic as ordered. *Outcomes:* • Members reported a decrease in pain levels and findings show a decrease in pain for the second half of 2021. • Education was provided to members on how to manage pain and improve mobility during monthly monitoring. • Pain was discussed at the provider meetings to ensure that caregivers are properly identifying when a member is in pain.		
3. *Prevalence of Falls*	[Goal not identified by waiver agency in QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = [17.33%] SFY 2021* [17.92%] ☑
Actions/Activities/Interventions: According to **Detroit Area Agency on Aging**'s MI Choice Actions & Outcome 2021 dated January 15, 2022, **Detroit Area Agency on Aging** completed the following activities and achieved outcomes: *Activities:* • Supports coordinators assess at every assessment as well as every monthly contact. • Supports coordinators evaluate for and provide assistive devices as need to help reduce falls. • Supports coordinators evaluate for and provide PERS when necessary. • Fall prevention training took place at the consumer advisory council in SFY 2021. • Fall prevention strategies were discussed during provider meetings as part of our educational meetings.		

QIP Topic	Goal	Measurement and Outcome
Outcome: • Members were educated on methods to increase their safety measures, reduce falls, and utilize the PERS when applicable. • **Detroit Area Agency on Aging** maintained a lower rate of falls than the State average, as shown on the Quality Indicator Report.		
4. *Prevalence of Any Injuries*	To improve skin integrity issues by 5% for SFY 2020[1]	SFY 2019 = [No baseline data reported] SFY 2020* = [Unable to determine][2] SFY 2021* = [3.70%] ☒
Actions/Activities/Interventions: According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 14, 2020, planned actions to achieve the goal are: • Follow up for all skin problems until skin integrity is at best possible state. • RN will make one or more visits as indicated to all members with skin integrity issues until skin issue is resolved or maintained. According to **Detroit Area Agency on Aging**'s MI Choice Actions & Outcome 2021 dated January 15, 2022, **Detroit Area Agency on Aging** completed the following activities and achieved outcomes: *Activities:* • Supports coordinators assess for fractures and major skin issues at each assessment • If issues are identified, supports coordinator will make appropriate referrals to physician, wound nurse, etc. and re-assess monthly. *Outcomes:* • **Detroit Area Agency on Aging** maintained a lower rate of injury than the State average, as shown on the Quality Indicator Report.		
5. *Prevalence of Dehydration*	To increase or maintain participant functionality and hydration by 3% for SFY 2020	SFY 2019 = [No baseline data reported] SFY 2020* = [5.57%] SFY 2021* = [6.84%] ☒
Actions/Activities/Interventions: According to **Detroit Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 14, 2020, planned actions to achieve the goal are: • Education and interventions to increase or maintain functionality and hydration. • Engage services of Community Health Worker. • Refer to MI Choice Certification Program. According to **Detroit Area Agency on Aging**'s MI Choice Actions & Outcome 2021 dated January 15, 2022, **Detroit Area Agency on Aging** completed the following activities and achieved outcomes:		

QIP Topic	Goal	Measurement and Outcome
Activities: • Provided training for Advisory Consumer Council members regarding incontinence and dehydration . • Supports coordinators assess for dehydration at each assessment. • Incontinence supplies are provided to members at times when J&B [J&B Medical] services are not available. *Outcomes:* • There was a decrease in the reports of dehydration in the last 6 months of SFY 2021.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*The SFY 2020 and 2021 rates were calculated by HSAG based on the numerators and denominators provided by the waiver agency in the QMP annual report. The outcome was based on the results provided by the waiver agency in the QMP annual report or based on a comparison to the statewide goal. This information was not validated by HSAG or confirmed as validated by MDHHS.
[1] The QMP only included clinical performance measures and not the identified QIP indicators. HSAG assumed that the performance measure goal aligned with the QIP indicator for *Prevalence of Any Injuries*.
[2] Refer to *Why the weakness exists* under *Weakness #1* for an explanation.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: The SFY 2021 percentage rates for **Detroit Area Agency on Aging**'s QIPs increased from SFY 2020, suggesting that the implemented interventions did not positively impact member outcomes. Therefore, no strengths were identified for **Detroit Area Agency on Aging**. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Inconsistencies within the SFY 2020–2021 QMP and SFY 2021 annual report created significant challenges in deciphering the QIP-related goals, interventions, prevalence rates, and outcomes. [**Quality**]

Why the weakness exists: Detroit Area Agency on Aging's SFY 2020–2021 QMP included a goal to focus on clinical performance measures. Under this goal were several objectives that appeared to relate to the quality indicators for the *Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Dehydration*, and potentially *Prevalence of Any Injuries* (i.e., improve skin integrity issues) QIPs. An additional goal focused on decreasing potential and/or actual neglect and verbal and/or physical abuse. These goals included an established benchmark to evaluate performance. The QMP did not

include any goals associated with falls and did not include a section that specifically identified the required QIPs. The SFY 2021 annual report included a summary of performance of the clinical performance measures and the goal to decrease potential and/or actual neglect and verbal and/or physical abuse in alignment with the QMP stated goals and objectives. However, as part of the outcomes summary within this section of the report, **Detroit Area Agency on Aging** identified the numerator and denominator but did not provide the percentage of improvement or a summary of whether the actual goal as stated in the QMP was met or not met. The SFY 2021 annual report also included a section that specifically identified each of the five QIPs required by MDHHS; however, no goals were identified and, although numerators and denominators were included within the QIP section of the report, it was not clear whether these numerators and denominators tied to the outcomes identified within the clinical performance measures and the performance goal to decrease potential and/or actual neglect and verbal and/or physical abuse. Also, for four of the five QIPs, **Detroit Area Agency on Aging** indicated that the denominator included all participants; however, the count of all participants was not consistently documented among each of these QIPs (i.e., 1,332 versus 1,322 versus 1,323), and for the *Prevalence of Dehydration* QIP, the numerator was documented as 90.5, which would indicate that half of a participant had insufficient fluid intake, which is not appropriate. Additionally, because there were no identified goals in the QIP section of the annual report, it was not clear how performance was evaluated using the numerators and denominators. Further, although the SFY 2020–2021 QMP contained a clinical performance measure with an objective to improve skin integrity issues (which was also included in the SFY 2021 annual report), and **Detroit Area Agency on Aging** reported that it maintained a lower rate of injury than the statewide average, the *Prevalence of Any Injuries* QIP quality indicator within this same report indicated the numerator included members with fractures or major skin problems, excluding current pressure or stasis ulcers. Therefore, HSAG was not able to clearly determine a performance rate related to the skin integrity issues as the QIP numerators and denominators included skin integrity issues and members with fractures.

Recommendation: HSAG recommends that **Detroit Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals that include baseline data, and these goals should specifically be identified as the state-required QIP indicators. Additionally, **Detroit Area Agency on Aging** should ensure that its annual report identifies the QIP goals and performance benchmarks, and an analysis on whether **Detroit Area Agency on Aging** met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating any identified barriers.

Weakness #2: The interventions implemented by **Detroit Area Agency on Aging** to meet performance goals were unclear as the SFY 2020–2021 QMP did not specifically describe the interventions related to the QIP indicators, except when these indicators specifically aligned with the clinical performance measure goals. Additionally, **Detroit Area Agency on Aging**'s prevalence rates increased for the *Prevalence of Neglect/Abuse*, *Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Falls*, and *Prevalence of Dehydration* QIPs, suggesting that the interventions implemented by **Detroit Area Agency on Aging** were not effective. As significant and sustained improvement results from developing and implementing effective improvement strategies, these

interventions should be clearly documented. **Detroit Area Agency on Aging**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. [**Quality**]

Why the weakness exists: **Detroit Area Agency on Aging**'s SFY 2020–2021 QMP did not list interventions specific to the QIP indicators and, although the SFY 2021 annual report included interventions, documentation did not support that a comprehensive causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Detroit Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Detroit Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Detroit Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Detroit Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: **Detroit Area Agency on Aging**'s SFY 2020–2021 QMP did not include details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs. **Detroit Area Agency on Aging**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included minimal details on the design developed and methodology followed by **Detroit Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Detroit Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Detroit Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-22. Table 3-22 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Detroit Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Detroit Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-22—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**84.71%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**92.66%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**92.26%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**98.78%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**89.02%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**91.36%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**78.57%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**92.86%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**95.12%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**97.56%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**83.15%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Detroit Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 8, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determination; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Detroit Area Agency on Aging performed substantially worse than other waiver agencies on Performance Measure 19, *number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*, as indicated by a performance rate of

more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always update the PCSP according to MDHHS requirements. [**Quality**]

Why the weakness exists: Detroit Area Agency on Aging's performance rate for Performance Measure 19 fell 9.88 percentage points below the statewide rate. Through the CQAR, of the 41 records reviewed, MPHI determined that 10 of the 41 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and five of the 29 applicable records did not demonstrate evidence that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements or provided the member/guardian with appropriate alternatives.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **Detroit Area Agency on Aging**'s CAP included, but was not limited to, additional staff training with a quiz that required 95 percent correctness to pass and 12 chart reviews. While **Detroit Area Agency on Aging** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Detroit Area Agency on Aging performed substantially worse than other waiver agencies on Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always ensure members had an individualized contingency plan for emergencies. [**Quality** and **Access**]

Why the weakness exists: Detroit Area Agency on Aging's performance rate for Performance Measure 30 fell 7.07 percentage points below the statewide rate. Through the CQAR, of the 41 records reviewed, MPHI determined that 14 of the 41 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan; and one of the 41 applicable records did not demonstrate evidence that the member/guardian received a copy of the contingency plan or was offered and declined.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies associated with Performance Measure 30. **Detroit Area Agency on Aging**'s CAP included, but was not limited to, additional staff training with a quiz that required 95 percent correctness to pass and 12 chart reviews. While **Detroit Area Agency on Aging** was required to conduct internal monitoring until compliance of 80 percent is achieved, HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-23 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-23 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-23—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	60.98%		**1.00**
Focus 3	Release of Information	75.61%		**2.00**
Focus 4	Status	92.56%		**4.00**
Focus 5	Pre-Planning	96.97%	100.00%	**4.00**
Focus 6	Assessment	94.52%	99.21%	**4.00**
Focus 7	Medication Record	90.71%	99.04%	**4.00**
Focus 8	Person-Centered Service Planning	90.22%	98.75%	**4.00**
Focus 9	MI Choice Services	91.45%	99.32%	**4.00**
Focus 10	Linking and Coordinating	92.16%	98.33%	**4.00**
Focus 11	Follow-Up and Monitoring	74.23%	96.43%	**2.02**
Focus 12	Service Provider	93.33%		**4.00**
Focus 13	Contingency Plan	84.04%	100.00%	**4.00**
Focus 14	Critical Incidents	66.67%	100.00%	**2.02**
Focus 15	Adverse Benefit Determination	22.06%		**1.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 17	Home and Community Based		NA	NA
	Totals	**89.01%**	**99.12%**	**3.73**

	Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Detroit Area Agency on Aging achieved a substantial compliance rating in 11 of the 16 applicable record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Detroit Area Agency on Aging did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid FOC form is on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 16 of the 41 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Detroit Area Agency on Aging**'s CAP included, but was not limited to, additional staff training and 48 chart reviews. While **Detroit Area Agency on Aging** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Detroit Area Agency on Aging did not consistently follow all Release of Information requirements; specifically, ensuring a valid Release of Information (ROI) form is on file. Waiver agencies are required to ensure the member record includes a valid ROI form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 of the 41 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Detroit Area Agency on Aging**'s CAP included, but was not limited to, additional staff training and 48 chart reviews. While **Detroit Area Agency on Aging** was required to conduct internal monitoring until compliance of 85 percent is achieved, HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: Detroit Area Agency on Aging did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting new members to ensure service delivery in accordance with MDHHS policy and contract requirements, and contacting members for follow-up and monitoring as specified in the member's PCSP. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the 15 applicable records did not include evidence that the supports coordinator contacted the new member/guardian to ensure service delivery in accordance with MDHHS policy and contract requirements; and 21 of the 41 applicable records did not include evidence that the supports coordinator contacted the member/guardian for follow-up and monitoring as specified in the PCSP.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Detroit Area Agency on Aging**'s CAP included, but was not limited to, additional staff training and 12 chart reviews. While **Detroit Area Agency on Aging** was required to conduct internal monitoring until compliance of 80 or 90 percent is achieved, HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **Detroit Area Agency on Aging** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members.

Weakness #4: Detroit Area Agency on Aging did not consistently follow all Critical Incidents requirements; specifically, addressing the incident(s) with the member/guardian and entering, reporting, and providing updates to the critical incident portal in accordance with MDHHS policy and contract requirements. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the four applicable records did not demonstrate evidence that the service coordinator addressed the incident with the member/guardian; and three of the four applicable records did not demonstrate evidence that the supports coordinator entered, reported, and provided updates to the critical incident portal in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Detroit Area Agency on Aging**'s CAP included, but was not limited to, additional staff training with a quiz that required 95 percent correctness to pass and 12 chart reviews. While **Detroit Area Agency on Aging** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #5: Detroit Area Agency on Aging did not consistently follow all Adverse Benefit Determination requirements; specifically, providing the member/guardian with the required AAN/ABD in accordance with MDHHS policy and contract requirements, and ensuring that the AAN/ABD was complete and accurate. Complete and accurate ABD notices are important to ensure members understand their appeal rights and the process to request an appeal. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 of the 19 applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and

two of the eight applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Detroit Area Agency on Aging**'s CAP included, but was not limited to, additional staff training and 12 chart reviews. While **Detroit Area Agency on Aging** was required to conduct internal monitoring until compliance of 80 percent is achieved, HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **Detroit Area Agency on Aging** ensure mechanisms are in place that verify timely completion of the PCSP as required.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-24 presents **Detroit Area Agency on Aging**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-24—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	94.6%	91.5%
Recommendation Measures	96.7%	92.6%
Staff are Reliable and Helpful	91.5%	91.9%
Staff Listen and Communicate Well	97.4%	95.0%
Case Manager is Helpful	99.1%	95.2%
Choosing the Services that Matter to You	94.0%	92.7%
Transportation to Medical Appointments	**87.2%**	92.5%
Personal Safety and Respect	100.0%	97.2%
Planning Your Time and Activities	71.5%	75.4%

Domain	Waiver Agency Score	Statewide Average Score
Met Need	99.1%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Detroit Area Agency on Aging achieved scores higher than the statewide results in the *Global Ratings Measures*, *Recommendation Measures*, *Staff Listen and Communicate Well, Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Personal Safety and Respect*, *Met Need*, and *Physical Safety Measure* domains, indicating that **Detroit Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Detroit Area Agency on Aging scored more than 5 percentage points below the statewide average on the *Transportation to Medical Appointments* domain at 87.2 percent compared to the statewide average of 92.5 percent. [**Quality** and **Access**]

Why the weakness exists: Of the three questions within the *Transportation to Medical Appointments* domain, **Detroit Area Agency on Aging** scored more than 5 percentage points lower than the statewide averages for two of the questions: *Able to get in and out of this ride easily* and *Ride arrives on time to pick you up*.

Recommendation: HSAG recommends that **Detroit Area Agency on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Transportation to Medical Appointments* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Transportation to Medical Appointments* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Detroit Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Detroit Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Detroit Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Detroit Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Detroit Area Agency on Aging** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Detroit Area Agency on Aging** should focus its efforts on improving members' experiences with access to transportation, waiver agency staff, and providers, as members reported lower satisfaction in the *Transportation to Medical Appointments*, *Staff are Reliable and Helpful*, and *Planning Your Time and Activities* domains. HSAG's assessment of **Detroit Area Agency on Aging** also identified continued opportunities for **Detroit Area Agency on Aging** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Detroit Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Detroit Area Agency on Aging** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Detroit Area Agency on Aging**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Milestone Senior Services

Validation of Performance Improvement Projects

Performance Results

Table 3-25 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Milestone Senior Services** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Milestone Senior Services** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Milestone Senior Services**' QMP reports are also provided in Table 3-25. The results in Table 3-25 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-25—QIP Results

QIP Topic	Goal‡	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 1% SFY 2021 = 1% ☑
Actions/Activities/Interventions: According to **Milestone Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Milestone Senior Services** planned to complete the following tasks: • [None identified] The **Milestone Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2022* dated January 5, 2022, identified the following: • [None identified]		
2. *Prevalence of Pain With Inadequate Pain Control*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 18% SFY 2021 = 18% ☑
Actions/Activities/Interventions: According to **Milestone Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Milestone Senior Services** planned to complete the following tasks: • [None identified] The **Milestone Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2022* dated January 5, 2022, identified the following: • [None identified]		

QIP Topic	Goal‡	Measurement and Outcome
3. *Prevalence of Falls*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 51% SFY 2021 = 48% ☒
Actions/Activities/Interventions: According to **Milestone Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Milestone Senior Services** planned to complete the following tasks: • [None identified] The **Milestone Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2022* dated January 5, 2022, identified the following: • [None identified]		
4. *Prevalence of Any Injuries*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 6% SFY 2021 = 6% ☒
Actions/Activities/Interventions: According to **Milestone Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Milestone Senior Services** planned to complete the following tasks: • [None identified] The **Milestone Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2022* dated January 5, 2022, identified the following: • [None identified]		

QIP Topic	Goal‡	Measurement and Outcome
5. *Prevalence of Dehydration*	[No goal identified]	SFY 2019 = [No baseline data reported] SFY 2020 = 1% SFY 2021 = 2% ☒
Actions/Activities/Interventions: According to **Milestone Senior Services**' Quality Management Plan FY 2020-2021 dated January 15, 2020, **Milestone Senior Services** planned to complete the following tasks: • [None identified] The **Milestone Senior Services** MI Choice Summary of Quality Management Plan (QMP) Activities and Outcomes Report FY 2022* dated January 5, 2022, identified the following: • [None identified]		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
* HSAG made the assumption that the report titled FY 2022 was a typographical error and should have read FY 2021 as the annual report included a summary of data for SFY 2021 and was due to MDHHS in January 2022.
‡Waiver agency did not identify any internal goals in the QMP reports; therefore, HSAG used the statewide goals and the performance rates identified by the waiver agency in the annual report to determine performance outcomes.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Milestone Senior Services met the statewide goal for two QIPs, *Prevalence of Neglect/Abuse* and *Prevalence of Pain With Inadequate Pain Control*, indicating that **Milestone Senior Services**' members experienced few reported incidents of neglect/abuse and uncontrolled pain. [**Quality**]

Weaknesses and Recommendations

Weakness #1: **Milestone Senior Services** did not identify a goal for any of the five state-required QIPs. Additionally, although **Milestone Senior Services**' SFY 2020–2021 QMP included its first quarter metrics for each of the five QIPs, it was not clear if these metrics were intended to be its baseline data to compare against final SFY 2021 performance outcomes. Specific goals (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities; therefore, the goal for each QIP needs to be identified in **Milestone Senior Services**' QMP reports. [**Quality**]

Why the weakness exists: Neither the SFY 2020–2021 QMP or SFY 2021 annual report identified **Milestone Senior Services**' goals for any of the five state-required QIPs. Additionally, the SFY 2021 annual report did not include a comparison of performance to the metrics identified in the SFY 2020–2021 QMP.

Recommendation: HSAG recommends that **Milestone Senior Services** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports (i.e., QMP, annual report). Additionally, **Milestone Senior Services** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. This analysis should be conducted based on **Milestone Senior Services**' baseline data included within its QMP.

Weakness #2: **Milestone Senior Services** did not include QIP interventions in its QMP reports. Additionally, the prevalence rate for the *Prevalence of Dehydration* QIP increased, suggesting that any interventions implemented by **Milestone Senior Services** were not effective. As significant and sustained improvement results from developing and implementing effective improvement strategies, interventions must be documented in **Milestone Senior Services**' QMP. **Milestone Senior Services**' choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. [**Quality**]

Why the weakness exists: **Milestone Senior Services**' SFY 2020–2021 QMP did not list planned interventions for each of the five state-required QIPs, and its SFY 2021 annual report did not demonstrate that a causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Milestone Senior Services** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Milestone Senior Services** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Milestone Senior Services** should analyze and interpret results at multiple points in time and test for statistical significance. **Milestone Senior Services** should evaluate the effectiveness of the

intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Milestone Senior Services**' QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report did not include details on the design developed and the methodology followed by **Milestone Senior Services** when implementing its QIPs.

Recommendation: HSAG recommends that **Milestone Senior Services** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Milestone Senior Services** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-26. Table 3-26 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Milestone Senior Services**' percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Milestone Senior Services**' impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-26—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**88.31%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**90.10%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**90.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**95.00%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**95.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**95.00%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**88.80%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**88.24%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**100.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**90.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**85.71%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 S statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Milestone Senior Services received a 100 percent performance rating for Performance Measures 8, 20, 22, 24, and 38, indicating that LOC criteria were accurately applied on initial determinations; members received all of the services and supports identified in the PCSP; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Milestone Senior Services performed substantially worse than other waiver agencies on Performance Measure 2, *number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that the waiver agency did not always enroll members in the MI Choice Waiver Program consistent with MDHHS policies and procedures. [**Quality**]

Why the weakness exists: Milestone Senior Services' performance rate for Performance Measure 2 fell 5.96 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that one of the 10 applicable records did not demonstrate evidence the waiver agency validated the accuracy of the nursing facility level of care determination (NFLOCD) enrollment Door, thus ensuring the validity of the NFLOCDs in the Community Health Automated Medicaid Processing System (CHAMPS); four of the applicable 10 records did not demonstrate evidence that there was a valid FOC form in the record; one of the two applicable records did not demonstrate evidence that the disenrollment date was supported in the record; one of the 10 applicable records did not demonstrate evidence that the correct care setting statuses were used; one of the four applicable records did not demonstrate that the enrollment/disenrollment dates were consistent with CHAMPS; and two of the 10 applicable records did not demonstrate evidence that the information in the assessment was consistent, providing a clear picture of the member's strengths, needs, and abilities, and contained relevant information and explanations.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies associated with Performance Measure 2. **Milestone Senior Services**' CAP included, but was not limited to, education and training for all staff and a review of 10 records monthly. However, **Milestone Senior Services** also indicated that once standards show compliance rates of 85 or 90 percent (depending on the requirements) for a consecutive three months, no further reporting will

be required. Therefore, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Milestone Senior Services performed substantially worse than other waiver agencies on Performance Measure 4, *number and percent of appropriate LOC determinations found after MDHHS review*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that the waiver agency did not always ensure the appropriate LOCDs were made. [**Quality**]

Why the weakness exists: Milestone Senior Services' performance rate for Performance Measure 4 fell 9.21 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that one of the 10 applicable records did not demonstrate evidence the waiver agency validated the accuracy of the NFLOCD enrollment Door, thus ensuring the validity of the NFLOCDs in CHAMPS.

Recommendation: MDHHS did not require **Milestone Senior Services** to submit a CAP to remediate the one deficiency associated with Performance Measure 4. However, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: Milestone Senior Services performed substantially worse than other waiver agencies on Performance Measure 18, *number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process,* as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always ensure the PCSP was developed in accordance with MDHHS policies and procedures. [**Quality** and **Access**]

Why the weakness exists: Milestone Senior Services' performance rate for Performance Measure 18 fell 5.95 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that two of the 10 applicable records did not demonstrate evidence that the supports coordinator contacted the member/guardian prior to assessments, home visits, and/or planning meetings to ensure the date/time/location were convenient for the member; six of the 10 applicable records did not demonstrate evidence that the supports coordinator assessed the member for risks, educated the member/guardian on assessed/identified risks, offered modifications to promote safety and independence, and provided the member/guardian the opportunity to manage risk through care planning and service delivery; two of the 10 applicable records did not demonstrate evidence that the information in the assessment was consistent, providing a clear picture of the member's strengths, needs, and abilities, and contained relevant information and explanations; one

of the 10 applicable records did not demonstrate evidence that the registered nurse and licensed social worker collaborated, demonstrating a team approach; one of the 10 applicable records did not demonstrate evidence that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements; one of the 10 applicable records did not demonstrate evidence that the PCSP identified the member's health and welfare issues, needs, and risks as preferred by the member; one of the 10 applicable records did not demonstrate evidence that the PCSP included the process for minimizing risk factors, planning, and supporting the member; one of the 10 applicable records did not demonstrate evidence that the services and supports on the PCSP included the provider, type, amount, frequency, and duration; two of the 10 applicable records did not demonstrate evidence that the PCSP included outcome evaluations for each goal; one of the 10 applicable records did not demonstrate evidence that the person responsible for monitoring the PCSP was identified in the plan; one of the 10 applicable records did not demonstrate evidence that the member/guardian approved the PCSP; seven of the 10 applicable records did not demonstrate evidence that the PCSP was understandable, written in plain language, and offered in a manner that was accessible to the member/guardian; one of the 10 applicable records did not demonstrate evidence that the service summary contained accurate and complete information; one of the 10 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian all appropriate MI Choice Waiver Program services; and one of the 10 applicable records did not demonstrate evidence that the authorized MI Choice Waiver Program services met the service standard requirements.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies associated with Performance Measure 18. **Milestone Senior Services**' CAP included, but was not limited to, education and training for all staff and a review of 10 records monthly. However, **Milestone Senior Services** also indicated that once standards show compliance rates of 80, 85, or 90 percent (depending on the requirements) for a consecutive three months, no further reporting will be required. Therefore, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #4: Milestone Senior Services performed substantially worse than other waiver agencies on Performance Measure 21, *number and percent of waiver participants whose records indicate choice was offered among waiver services*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that members were not always offered a choice among waiver services. [**Quality**]

Why the weakness exists: Milestone Senior Services' performance rate for Performance Measure 21 fell 5.01 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that one of the 10 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian a choice of appropriate MI Choice Waiver Program services.

Recommendation: MDHHS did not require **Milestone Senior Services** to submit a CAP to remediate the one deficiency associated with Performance Measure 21. However, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-27 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-27 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-27—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	95.45%	100.00%	**4.00**
Focus 2	Freedom of Choice	60.00%		**1.00**
Focus 3	Release of Information	50.00%		**1.00**
Focus 4	Status	89.29%		**3.00**
Focus 5	Pre-Planning	97.75%	100.00%	**4.00**
Focus 6	Assessment	88.89%	100.00%	**3.33**
Focus 7	Medication Record	87.04%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	88.28%	100.00%	**4.00**
Focus 9	MI Choice Services	92.98%	100.00%	**4.00**
Focus 10	Linking and Coordinating	91.67%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	72.73%	100.00%	**2.00**
Focus 12	Service Provider	62.50%		**1.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 13	Contingency Plan	88.00%	100.00%	**4.00**
Focus 14	Critical Incidents	75.00%	100.00%	**2.00**
Focus 15	Adverse Benefit Determination	50.00%		**1.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**88.07%**	**100.00%**	**3.59**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Five home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the areas of Follow-Up and Monitoring and Critical Incidents as the overall ratings for these program areas were less than full compliance. [**Quality**]

Strength #2: Milestone Senior Services achieved a substantial compliance rating in 11 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Milestone Senior Services did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid FOC form is on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that four of the 10 applicable records did not demonstrate evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. **Milestone Senior Services**' CAP included, but was not limited to, education and training for all staff and a review of 10 records monthly. However, **Milestone Senior Services** also indicated that once standards show a compliance rate of 90 percent for a consecutive three months, no further reporting will be required. Therefore, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Milestone Senior Services did not consistently follow all Release of Information requirements; specifically, ensuring a valid ROI form is on file. Waiver agencies are required to ensure the member record includes a valid ROI form during the review period.

Why the weakness exists: Through the CQAR, MPHI determined that five of the 10 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record. [**Quality**]

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. **Milestone Senior Services**' CAP included, but was not limited to, education and training for all staff and a review of 10 records monthly. However, **Milestone Senior Services** also indicated that once standards show a compliance rate of 85 percent for a consecutive three months, no further reporting will be required. Therefore, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: Milestone Senior Services did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting members for follow-up and monitoring as specified in the member's PCSP. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that six of the 10 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. **Milestone Senior Services**' CAP included, but was not limited to, education and training for all staff and a review of 10 records monthly. However, **Milestone Senior Services** also indicated that once standards show a compliance rate of 80 percent for a consecutive three months, no further reporting will be required. Therefore, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **Milestone Senior Services** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members.

Weakness #4: Milestone Senior Services did not consistently follow all Service Provider requirements; specifically, ensuring that if the member experienced a health and welfare issue, the service provider contacted the waiver agent and/or supports coordinator to inform them of the issue. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three of the eight applicable records did not demonstrate evidence that the service provider contacted the waiver agent or the supports coordinator to inform them of a member's health and welfare issue.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. **Milestone Senior Services**' CAP included, but was not limited to, education and training for all staff and a review of 10 records monthly. However, **Milestone Senior Services** also indicated that once standards show a compliance rate of 90 percent for a consecutive three months, no further reporting will be required. Therefore, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #5: Milestone Senior Services did not consistently follow all Critical Incidents requirements; specifically, entering, reporting, and providing updates to the critical incident portal in accordance with MDHHS policy and contract requirements. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that the one applicable record did not demonstrate evidence that the supports coordinator entered, reported, and provided updates to the critical incident portal in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. **Milestone Senior Services**' CAP included, but was not limited to, education and training for all staff and a review of 10 records monthly. However, **Milestone Senior Services** also indicated that once standards show a compliance rate of 90 percent for a consecutive three months, no further reporting will be required. Therefore, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #6: Milestone Senior Services did not consistently follow all Adverse Benefit Determination requirements; specifically, providing the member/guardian with the required AAN/ABD in accordance with MDHHS policy and contract requirements, and ensuring that the AAN/ABD was complete and accurate. Complete and accurate ABD notices are important to ensure members understand their appeal rights and the process to request an appeal. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the three applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and two of the three applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. **Milestone Senior Services**' CAP included, but was not limited to, education and training for all staff and a review of 10 records monthly. However, **Milestone Senior Services** also indicated that once standards show a compliance rate of 80 percent for a consecutive three months, no further reporting will be required. Therefore, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **Milestone Senior Services** ensure mechanisms are in place to verify timely completion of the PCSP as required.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-28 presents **Milestone Senior Services**' domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-28—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	90.8%	91.5%
Recommendation Measures	91.9%	92.6%
Staff are Reliable and Helpful	91.4%	91.9%
Staff Listen and Communicate Well	95.4%	95.0%
Case Manager is Helpful	93.8%	95.2%
Choosing the Services that Matter to You	91.6%	92.7%
Transportation to Medical Appointments	93.0%	92.5%
Personal Safety and Respect	97.5%	97.2%
Planning Your Time and Activities	75.2%	75.4%
Met Need	92.0%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Milestone Senior Services achieved scores higher than the statewide results in the *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, and *Physical Safety Measure* domains, indicating that **Milestone Senior Services** provides services in a manner that meets or exceeds members' expectations in some domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Milestone Senior Services did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **Milestone Senior Services** scored below the statewide average on the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains. Therefore, HSAG recommends that **Milestone Senior Services** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains; conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Global Ratings Measures, Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary. The CAHPS survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. However, the waiver agency should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agency should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.

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

To identify strengths and weaknesses and draw conclusions for **Milestone Senior Services**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Milestone Senior Services** across all EQR activities. The overarching aggregated findings showed that **Milestone Senior Services**' quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Milestone Senior Services** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Milestone Senior Services** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Milestone Senior Services** should focus its efforts on improving members' experiences with waiver agency staff and providers, case manager effectiveness, and some waiver services, as members reported lower satisfaction in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains. HSAG's assessment of **Milestone Senior Services** also identified continued opportunities for **Milestone Senior Services** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Milestone Senior Services** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Milestone Senior Services** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Milestone Senior Services**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

MORC Home Care

Validation of Performance Improvement Projects

Performance Results

Table 3-29 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **MORC Home Care** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **MORC Home Care** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **MORC Home Care**'s QMP reports are also provided in Table 3-29. The results in Table 3-29 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-29—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 4.9% [Quarter 1 results only] SFY 2021*: ☒ Quarter 1 = 6.57% Quarter 2 = 2.46% Quarter 3 = 3.5% Quarter 4 = 0.0%
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020, did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of pain with inadequate pain control and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 Activities & Outcomes Summary Report FY 2021 dated January 15, 2022, **MORC Home Care** identified that **MORC Home Care** will utilize the Compass QI Detail Report to track and monitor goals, results will be sent to the Clinical Supervisor and Program Director to review and monitor with clinical staff.		
2. *Prevalence of Pain With Inadequate Pain Control*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 14.9% [Quarter 1 results only] SFY 2021*:☑

QIP Topic	Goal	Measurement and Outcome
		Quarter 1 = 14.9% Quarter 2 = 15.5% Quarter 3 = 14.4% Quarter 4 = 8.90%
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020, did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of pain with inadequate pain control and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 Activities & Outcomes Summary Report FY 2021 dated January 15, 2022, **MORC Home Care** identified that **MORC Home Care** will utilize the Compass QI Detail Report to track and monitor goals, results will be sent to the Clinical Supervisor and Program Director to review and monitor with clinical staff.		
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 23.3% [Quarter 1 results only] SFY 2021*: ☒ Quarter 1 = 23.3% Quarter 2 = 27.2% Quarter 3 = 26.5% Quarter 4 = 21.7%
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020, did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of falls and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 Activities & Outcomes Summary Report FY 2021 dated January 15, 2022, **MORC Home Care** identified that **MORC Home Care** will utilize the Compass QI Detail Report to track and monitor goals, results will be sent to the Clinical Supervisor and Program Director to review and monitor with clinical staff.		
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 4.1% [Quarter 1 results only] SFY 2021*: ☒

QIP Topic	Goal	Measurement and Outcome
		Quarter 1 = 4.1% Quarter 2 = 6.26% Quarter 3 = 6.5% Quarter 4 = 4.7%
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020, did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of any injuries and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 Activities & Outcomes Summary Report FY 2021 dated January 15, 2022, **MORC Home Care** identified that **MORC Home Care** will utilize the Compass QI Detail Report to track and monitor goals, results will be sent to the Clinical Supervisor and Program Director to review and monitor with clinical staff.		
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020 = 2.2% [Quarter 1 results only] SFY 2021*: ☒ Quarter 1 = 0.7% Quarter 2 = 2.46% Quarter 3 = 2.06% Quarter 4 = 2.53%
Actions/Activities/Interventions: **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 dated January 15, 2020, did not include specific interventions but reported the following: • Utilize the COMPASS QI Detail Report to track and monitor prevalence of dehydration and will report quarterly for the fiscal year of October 1 to September 30. The results will be sent to the Clinical Supervisor and Program Director and will monitor and review with clinical staff at monthly meeting. According to **MORC Home Care**'s Quality Management Plan (QMP) FY 2020 and 2021 Activities & Outcomes Summary Report FY 2021 dated January 15, 2022, **MORC Home Care** identified that **MORC Home Care** will utilize the Compass QI Detail Report to track and monitor goals, results will be sent to the Clinical Supervisor and Program Director to review and monitor with clinical staff.		

FY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*The waiver agency provided only the percentages for each quarter, and did not include the numerators and denominators; therefore, HSAG was unable to calculate the percentage for SFY 2021.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: MORC Home Care's *Prevalence of Pain With Inadequate Pain Control* QIP met the statewide goal for each reporting quarter of SFY 2021, suggesting that **MORC Home Care**'s members experienced better pain control. [**Quality**]

Weaknesses and Recommendations

Weakness #1: MORC Home Care's SFY 2020–2021 QMP and the SFY 2021 annual report did not identify the goal for any of the five state-required QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: Since **MORC Home Care** did not identify its internal QIP goals or the statewide goals established by MDHHS for the five QIPs, determining if **MORC Home Care** met its goals could not be verified due to the lack of information. However, HSAG evaluated each quarter's results as compared to the statewide goals.

Recommendation: HSAG recommends that **MORC Home Care** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **MORC Home Care** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: The interventions implemented by **MORC Home Care** to impact performance were not identified in the QMP reports. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **MORC Home Care**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. [**Quality**]

Why the weakness exists: MORC Home Care's SFY 2020–2021 QMP identified a process to track and monitor each QIP; however, neither the SFY 2020–2021 QMP nor the SFY 2021 annual report identified the interventions implemented during SFY 2021 for the QIPs. Additionally, there

was no evidence to support that a causal/barrier analysis was conducted for any interventions to ensure they were logically linked to any identified barriers.

Recommendation: HSAG recommends that **MORC Home Care** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **MORC Home Care** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **MORC Home Care** should analyze and interpret results at multiple points in time and test for statistical significance. **MORC Home Care** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: MORC Home Care's QIP performance results reported in the SFY 2021 annual report were not comparable to the prevalence rates reported by other waiver agencies. [**Quality**]

Why the weakness exists: The prevalence rates in the SFY 2021 annual report only reported data for each quarter of SFY 2021, and no annual rate was available. It is unknown why **MORC Home Care** only reported data quarterly for the SFY 2021 annual results.

Recommendation: HSAG recommends that **MORC Home Care**'s annual report include the full year's annual performance results for each QIP quality indicator.

Weakness #4: MORC Home Care's SFY 2020–2021 QMP did not include details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs. **MORC Home Care**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included minimal details on the design developed and methodology followed by **MORC Home Care** when implementing its QIPs.

Recommendation: HSAG recommends that **MORC Home Care** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **MORC Home Care** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-30. Table 3-30 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **MORC Home Care**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **MORC Home Care**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-30—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**97.47%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**99.07%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**95.00%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**98.85%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**94.74%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**100.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**91.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: MORC Home Care received a 100 percent performance rating for Performance Measures 4, 8, 15, 16, 20, 21, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determination; PCSPs included services and supports that aligned with members' assessed needs; PCSPs included strategies to address health and safety risks; members received all the services documented in their PCSPs; waiver service choice was offered to members; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although **MORC Home Care** met or exceeded the statewide performance rate for all performance measures, HSAG recommends that **MORC Home Care** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-31 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-31 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-31—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	100.00%		**4.00**
Focus 3	Release of Information	100.00%		**4.00**
Focus 4	Status	97.06%		**4.00**
Focus 5	Pre-Planning	98.90%	100.00%	**4.00**
Focus 6	Assessment	98.89%	100.00%	**4.00**
Focus 7	Medication Record	96.00%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	99.30%	100.00%	**4.00**
Focus 9	MI Choice Services	98.31%	97.14%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 10	Linking and Coordinating	95.24%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	90.48%	100.00%	**4.00**
Focus 12	Service Provider	100.00%		**4.00**
Focus 13	Contingency Plan	92.59%	100.00%	**4.00**
Focus 14	Critical Incidents	91.67%	100.00%	**4.00**
Focus 15	Adverse Benefit Determination	100.00%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**97.90%**	**99.60%**	**4.00**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: MORC Home Care achieved a substantial compliance rating in all 17 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore,

CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: MORC Home Care did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: No substantial weaknesses were identified within any of the program areas under review; however, HSAG recommends **MORC Home Care** implement an ongoing and robust internal auditing process of individual supports coordinators as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-32 presents **MORC Home Care**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-32—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	89.1%	91.5%
Recommendation Measures	89.2%	92.6%
Staff are Reliable and Helpful	88.4%	91.9%
Staff Listen and Communicate Well	90.5%	95.0%
Case Manager is Helpful	98.9%	95.2%
Choosing the Services that Matter to You	93.8%	92.7%
Transportation to Medical Appointments	90.0%	92.5%
Personal Safety and Respect	99.2%	97.2%
Planning Your Time and Activities	78.7%	75.4%

Domain	Waiver Agency Score	Statewide Average Score
Met Need	100.0%	95.3%
Physical Safety Measure	97.5%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: MORC Home Care achieved scores higher than the statewide results in the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains, indicating that **MORC Home Care** provides services in a manner that meets or exceeds members' expectations in many domains. It should be noted that while **MORC Home Care** achieved a higher score than the statewide results for *Planning Your Time and Activities*, this domain received the lowest statewide score across all domains. [**Quality**]

Weaknesses and Recommendations

Weakness #1: MORC Home Care did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality** and **Access**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **MORC Home Care** scored below the statewide average on the *Global Ratings Measures*, *Recommendation Measures, Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, and *Physical Safety Measure* domains. Therefore, HSAG recommends that **MORC Home Care** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, and *Physical Safety Measure* domains;

conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, and *Physical Safety Measure* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **MORC Home Care**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **MORC Home Care** across all EQR activities. The overarching aggregated findings showed that **MORC Home Care**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **MORC Home Care** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **MORC Home Care** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **MORC Home Care** should focus its efforts on improving members' experiences with waiver agency staff, access to transportation, and some waiver services, as members reported lower satisfaction in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, and *Physical Safety Measure* domains. HSAG's assessment of **MORC Home Care** also identified continued opportunities for **MORC Home Care** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **MORC Home Care** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **MORC Home Care** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **MORC Home Care**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Northern Healthcare Management

Validation of Performance Improvement Projects

Performance Results

Table 3-33 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Northern Healthcare Management** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Northern Healthcare Management** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Northern Healthcare Management**'s QMP reports are also provided in Table 3-33. The results in Table 3-33 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-33—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Continue to have reported abuse/neglect at or below the state average by assessing safety/environment of participants during assessments, face to face meetings, and as needs or environment changes	SFY 2019 = [No baseline data reported] SFY 2020* = [3.2%][1] SFY 2021* = [2.44%] ☑

Actions/Activities/Interventions:

Northern Healthcare Management's Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are:

- The QI Program Manager will look at the data and details of members reporting inadequate neglect/abuse via QI Summary and Detail Report. Critical incidents will be submitted by the supports coordinators to their supervisors for review and monitoring at the time of neglect/abuse being discovered/reported.
- Educate staff on importance of providing services and assessments that will help decrease the risk for neglect/abuse. Provide resources and tools for supports coordinators to use to better assist the members. Provide education to staff regarding consistency and review of data collection.
- The QI Program Manager will continue to monitor the number of members reporting pain with inadequate pain control at least quarterly.

According to **Northern Healthcare Management**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Summary Report FY 2021 dated January 10, 2022, **Northern Healthcare Management** identified the following:

- State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve member safety, health, and outcomes with Waiver services. The Program Administrator reviewed metric data quarterly via Compass QI Summary and Detail Reports. Staff continued to receive education on the importance of providing services and assessments to decrease the risk for health of safety concerns/issues. Managers provided one on one guidance to supports coordinators when needed by discussing resources, interventions, and tools.

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Decrease percentage of participants reporting pain with inadequate pain control to a statewide averse of 25.6%.	SFY 2019 = [No baseline data reported] SFY 2020* = [31.86%] SFY 2021* [31.98%] ☒
Actions/Activities/Interventions: **Northern Healthcare Management**'s Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are: • The QI Program Manager will look at the data and details of members reporting inadequate pain control via QI Summary and Detail Report. • Educate staff on importance of providing services that will help with pain control. Provide resources and tools for supports coordinators to use to better assist the member. Provide education to staff regarding consistency and review of data collection. • The QI Program Manager will continue to monitor the number of members reporting pain with inadequate pain control at least quarterly. According to **Northern Healthcare Management**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Summary Report FY 2021 dated January 10, 2022, **Northern Healthcare Management** identified the following: • State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve member safety, health, and outcomes with Waiver services. The Program Administrator reviewed metric data quarterly via Compass QI Summary and Detail Reports. Staff continued to receive education on the importance of providing services and assessments to decrease the risk for health of safety concerns/issues. Managers provided one on one guidance to supports coordinators when needed by discussing resources, interventions, and tools.		
3. *Prevalence of Falls*	Decrease fall risks and fall percentages reported by participants by improving physical functioning to a statewide average of 27.4%	SFY 2019 = [No baseline data reported] SFY 2020* = [37.78%] SFY 2021* = [35.58%] ☒
Actions/Activities/Interventions: **Northern Healthcare Management**'s Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are: • The QI Program Manager will look at the data and details of members reporting fall via QI Summary and Detail Report • Educate staff on importance of providing services that will help improve physical functioning to reduce fall risks. Provide resources and tools for supports coordinators to use to better assist the member with reducing risk factors that contribute to falls. Provide education to staff regarding consistency and review of data collection. • The QI Program Manager will continue to monitor the number of members reporting falls at least quarterly.		

QIP Topic	Goal†	Measurement and Outcome
According to **Northern Healthcare Management**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Summary Report FY 2021 dated January 10, 2022, **Northern Healthcare Management** identified the following: • State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve member safety, health, and outcomes with Waiver services. The Program Administrator reviewed metric data quarterly via Compass QI Summary and Detail Reports. Staff continued to receive education on the importance of providing services and assessments to decrease the risk for health of safety concerns/issues. Managers provided one on one guidance to supports coordinators when needed by discussing resources, interventions, and tools.		
4. *Prevalence of Any Injuries*	Decrease percentage of participants reporting any injury to a statewide average of 6.0% by assessing safety/environment.	SFY 2019 = [No baseline data reported] SFY 2020* = [11.2%] SFY 2021* = [7.93%] ☒
Actions/Activities/Interventions: **Northern Healthcare Management**'s Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are: • The QI Program Manager will look at the data and details of members reporting fall via QI Summary and Detail Report. • Educate staff on importance of providing services that will help improve safety/environment for members reporting any injuries within this standard. Provide resources and tools for supports coordinators to use to better assist the member with reducing risk factors that contribute to injuries. Provide education to staff regarding consistency and review of data collection. • The QI Program Manager will continue to monitor the number of members reporting any qualifying injury for this standard at least quarterly. According to **Northern Healthcare Management**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Summary Report FY 2021 dated January 10, 2022, **Northern Healthcare Management** identified the following: • State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve member safety, health, and outcomes with Waiver services. The Program Administrator reviewed metric data quarterly via Compass QI Summary and Detail Reports. Staff continued to receive education on the importance of providing services and assessments to decrease the risk for health of safety concerns/issues. Managers provided one on one guidance to supports coordinators when needed by discussing resources, interventions, and tools.		

QIP Topic	Goal†	Measurement and Outcome
5. *Prevalence of Dehydration*	Decreasing percentage of participants reporting dehydration to a statewide average of 3.5% by increasing enough fluid intake.	SFY 2019 = [No baseline data reported] SFY 2020* = [2.94%] SFY 2021* = [1.63%] ☑

Actions/Activities/Interventions:

Northern Healthcare Management's Quality Management Plan FY 2020 and 2021 dated January 14, 2020, identified that **Northern Healthcare Management** planned actions to achieve the goal are:

- The QI Program Manager will look at the data and details of participants reporting dehydration via QI Summary and Detail Report
- Educate staff on importance of providing services that will help improve fluid intake for members reporting dehydration. Provide resources and tools for supports coordinators to use to better assist the member with reducing risk factors that to dehydration. Provide education to staff regarding consistency and review of data collection.
- The QI Program Manager will continue to monitor the number of members reporting dehydration at least quarterly.

According to **Northern Healthcare Management**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Summary Report FY 2021 dated January 10, 2022, **Northern Healthcare Management** identified the following:

- State quality goal for each of the five determined goals is to improve reporting data at or below the state average to improve member safety, health, and outcomes with Waiver services. The Program Administrator reviewed metric data quarterly via Compass QI Summary and Detail Reports. Staff continued to receive education on the importance of providing services and assessments to decrease the risk for health of safety concerns/issues. Managers provided one on one guidance to supports coordinators when needed by discussing resources, interventions, and tools.

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Although the waiver agency provided numerators and denominators in the annual report, the reported percentage rates did not align with the numerators and denominators. To calculate a rate and outcomes, HSAG added the numerators and denominators from the quarters provided and compared those results to the end of the SFY statewide average rate as provided by MDHHS.
†Goals presented were identified through the waiver agency's QMP although the annual report listed the statewide goal, which did not align with the QMP goals. Performance was determined based on the QMP goals. When the QMP goal was not specific, HSAG used the statewide average for SFY 2021.
[1] The FY 2020 1st/2nd quarter numerator was reported as "85." Since the waiver agency reported a rate of 3.2 percent, HSAG assumed the numerator was a typographical error and it should have been reported as "5."

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Northern Healthcare Management's *Prevalence of Neglect/Abuse* and *Prevalence of Dehydration* QIPs met **Northern Healthcare Management**'s goals and prevalence rates decreased, suggesting members experienced fewer incidents of neglect/abuse and dehydration than the prior year. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Northern Healthcare Management's SFY 2020–2021 QMP and SFY 2021 annual report included conflicting goals, which created confusion as to the true goals established by **Northern Healthcare Management** when initiating the QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented and should not change through the measurement period of the QIP unless documentation is provided to support the rationale for the change. Additionally, the SFY 2020–2021 QMP did not include baseline data for any of the QIPs, which would allow for year-to-year comparative data. [**Quality**]

Why the weakness exists: Northern Healthcare Management's goals as identified in the SFY 2020–2021 QMP did not align with the statewide goals established by MDHHS. Additionally, **Northern Healthcare Management**'s SFY 2021 annual report did not include an analysis of whether **Northern Healthcare Management** met its SFY 2021 goals as established in the SFY 2020–2021 QMP. Further, the results presented in the annual report also contained errors in the rate calculation compared to the numerators and denominators provided, which suggested the QIP performance was not appropriately validated by **Northern Healthcare Management**.

Recommendation: HSAG recommends that **Northern Healthcare Management** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should consistently align with the goals established by MDHHS. Additionally, **Northern Healthcare Management** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. Further, **Northern Healthcare Management** should develop a mechanism to validate QIP performance and present performance rates for the entire state fiscal year.

Weakness #2: The interventions implemented by **Northern Healthcare Management** to impact performance were unclear. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **Northern Healthcare Management**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. [**Quality**]

Why the weakness exists: **Northern Healthcare Management**'s SFY 2020–2021 QMP listed planned activities; however, the SFY 2021 annual report did not clearly identify the interventions implemented during SFY 2021 for all QIPs, or support that a causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Northern Healthcare Management** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Northern Healthcare Management** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Northern Healthcare Management** should analyze and interpret results at multiple points in time and test for statistical significance. **Northern Healthcare Management** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: **Northern Healthcare Management**'s SFY 2020–2021 QMP did not include details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs. **Northern Healthcare Management**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2020 annual report included minimal details on the design developed and methodology followed by **Northern Healthcare Management** when implementing its QIPs.

Recommendation: HSAG recommends that **Northern Healthcare Management** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Northern Healthcare Management** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-34. Table 3-34 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Northern Healthcare Management**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Northern Healthcare Management**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-34—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**87.01%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**92.08%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**97.62%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**75.00%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**93.89%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**82.35%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**100.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**90.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**86.36%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Northern Healthcare Management received a 100 percent performance rating for Performance Measures 4, 8, 16, 20, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determination; PCSPs included strategies to address health and safety risks; members received all of the services and supports identified in the PCSPs; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Northern Healthcare Management performed substantially worse than other waiver agencies on Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, as indicated by a

performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always include the goals and preferences desired by the member in the PCSP. [**Quality**]

Why the weakness exists: Northern Healthcare Management's performance rate for Performance Measure 17 fell 16.34 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that five of the 10 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member.

Recommendation: MDHHS required **Northern Healthcare Management** to submit a CAP to remediate the deficiencies associated with Performance Measure 17. **Northern Healthcare Management**'s CAP included, but was not limited to, education and training for all supports coordinators, internal monitoring of 10 records monthly for those supports coordinators, and individual plans for improvement for supports coordinators who continue to be out of compliance. While **Northern Healthcare Management**'s CAP required internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Northern Healthcare Management** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor all staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Northern Healthcare Management performed substantially worse than other waiver agencies on Performance Measure 19, *number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always update the PCSP according to MDHHS requirements. [**Quality** and **Access**]

Why the weakness exists: Northern Healthcare Management's performance rate for Performance Measure 19 fell 6.10 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that two of the 10 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and one of the seven applicable records did not demonstrate evidence that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements or provided the member/guardian with appropriate alternatives.

Recommendation: MDHHS required **Northern Healthcare Management** to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **Northern Healthcare Management**'s CAP included, but was not limited to, education and training for all supports coordinators, internal monitoring of 10 records monthly for those supports coordinators, and individual plans for improvement for supports coordinators who continue to be out of compliance. While **Northern Healthcare Management**'s CAP required internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Northern Healthcare Management** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved,

as it is important to regularly monitor all staff members to ensure performance stays consistent and requirements are met.

Weakness #3: Northern Healthcare Management performed substantially worse than other waiver agencies on Performance Measure 21, *number and percent of waiver participants whose records indicate choice was offered among waiver services*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that members were not always offered a choice among waiver services. [**Quality**]

Why the weakness exists: Northern Healthcare Management's performance rate for Performance Measure 21 fell 5.01 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that one of the 10 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian a choice of appropriate MI Choice Waiver Program services.

Recommendation: MDHHS did not require **Northern Healthcare Management** to submit a CAP to remediate the one deficiency associated with Performance Measure 21. However, HSAG recommends that **Northern Healthcare Management** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor all staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-35 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-35 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-35—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	90.00%		**4.00**
Focus 3	Release of Information	70.00%		**1.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 4	Status	82.76%		**2.00**
Focus 5	Pre-Planning	98.92%	100.00%	**4.00**
Focus 6	Assessment	95.60%	100.00%	**4.00**
Focus 7	Medication Record	98.04%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	89.26%	100.00%	**4.00**
Focus 9	MI Choice Services	94.74%	100.00%	**4.00**
Focus 10	Linking and Coordinating	100.00%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	90.48%	100.00%	**4.00**
Focus 12	Service Provider	100.00%		**4.00**
Focus 13	Contingency Plan	86.36%	100.00%	**4.00**
Focus 14	Critical Incidents	NA	100.00%	NA
Focus 15	Adverse Benefit Determination	75.00%		**3.00**
Focus 16	Complaints and Grievances	NA		NA
Focus 17	Home and Community Based		93.33%	**4.00**
	Totals	**93.03%**	**99.61%**	**3.89**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Northern Healthcare Management achieved a substantial compliance rating in 13 of the applicable 15 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Northern Healthcare Management did not consistently follow all Release of Information requirements; specifically, ensuring a valid ROI form is on file. Waiver agencies are required to ensure the member record includes a valid ROI form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three of the 10 applicable records did not demonstrate evidence that the waiver agency ensured a valid ROI form was included in the member record.

Recommendation: MDHHS required **Northern Healthcare Management** to submit a CAP to remediate the deficiencies. **Northern Healthcare Management**'s CAP included, but was not limited to, education and training for all supports coordinators, internal monitoring of 10 records monthly for those supports coordinators, and individual plans for improvement for supports coordinators who continue to be out of compliance. While **Northern Healthcare Management**'s CAP required internal monitoring until compliance of 85 percent is achieved, HSAG recommends that **Northern Healthcare Management** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor all staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Northern Healthcare Management did not consistently follow all Status requirements; specifically, ensuring the MI Choice Waiver Program enrollment and disenrollment

dates were supported in the member's record, and enrollment/disenrollment dates in the waiver agency's information technology system were consistent with those in CHAMPS. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the 10 applicable records did not demonstrate evidence that the correct program eligibility status was used, one of the two applicable records did not demonstrate evidence that the enrollment date was supported in the member's record, one of the three applicable records did not demonstrate evidence that the disenrollment date was supported in the member's record, one of the 10 applicable records did not demonstrate evidence that the correct care setting statuses were used, and one of the four applicable records did not demonstrate evidence that the enrollment/disenrollment dates in the waiver agency's information technology system were consistent with those in CHAMPS.

Recommendation: MDHHS required **Northern Healthcare Management** to submit a CAP to remediate the deficiencies. **Northern Healthcare Management**'s CAP included, but was not limited to, education and training for all supports coordinators, internal monitoring of 10 records monthly for those supports coordinators, and individual plans for improvement for supports coordinators who continue to be out of compliance. While **Northern Healthcare Management**'s CAP required internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Northern Healthcare Management** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor all staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-36 presents **Northern Healthcare Management**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-36—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	90.1%	91.5%
Recommendation Measures	94.0%	92.6%
Staff are Reliable and Helpful	91.8%	91.9%
Staff Listen and Communicate Well	96.7%	95.0%

Domain	Waiver Agency Score	Statewide Average Score
Case Manager is Helpful	**89.1%**	95.2%
Choosing the Services that Matter to You	92.6%	92.7%
Transportation to Medical Appointments	92.6%	92.5%
Personal Safety and Respect	95.7%	97.2%
Planning Your Time and Activities	75.8%	75.4%
Met Need	99.2%	95.3%
Physical Safety Measure	97.5%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Northern Healthcare Management achieved scores higher than the statewide results in the *Recommendation Measures*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Met Need* domains, indicating that **Northern Healthcare Management** provides services in a manner that meets or exceeds members' expectations in many domains. It should be noted that while **Northern Healthcare Management** achieved a higher score than the statewide results for *Planning Your Time and Activities*, this domain received the lowest statewide score across all domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Northern Healthcare Management scored more than 5 percentage points below the statewide average on the *Case Manager is Helpful* domain at 89.1 percent compared to the statewide average of 95.2 percent. [**Quality**]

Why the weakness exists: Of the three questions within the *Case Manager is Helpful* domain, **Northern Healthcare Management** scored 5 percentage points or more below the statewide average for two of the questions: C*ase manager helped when asked for help with getting or fixing equipment* and *Case manager helped when asked for help with getting other changes to services*. Additionally, **Northern Healthcare Management** scored below the statewide average on the remaining question, *Able to contact this case manager when needed*.

Recommendation: HSAG recommends that **Northern Healthcare Management** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Case Manager is Helpful* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Case Manager is Helpful* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Northern Healthcare Management**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Northern Healthcare Management** across all EQR activities. The overarching aggregated findings showed that **Northern Healthcare Management**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Northern Healthcare Management** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Northern Healthcare Management** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Northern Healthcare Management** should focus its efforts on improving members' experiences with waiver agency staff and case manager effectiveness, as members reported lower satisfaction in the *Global Ratings Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Personal Safety and Respect*, and *Physical Safety Measure* domains. HSAG's assessment of **Northern Healthcare Management** also identified continued opportunities for **Northern Healthcare Management** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Northern Healthcare Management** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.

- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Northern Healthcare Management** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Northern Healthcare Management**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Region 2 Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-37 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region 2 Area Agency on Aging** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region 2 Area Agency on Aging** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Region 2 Area Agency on Aging**'s QMP reports are also provided in Table 3-37. The results in Table 3-37 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-37—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Goal will be to be at or less than the state average for this Indicator	SFY 2019 = [No baseline data reported] SFY 2020* = [2.5%] SFY 2021* = [1.60%] ☑
Actions/Activities/Interventions: According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020-FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks: • Monitor quality indicators at the Quality Improvement Risk Management Meeting (QIRM). • Review incident reports at least biweekly. • Utilize the Safe Haven Program for safe housing in situations where a member is removed from the situation by APS [Adult Protective Services]. The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2021 dated December 2, 2021, identified the following: • Reports are reviewed at QIRM. • Supports coordinators have training at least annually regarding mandatory reporting of Abuse and Neglect. • Supports coordinators are trained on the Quality Indicators. • Incident reports are reviewed at weekly Quality Team Meetings. • Monthly audits are completed for one chart per supports coordinator per month. If any incidents of neglect or abuse are noted, the critical incident portal is reviewed to ensure that it has been entered. • Safe Haven has been utilized to assist members who have been neglected or abused. • COVID has created a situation where there aren't as many caregivers or supports coordinators going into the home.		

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Goal will be to be at or below the State wide average	SFY 2019 = [No baseline data reported] SFY 2020* = [16.07%] SFY 2021* = [15.76%] ☑
Actions/Activities/Interventions: According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020-FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks: • Monitor quality indicators bimonthly at QIRM. • Supports coordinators follow up with physician and assist the member in exploring options for alternate therapies as needed. • Supports coordinators will discuss the Pain Path Program with members as part of the Person Centered Service Planning Process. For those members willing to participate, arrangements will be made for them to attend. The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2021 dated December 2, 2021, identified the following: • Reports are reviewed at the bimonthly QIRM meetings. • Education is provided on various Quality Indicators throughout the fiscal year. • Medication Reconciliations are completed as warranted. • Person-Centered Planning processes are used when discussing and planning services for members.		
3. *Prevalence of Falls*	Goal will be to be at the state average or below	SFY 2019 = [No baseline data reported] SFY 2020* = [35.37%] SFY 2021* = [33.52%] ☒
Actions/Activities/Interventions: According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020 - FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks: • Monitor quality indicators bimonthly at QIRM meeting. • Education has been provided to supports coordinators to review reasons for fall and assist in putting preventative measures in place. • Supports coordinators will offer Matter of Balance Classes to member during the person-centered planning process. For those members willing to participate, arrangements will be made for them to attend. The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2021 dated December 2, 2021, identified the following: • Quality Indicators are reviewed at the bimonthly QIRM meetings • Education is provided to supports coordinators on fall prevention. • Environmental assessments are done at the new assessment and annual reassessment in non-COVID times. This year has been difficult to assess the environment due to not being able to be in the homes. • Referrals are made as needed to the Matter of Balance Classes as part of the person-centered planning process.		

QIP Topic	Goal†	Measurement and Outcome
4. *Prevalence of Any Injuries*	Goal is to be at or below the state average	SFY 2019 = [No baseline data reported] SFY 2020* = [7.04%] SFY 2021* = [6.28%] ☒
Actions/Activities/Interventions: According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020- FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks: • Monitor quality indicators bimonthly at QIRM meetings • Cases will be discussed and guidance given to supports coordinators The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2021 dated December 2, 2021, identified the following: • Quality Indicators are reviewed at the bimonthly QIRM meetings and findings are discussed. • Education is provided to supports coordinators on the various Quality Indicators. • Quality Assistants audit one chart per supports coordinator per month. If issues are found, education is provided and follow-up is completed. • Referrals to Chronic Condition or Matter of Balance classes [educational classes] were made as part of the person-centered planning process.		
5. *Prevalence of Dehydration*	Goal is to be at or below the state average	SFY 2019 = [No baseline data reported] SFY 2020* = [0.53%] SFY 2021* = [1.60%] ☒
Actions/Activities/Interventions: According to **Region 2 Area Agency on Aging**'s MI Choice Quality Management Plan FY 2020 - FY2021 dated November 18, 2019, **Region 2 Area Agency on Aging** planned to complete the following tasks: • Monitor quality indicators bimonthly at QIRM meetings. • Cases will be reviewed for trends, education created for staff as we work towards our goal. The **Region 2 Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities and Outcomes Report for FY 2021 dated December 2, 2021, identified the following: • Quality Indicators are reviewed at bimonthly QIRM meetings. • Education is provided to members by supports coordinators on the need to drink enough water. During the hot summer months, members are reminded more frequently. • COVID has disrupted the normal in-person visits; phone assessments/visits are being done.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*HSAG calculated the SFY 2020 and 2021 performance rates using the numerators and denominators provided by the waiver agency in the annual report.

†The goals identified by the waiver agency did not include the percentage for the statewide average; therefore, HSAG measured performance outcomes using the statewide goal.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Region 2 Area Agency on Aging met the statewide goals for the *Prevalence of Neglect/Abuse* and *Prevalence of Pain With Inadequate Pain Control* QIPs, indicating that **Region 2 Area Agency on Aging**'s members experienced a lower prevalence of neglect/abuse and uncontrolled pain as compared to the overall MI Choice Waiver Program. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The **Region 2 Area Agency on Aging** goals identified in the SFY 2020–2021 QMP dated November 18, 2019, were not specific and measurable. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly identified. [**Quality**]

Why the weakness exists: The goals for each quality indicator were included in the SFY 2020–2021 QMP dated November 18, 2019, under a header titled "FY 2021 Quality Improvement Projects, goals, strategies, and results"; since the QMP was dated November 18, 2019, it was unclear if the goals were for SFY 2020, if the QMP was updated with new goals for SFY 2021 but the date on the QMP was not revised, or if the goals were for SFY 2020 and 2021. Further, the goals were not specific as they were presented using the statewide average but did not include the statewide average percentage.

Recommendation: HSAG recommends that **Region 2 Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP. Additionally, the goals should include a static performance measurement and the measurement should not change through the QIP measurement period unless documentation is provided to support the rationale for the change (the statewide average will continually change; therefore, this fluid measurement may not lead to improvement).

Weakness #2: Region 2 Area Agency on Aging did not measure improvements to the quality indicators on an ongoing basis. To effectively measure improvement of the quality indicators, it is important to identify and measure against a baseline rate. [**Quality**]

Why the weakness exists: **Region 2 Area Agency on Aging** did not identify the baseline rate for each quality indicator within its QMP reports.

Recommendation: HSAG recommends **Region 2 Area Agency on Aging** identify the baseline period and rate for each quality indicator and measure them frequently to determine if interventions implemented are effective.

Weakness #3: In the SFY 2021 annual report, **Region 2 Area Agency on Aging** reported the numerator and denominator for each quarter of SFY 2021 for each quality indicator but did not calculate the percentages. It is important to monitor not only the numerator and denominator on an ongoing basis, but also the percentage in order to identify any significant increases or decreases in the rate. [**Quality**]

Why the weakness exists: **Region 2 Area Agency on Aging** did not report percentages on its quality indicators in the annual report.

Recommendation: HSAG recommends that **Region 2 Area Agency on Aging** monitor the percentage results for each quality indicator on an ongoing basis to determine if interventions are successful throughout the time period of the QIP.

Weakness #4: The interventions implemented by **Region 2 Area Agency on Aging** to meet performance goals were unclear. Additionally, the prevalence rate for the *Prevalence of Dehydration* QIP increased, indicating that the interventions implemented by **Region 2 Area Agency on Aging** were not effective. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. [**Quality**]

Why the weakness exists: **Region 2 Area Agency on Aging**'s SFY 2020–2021 QMP dated November 18, 2019, listed planned activities; however, the SFY 2021 annual report did not clearly identify the interventions implemented during SFY 2021 for all QIPs, or include an assessment of whether a specific intervention(s) was/were successful or unsuccessful in achieving increased performance. Additionally, for some QIPs it was unclear if the interventions listed in the annual report were interventions implemented during SFY 2021 or were planned interventions for the future. Further, no conclusions were drawn regarding whether the interventions had an impact on the rate.

Recommendation: HSAG recommends that **Region 2 Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Region 2 Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 2 Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #5: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Region 2 Area Agency on Aging**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and methodology followed by **Region 2 Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Region 2 Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 2 Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-38. Table 3-38 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Region 2 Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region 2 Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-38—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**91.61%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**94.20%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**94.44%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**91.67%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**95.44%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**94.29%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**95.83%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**94.74%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Region 2 Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 8, 16, 21, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included strategies to address health and safety risks; waiver service choice was offered to members; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses. While Performance Measures 2 and 15 did not meet the statewide performance rate, none of the performance measures fell below the statewide rate by more than 5 percentage points. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Region 2 Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 2 and 15. **Region 2 Area Agency on Aging**'s CAP included, but was not limited to, staff training; a review of one member record per supports coordinator, typically monthly by quality staff members; and the implementation of additional training, if necessary, based on the results of subsequent reviews. However, HSAG recommends that **Region 2 Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-39 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-39 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-39—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	89.36%	100.00%	**3.33**
Focus 2	Freedom of Choice	77.78%		**1.00**
Focus 3	Release of Information	100.00%		**4.00**
Focus 4	Status	100.00%		**4.00**
Focus 5	Pre-Planning	99.35%	100.00%	**4.00**
Focus 6	Assessment	96.30%	100.00%	**4.00**
Focus 7	Medication Record	91.75%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	93.18%	100.00%	**4.00**
Focus 9	MI Choice Services	96.26%	100.00%	**4.00**
Focus 10	Linking and Coordinating	97.73%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	97.62%	100.00%	**4.00**
Focus 12	Service Provider	100.00%		**4.00**
Focus 13	Contingency Plan	95.45%	100.00%	**4.00**
Focus 14	Critical Incidents	NA	100.00%	**NA**
Focus 15	Adverse Benefit Determination	80.00%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 17	Home and Community Based		NA	**NA**
	Totals	**94.95%**	**100.00%**	**3.95**

	Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Nine home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the area of Freedom of Choice as the overall rating for this program area was less than full compliance. [**Quality**]

Strength #2: Region 2 Area Agency on Aging achieved a substantial compliance rating in 14 of the applicable 15 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member;

therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Region 2 Area Agency on Aging did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid FOC form was on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that four of the 18 applicable records did not demonstrate evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **Region 2 Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Region 2 Area Agency on Aging**'s CAP included, but was not limited to, staff training; a review of one member record per supports coordinator, typically on a monthly basis by quality staff members; and the implementation of additional group or individualized staff training, if necessary, based on the results of subsequent reviews. However, HSAG recommends that **Region 2 Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-40 presents **Region 2 Area Agency on Aging**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-40—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	92.3%	91.5%
Recommendation Measures	94.3%	92.6%
Staff are Reliable and Helpful	92.9%	91.9%
Staff Listen and Communicate Well	94.6%	95.0%

Domain	Waiver Agency Score	Statewide Average Score
Case Manager is Helpful	99.1%	95.2%
Choosing the Services that Matter to You	95.1%	92.7%
Transportation to Medical Appointments	93.7%	92.5%
Personal Safety and Respect	98.4%	97.2%
Planning Your Time and Activities	79.3%	75.4%
Met Need	96.6%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Region 2 Area Agency on Aging achieved scores higher than the statewide results in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activities*, *Met Need*, and *Physical Safety Measure* domains, indicating that **Region 2 Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. It should be noted that while **Region 2 Area Agency on Aging** achieved a higher score than the statewide results for *Planning Your Time and Activities*, this domain received the lowest statewide score across all domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Region 2 Area Agency on Aging did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **Region 2 Area Agency on Aging** scored below the statewide average on the *Staff Listen and Communicate Well* domain; therefore, HSAG recommends that **Region 2 Area Agency on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Staff Listen and Communicate Well* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Staff Listen and Communicate Well* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Region 2 Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region 2 Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region 2 Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region 2 Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Region 2 Area Agency on Aging** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Region 2 Area Agency on Aging** should focus its efforts on improving members' experiences with waiver agency staff, as members reported lower satisfaction in the *Staff Listen and Communicate Well* domain. HSAG's assessment of **Region 2 Area Agency on Aging** also identified continued opportunities for **Region 2 Area Agency on Aging** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region 2 Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.

- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Region 2 Area Agency on Aging** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Region 2 Area Agency on Aging**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Region 3B Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-41 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region 3B Area Agency on Aging** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region 3B Area Agency on Aging** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Region 3B Area Agency on Aging**'s QMP reports are also provided in Table 3-41. The results in Table 3-41 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-41—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Decrease number of participants who have been neglected/abused, have poor hygiene, are fearful of family member or who have been restrained to a 3% percentage less than statewide	SFY 2019 = [No baseline data reported] SFY 2020* = [4.22%] SFY 2021* = [2.29%] ☒

Actions/Activities/Interventions:

According to **Region 3B Area Agency on Aging**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B Area Agency on Aging** planned to complete the following tasks:

- Initial training will be conducted for staff by Quality Assurance (QA) team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per supports coordinator. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with supports coordinator also. Quarterly findings to be reported at QA quarterly meeting.

The **Region 3B Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcome Summary Report FY2021 dated January 12, 2022, identified the following:

- An educational tool was developed, which provided different ideas for educating participants/designated representatives on ways to decrease neglect/abuse and was shared with supports coordinators. Monthly QI reports are generated, and information for each member who triggers is entered onto a spreadsheet. The Quality Manager reviews documentation in progress notes to identify that there is a complete and accurate description of the neglect/abuse, and that education was provided. Supports coordinator interventions must include monitoring of neglect/abuse. The CI [critical incident] portal is checked for documentation. If any of the required components have not been documented or there is a discrepancy, the supports coordinator and their supervisor are emailed with a request to amend any areas that are incorrect. Documentation is reviewed once corrections are completed.

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Decrease number of participants who experienced pain and inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain to a 2% less that statewide	SFY 2019 = [No baseline data reported] SFY 2020* = [18.87%] SFY 2021* = [20.38%] ☑

Actions/Activities/Interventions:

According to **Region 3B Area Agency on Aging**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B Area Agency on Aging** planned to complete the following tasks:

- Initial training will be conducted for staff by QA team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per supports coordinator. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with supports coordinator also. Quarterly findings to be reported at QA quarterly meeting.

The **Region 3B Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcome Summary Report FY2021 dated January 12, 2022, identified the following:

- An educational tool was developed, which provided different ideas for educating participants/designated representatives on ways to decrease pain and was shared with supports coordinators. Monthly QI reports are generated, and information for each member who triggers is entered onto a spreadsheet. The quality manager reviews documentation in progress notes to identify that there is a complete and accurate description of the pain, pain management techniques and that education was provided. Supports coordinator interventions must include monitoring of pain. If any of the required components have not been documented or there is a discrepancy, the supports coordinator and their supervisor are emailed with a request to amend any areas that are incorrect. Documentation is reviewed once corrections are completed.

QIP Topic	Goal†	Measurement and Outcome
3. *Prevalence of Falls*	Decrease the number of participants who experienced falls excluding those completely dependent in bed mobility to 3% less than statewide	SFY 2019 = [No baseline data reported] SFY 2020* = [4.54%] SFY 2021* = [25.17%] ☒

Actions/Activities/Interventions:

According to **Region 3B Area Agency on Aging**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B Area Agency on Aging** planned to complete the following tasks:

- Initial training will be conducted for staff by QA team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per supports coordinator. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with supports coordinator also. Quarterly findings to be reported at QA quarterly meeting.

The **Region 3B Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcome Summary Report FY2021 dated January 12, 2022, identified the following:

- An educational tool was developed, which provided different ideas for educating participants/designated representatives on ways to decrease falls and was shared with supports coordinators. Monthly QI reports are

QIP Topic	Goal†	Measurement and Outcome
generated, and information for each member who triggers is entered onto a spreadsheet. The quality manager reviews documentation in the description of Section J of the assessment to identify that there is a complete and accurate description of falls, fall prevention techniques and that education was provided. Supports coordinator interventions must include monitoring of falls. If any of the required components have not been documented or there is a discrepancy, the supports coordinator and their supervisor are emailed with a request to amend any areas that are incorrect. Documentation is reviewed once corrections are completed		
4. *Prevalence of Any Injuries*	Decrease the number of participants with any injuries with fractures or major skin problems by 2% statewide	SFY 2019 = [No baseline data reported] SFY 2020* = [5.41%] SFY 2021* = [4.46%] ☒
Actions/Activities/Interventions: According to **Region 3B Area Agency on Aging**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B Area Agency on Aging** planned to complete the following tasks: • Initial training will be conducted for staff by QA team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per supports coordinator. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are questionable, QA team to discuss with supports coordinator also. Quarterly findings to be reported at QA quarterly meeting. The **Region 3B** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcome Summary Report FY2021 dated January 12, 2022, identified the following: • An educational tool was developed, which provided different ideas for educating participants/designated representatives on ways to decrease injuries and was shared with supports coordinators. Monthly QI reports are generated, and information for each member who triggers is entered onto a spreadsheet. The quality manager reviews documentation in the section of the assessment that triggered for an injury to identify that there is a complete and accurate description of the injury, treatment for injury and that education was provided. Supports coordinator interventions must include monitoring of injuries. If any of the required components have not been documented or there is a discrepancy, the supports coordinator and their supervisor are emailed with a request to amend any areas that are incorrect. Documentation is reviewed once corrections are completed.		
5. *Prevalence of Dehydration*	Reduce the prevalence of participants who were dehydrated due to insufficient fluid intake to less than 3.5%	SFY 2019 = [No baseline data reported] SFY 2020* = [2.64%] SFY 2021* = [3.69%] ☒
Actions/Activities/Interventions: According to **Region 3B Area Agency on Aging**'s MI Choice Quality Management Plan dated January 15, 2020, **Region 3B Area Agency on Aging** planned to complete the following tasks: • Initial training will be conducted for staff by QA team to discuss assessing, monitoring, and documentation for this indicator. QA staff to review and audit indicator each month on 2-3 charts per supports coordinator. Findings will be tallied, analyzed, and discussed within the QA and management team. If findings are		

QIP Topic	Goal†	Measurement and Outcome
questionable, QA team to discuss with supports coordinator also. Quarterly findings to be reported at QA quarterly meeting. The **Region 3B Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcome Summary Report FY2021 dated January 12, 2022, identified the following: • An educational tool was developed, which provided different ideas for educating participants/designated representatives on ways to decrease dehydration and was shared with supports coordinators. Monthly QI reports are generated, and information for each member who triggers is entered onto a spreadsheet. The quality manager reviews documentation in progress notes to identify that there is a complete and accurate description of the dehydration, reason for dehydration and that education was provided. Supports coordinator interventions must include monitoring of dehydration. If any of the required components have not been documented or there is a discrepancy, the supports coordinator and their supervisor are emailed with a request to amend any areas that are incorrect. Documentation is reviewed once corrections are completed.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*HSAG calculated the SFY 2020 and 2021 performance rates using the numerators and denominators provided by the waiver agency in the annual report.
†HSAG made the assumption that any reference to "statewide" in each goal referred to the statewide rate at the time the QIP quality indicators were selected by MDHHS and the percentage of reduction was based on percentage points less than these statewide rates.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Region 3B Area Agency on Aging met its goal for the *Prevalence of Pain With Inadequate Pain Control* QIP, indicating that **Region 3B Area Agency on Aging**'s members experienced few incidents of uncontrolled pain. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The **Region 3B Area Agency on Aging** goals indicated in the SFY 2020–2021 QMP were not clear and specific. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of

quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: Each QIP goal identified within the QMP reports was not stated as a specific goal. The goals were presented using "statewide"; however, it was unclear if this referred to the statewide average or the statewide goal, and the point in time to which these percentages applied was not stated.

Recommendation: HSAG recommends that **Region 3B Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals.

Weakness #2: **Region 3B Area Agency on Aging** did not measure improvements to the quality indicators on an ongoing basis. To effectively measure improvement of the quality indicators, it is important to identify and measure against a baseline rate. [**Quality**]

Why the weakness exists: **Region 3B Area Agency on Aging** did not indicate the baseline rate for each quality indicator within its QMP reports.

Recommendation: HSAG recommends **Region 3B Area Agency on Aging** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective.

Weakness #3: In the SFY 2021 annual report, **Region 3B Area Agency on Aging** reported the numerator and denominator for each quarter of SFY 2021 for each quality indicator but did not calculate the percentages. It is important to monitor not only the numerator and denominator on an ongoing basis, but also the percentage to identify any significant increases or decreases in the rate. [**Quality**]

Why the weakness exists: **Region 3B Area Agency on Aging** did not report percentages on its quality indicators in the annual report.

Recommendation: HSAG recommends that **Region 3B Area Agency on Aging** monitor the percentage results for each quality indicator on an ongoing basis to determine if interventions are successful throughout the time period of the QIP.

Weakness #4: The interventions implemented by **Region 3B Area Agency on Aging** did not appear to be effective as **Region 3B Area Agency on Aging** did not meet the statewide goals for four of the five QIPs (*Prevalence of Neglect/Abuse*, *Prevalence of Falls*, *Prevalence of Any Injuries*, and *Prevalence of Dehydration*). Additionally, **Region 3B Area Agency on Aging**'s rate for the *Prevalence of Falls* QIP increased significantly (20.63 percentage points) from SFY 2020 to SFY 2021. **Region 3B Area Agency on Aging**'s choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. [**Quality**]

Why the weakness exists: **Region 3B Area Agency on Aging** did not meet the statewide goals for four QIPs. Additionally, documentation did not support that a comprehensive causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Region 3B Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Region 3B Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Region 3B Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 3B Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #5: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Region 3B Area Agency on Aging**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and methodology followed by **Region 3B Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Region 3B Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 3B Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-42. Table 3-42 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Region 3B Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region 3B Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-42—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**97.39%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**99.38%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**90.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**100.00%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**97.68%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**92.00%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**89.47%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**97.37%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Region 3B Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 8, 15, 17, 21, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included services and supports that aligned with members' assessed needs; PCSPs included goals and preferences desired by the member; waiver service choice was offered to members; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Region 3B Area Agency on Aging performed substantially worse than other waiver agencies on Performance Measure 16, *number and percent of participants whose person-centered*

service plan had strategies to address their assessed health and safety risks, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always ensure the PCSP included strategies to address health and safety risks. [**Quality**]

Why the weakness exists: **Region 3B Area Agency on Aging**'s performance rate for Performance Measure 16 fell 8.69 percentage points below the statewide rate. Through the CQAR, of the 15 records reviewed, MPHI determined that three of the 15 applicable records did not demonstrate evidence that the PCSP identified the member's health and welfare issues, needs, and risks as preferred by the member and as needed for continued monitoring by the supports coordinator.

Recommendation: MDHHS required **Region 3B Area Agency on Aging** to submit a CAP to remediate the deficiencies associated with Performance Measure 16. **Region 3B Area Agency on Aging**'s CAP included, but was not limited to, education and training for all staff and a review of one record for each supports coordinator. While **Region 3B Area Agency on Aging** identified it would conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Region 3B Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-43 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-43 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-43—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	97.14%	100.00%	**4.00**
Focus 2	Freedom of Choice	100.00%		**4.00**
Focus 3	Release of Information	80.00%		**3.00**
Focus 4	Status	100.00%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 5	Pre-Planning	100.00%	98.86%	**4.00**
Focus 6	Assessment	97.04%	100.00%	**4.00**
Focus 7	Medication Record	91.03%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	95.05%	98.41%	**4.00**
Focus 9	MI Choice Services	98.82%	100.00%	**4.00**
Focus 10	Linking and Coordinating	97.62%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	73.53%	100.00%	**2.04**
Focus 12	Service Provider	91.67%		**4.00**
Focus 13	Contingency Plan	97.67%	100.00%	**4.00**
Focus 14	Critical Incidents	100.00%	100.00%	**4.00**
Focus 15	Adverse Benefit Determination	100.00%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		92.00%	**4.00**
	Totals	**95.76%**	**99.05%**	**3.91**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Region 3B Area Agency on Aging achieved a substantial compliance rating in 16 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Region 3B Area Agency on Aging did not consistently follow all Follow-Up and Monitoring requirements—specifically, contacting new members to ensure service delivery in accordance with MDHHS policy and contract requirements; contacting members for follow-up and monitoring as specified in the member's PCSP; and, if there were no changes in service delivery, ensuring ongoing receipt and satisfaction of services. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the four applicable records did not demonstrate evidence that the waiver agency contacted new members/guardians to ensure service delivery in accordance with MDHHS policy and contract requirements; seven of the 15 applicable records did not demonstrate evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP; and one of the seven applicable records did not demonstrate evidence that, if there were no changes in services, the supports coordinator ensured ongoing receipt and satisfaction with services.

Recommendation: MDHHS required **Region 3B Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Region 3B Area Agency on Aging**'s CAP included, but was not limited to, education and training for all staff and a review of 10 to 12 records for each supports coordinator depending on the standard. While **Region 3B Area Agency on Aging** was required to conduct internal monitoring until compliance of 80 or 90 percent is achieved (depending on the specific area), HSAG recommends that **Region 3B Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g.,

monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **Region 3B Area Agency on Aging** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-44 presents **Region 3B Area Agency on Aging**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-44—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	**97.1%**	91.5%
Recommendation Measures	96.2%	92.6%
Staff are Reliable and Helpful	95.4%	91.9%
Staff Listen and Communicate Well	97.9%	95.0%
Case Manager is Helpful	94.6%	95.2%
Choosing the Services that Matter to You	92.0%	92.7%
Transportation to Medical Appointments	93.0%	92.5%
Personal Safety and Respect	99.1%	97.2%
Planning Your Time and Activities	70.6%	75.4%
Met Need	94.7%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Region 3B Area Agency on Aging achieved scores higher than the statewide results in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, and *Physical Safety Measure* domains, indicating that **Region 3B Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. Additionally, **Region 3B Area Agency on Aging** scored more than 5 percentage points above the statewide average for the *Global Ratings Measures* domain. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Region 3B Area Agency on Aging did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **Region 3B Area Agency on Aging** scored below the statewide average on the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains. Therefore, HSAG recommends that **Region 3B Area Agency on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains; conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary. The CAHPS survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. However, the waiver agency should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agency should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.

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

To identify strengths and weaknesses and draw conclusions for **Region 3B Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region 3B Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region 3B Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region 3B Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Region 3B Area Agency on Aging** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Region 3B Area Agency on Aging** should focus its efforts on improving members' experiences with waiver agency staff, case manager effectiveness, and some waiver services, as members reported lower satisfaction in the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains. HSAG's assessment of **Region 3B Area Agency on Aging** also identified continued opportunities for **Region 3B Area Agency on Aging** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region 3B Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Region 3B Area Agency on Aging** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Region 3B Area Agency on Aging**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Region IV Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-45 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region IV Area Agency on Aging** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region IV Area Agency on Aging** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Region IV Area Agency on Aging**'s QMP reports are also provided in Table 3-45. The results in Table 3-45 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-45—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	State Goal: 3%	SFY 2019 = [No baseline data reported] SFY 2020 = 1.7% SFY 2021* = [1.95%] ☑
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • State goal was met; no further activities completed.		
2. *Prevalence of Pain With Inadequate Pain Control*	State Goal: 20%	SFY 2019 = [No baseline data reported] SFY 2020 = 33.4% SFY 2021* = [27.67%] ☒
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following:		

QIP Topic	Goal†	Measurement and Outcome
• State goal not yet met however numbers indicate continued decline from first quarter to fourth quarter. On June 24, 2021, **Region IV Area Agency on Aging** Care Management staff had a training presented by an RN educator that included multiple topics related to pain. • **Region IV Area Agency on Aging** did not meet the goal of 20%, however **Region IV Area Agency on Aging** did decrease the percent of members with inadequate pain control from 30% to 25%.		
3. *Prevalence of Falls*	State Goal: 23%	SFY 2019 = [No baseline data reported] SFY 2020 = 29.5% SFY 2021* = [30.00%] ☒
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • State goal not yet met. The PDSA [plan, do, study, act] cycle completed in first and second quarter 2021 utilized a sample of 4 Care Managers. In evaluation of this PDSA discovered that use of STEADI actually increased reporting of falls instead of decreasing it. One possible hypothesis for this is that the increase in focus on falls lead to more accurate reporting by members and Care Managers. Additionally, **Region IV Area Agency on Aging** is not far from the statewide average. **Region IV Area Agency on Aging** will plan to continue to address falls in SFY 2022.		
4. *Prevalence of Any Injuries*	State Goal: 3%	SFY 2019 = [No baseline data reported] SFY 2020 = 4.6% SFY 2021* = [4.69%] ☒
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • **Region IV Area Agency on Aging** has begun to focus on this indicator in December 2020 by analyzing the detailed QI report. **Region IV Area Agency on Aging** staff had education provided on proper use of fracture questions on iHC assessment on 12/17/20. In an in-depth analysis of Q4, **Region IV Area Agency on Aging** found that many of the reasons selected for "major skin problems" in the iHC assessment did not result from an injury. Additionally, **Region IV Area Agency on Aging** found two selections for fracture that were incorrectly selected, and one selection which was from an initial assessment, which also should not be counted as it occurred prior to enrollment. **Region IV Area Agency on Aging** also notes that currently the QI		

QIP Topic	Goal†	Measurement and Outcome
report counts "major skin problems" in the iHC assessment which includes healing surgical wounds. These would not meet the criteria for an "injury" and should not be counted. **Region IV Area Agency on Aging** encourages MDHHS to consider looking at a new way to measure this QI. If we account for those selections the adjusted score for Q4 would be 10/404 which is 2.5%, below the states goal of 3%.		
5. *Prevalence of Dehydration*	State Goal: 1.5%	SFY 2019 = [No baseline data reported] SFY 2020 = 3% SFY 2021* = [2.93%] ☒
Actions/Activities/Interventions: According to **Region IV Area Agency on Aging**'s MI Choice Quality Management Plan FY' 2020 & FY' 2021, dated January 15, 2020, **Region IV Area Agency on Aging** planned to complete the following tasks: • [None identified] The **Region IV Area Agency on Aging** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • In an evaluation of the detailed QI report for 4th quarter SFY 2021, Quality Manager discovered that seven participants triggered to the selection of "Fluid intake less than 1,000 cc per day" related to a medically prescribed fluid restriction. These members should not be counted as "insufficient fluid intake" as their fluid intake is at the prescribed level. This is a flaw in the logic of the QI tool and should be corrected. In addition, three members triggered for dehydration at their initial assessment which documents status prior to enrollment and does not account for dehydration after MI Choice intervention. If the score is adjusted to remove the above individuals Q4 becomes 6/404=1.5% meeting the states goal.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
* HSAG calculated the SFY 2021 performance rates using the numerators and denominators provided by the waiver agency in the annual report.
†QIP goals were identified through the annual report as no goals were included as part of the QMP.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Region IV Area Agency on Aging met the state goal for the *Prevalence of Neglect/Abuse* QIP, suggesting that **Region IV Area Agency on Aging**'s members experienced few incidents of reported neglect/abuse. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region IV Area Agency on Aging did not identify any goals for the QIPs in the SFY 2020–2021 QMP. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: Although the statewide goal was identified in the SFY 2021 annual report, **Region IV Area Agency on Aging**'s SFY 2020–2021 QMP did not initially establish any goals for the QIPs. Once a QIP is selected by the QMC, the QMP should be updated with **Region IV Area Agency on Aging**'s internally established goals. Further, the goals only indicated a percentage, but not whether the performance outcome was to be above or below that percentage.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be documented within its QMP, and an evaluation of these specific goals should be included in the annual report.

Weakness #2: Region IV Area Agency on Aging did not measure improvements to the quality indicators on an ongoing basis. To effectively measure improvement in the quality indicators, it is important to identify and measure against a baseline rate. [**Quality**]

Why the weakness exists: Region IV Area Agency on Aging did not indicate the baseline for each quality indicator within its QMP reports.

Recommendation: HSAG recommends **Region IV Area Agency on Aging** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective.

Weakness #3: Region IV Area Agency on Aging's interventions appeared to be ineffective as **Region IV Area Agency on Aging** did not meet the statewide goals for four QIPs. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. [**Quality**]

Why the weakness exists: Region IV Area Agency on Aging's SFY 2021 annual report listed some activities conducted; however, the SFY 2021 annual report did not identify the interventions for all QIPs or include an assessment of whether a specific intervention(s) was/were successful or

unsuccessful in achieving increased performance. Further, no conclusions were drawn regarding whether the interventions had an impact on the rate.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Region IV Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region IV Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #4: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Region IV Area Agency on Aging**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and methodology followed by **Region IV Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region IV Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-46. Table 3-46 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Region IV Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region IV Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-46—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**92.42%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**97.77%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**95.65%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**97.06%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**91.18%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**96.54%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**87.10%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**94.74%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**89.19%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Region IV Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 8, 21, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; waiver service choice was offered to members; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 15, 16, 17, 19, and 30 did not meet the statewide performance rate, none of the performance measures fell below the statewide rate by more than 5 percentage points. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Region IV Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 15, 16, 17, 19, and 30. **Region IV Area Agency on Aging**'s CAP included, but was not limited to, development of a job aid and workflow; staff training; a review of 10 member records; and the implementation of additional performance improvement strategies, if necessary, based on the results of the subsequent reviews. However, the CAP also indicated internal monitoring is required by **Region IV Area Agency on Aging** until compliance of 90 percent is achieved. Therefore, HSAG recommends that **Region IV Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-47 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-47 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-47—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	82.35%		**2.00**
Focus 3	Release of Information	88.24%		**4.00**
Focus 4	Status	100.00%		**4.00**
Focus 5	Pre-Planning	100.00%	100.00%	**4.00**
Focus 6	Assessment	97.39%	100.00%	**4.00**
Focus 7	Medication Record	94.62%	100.00%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 8	Person-Centered Service Planning	95.10%	100.00%	**4.00**
Focus 9	MI Choice Services	94.95%	100.00%	**4.00**
Focus 10	Linking and Coordinating	94.74%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	61.11%	100.00%	**2.04**
Focus 12	Service Provider	100.00%		**4.00**
Focus 13	Contingency Plan	90.24%	100.00%	**4.00**
Focus 14	Critical Incidents	91.67%	100.00%	**4.00**
Focus 15	Adverse Benefit Determination	96.00%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**94.83%**	**100.00%**	**3.90**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Nine home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the areas of Freedom of Choice and Follow-Up and Monitoring as the overall rating for these program areas was less than full compliance. [**Quality**]

Strength #2: Region IV Area Agency on Aging achieved a substantial compliance rating in 15 of the 17 record review standards reviewed as part of the CQAR, which include the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Region IV Area Agency on Aging did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid FOC form was on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three of the 17 applicable records did not demonstrate evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **Region IV Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Region IV Area Agency on Aging**'s CAP included, but was not limited to, development of a job aid; staff training; a review of 10 member records; and the implementation of additional performance improvement strategies, if necessary, based on the results of the review. However, HSAG recommends that **Region IV Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis

(e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: **Region IV Area Agency on Aging** did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting new members to ensure service delivery in accordance with MDHHS policy and contract requirements, and contacting members for follow-up and monitoring as specified in the member's PCSP. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the two applicable records did not include evidence that the waiver agency contacted new members/guardians to ensure service delivery in accordance with MDHHS policy and contract requirements, and 13 of the 17 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP.

Recommendation: MDHHS required **Region IV Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Region IV Area Agency on Aging**'s CAP included, but was not limited to, development of a job aid; staff training; a review of 11 member records; and the implementation of additional performance improvement strategies, if necessary, based on the results of the review. However, the CAP also indicated internal monitoring is required by **Region IV Area Agency on Aging** until compliance of 90 percent is achieved. Therefore, HSAG recommends that **Region IV Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **Region IV Area Agency on Aging** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-48 presents **Region IV Area Agency on Aging**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-48—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	94.9%	91.5%
Recommendation Measures	94.1%	92.6%
Staff are Reliable and Helpful	93.0%	91.9%
Staff Listen and Communicate Well	94.1%	95.0%
Case Manager is Helpful	97.5%	95.2%
Choosing the Services that Matter to You	95.4%	92.7%
Transportation to Medical Appointments	92.2%	92.5%
Personal Safety and Respect	96.7%	97.2%
Planning Your Time and Activities	74.7%	75.4%
Met Need	95.3%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Region IV Area Agency on Aging achieved scores higher than the statewide results in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful, Case Manager is Helpful*, *Choosing the Services that Matter to You*, and *Physical Safety Measure* domains, indicating that **Region IV Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region IV Area Agency on Aging did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality** and **Access**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **Region IV Area Agency on Aging** scored below the statewide average on the *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activitie*s, and *Met Need* domains. Therefore, HSAG recommends that **Region IV Area Agency on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains; conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary. It should be noted that the *Planning Your Time and Activities* domain received the lowest statewide score across all domains. The CAHPS survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. However, the waiver agency should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agency should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.

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

To identify strengths and weaknesses and draw conclusions for **Region IV Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region IV Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region IV Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region IV Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Region IV Area Agency on Aging** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Region IV Area Agency on Aging** should focus its efforts on improving members' experiences with waiver agency staff,

access to transportation, and some waiver services, as members reported lower satisfaction in the *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains. HSAG's assessment of **Region IV Area Agency on Aging** also identified continued opportunities for **Region IV Area Agency on Aging** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region IV Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Region IV Area Agency on Aging** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Region IV Area Agency on Aging**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Region VII Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-49 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region VII Area Agency on Aging** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region VII Area Agency on Aging** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Region VII Area Agency on Aging**'s QMP reports are also provided in Table 3-49. The results in Table 3-49 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-49—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Reduce the percentage of MI Choice Waiver participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained to a statewide average of 5.0% or less	SFY 2019 = 6.4% SFY 2020 = 4.9% SFY 2021 = 5.1% ☒

Actions/Activities/Interventions:

According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks:

- **Region VII Area Agency on Aging** members are monitored for neglect, abuse, poor hygiene, and fear of family members by the supports coordinators at the initial assessment, reassessments at least every 180 days, and with monitoring contacts every 90 days or less.
- Supports coordinators who suspect any incidence of neglect or abuse immediately report the information obtained to their waiver manager, APS, and, if the member is in imminent danger emergency services is contacted.
- A critical incident is completed for reporting to MDHHS along with a resolution. Supports coordinators also follow up with the member to offer additional services as needed including respite care and future planning to prevent future neglect or abuse.

The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following:

Improvement Projects and Strategies:

- At the February 2021 Statewide Quality Management Collaborative (QMC) meeting, the QMC made the decision to focus primarily on the quality indicator for Fall Prevention and the goal of reducing falls. At the March 2021 **Region VII Area Agency on Aging** Local QMC meeting, two **Region VII Area Agency on**

QIP Topic	Goal	Measurement and Outcome

Aging members expressed their concerns that the decision to focus primarily on fall prevention was too limited and they wanted to take their concerns to the next statewide QMC meeting in May 2021. The **Region VII Area Agency on Aging** members expressed their concerns regarding lack of focus on abuse/neglect at the May 2021 statewide QMC meeting, however, they were told that the steering committee had decided that they were going to focus primarily on fall prevention and that **Region VII Area Agency on Aging** members were welcome to work on their own goals outside of the ones chosen by the steering committee. At the June 2021 **Region VII Area Agency on Aging** local QMC meeting, one of the **Region VII Area Agency on Aging** members announced that they had joined the steering committee at the state level in the hope of affecting change and advocating for all members. **Region VII Area Agency on Aging**'s local QMC continues to discuss ways to improve the prevalence of neglect/abuse and there are at least an average of three or more **Region VII Area Agency on Aging** members who attend the statewide QMC meetings each quarter.

- **Region VII Area Agency on Aging** waiver staff receive critical incident training and elder abuse training on an annual basis. All identified critical incidents are entered into the MDHHS statewide critical incident website and the quality manager reviews each one to ensure appropriate resolution and thorough documentation. The quality support specialist reviews all hospitalizations and emergency room visits reported through the Connected 2 Care system for waiver members and identifies any potential critical incidents that may not have been reported to **Region VII Area Agency on Aging** by the member or their allies. Follow up is requested by the supports coordinators and the waiver managers are notified to ensure that the member is contacted and their health, safety and welfare needs are being properly addressed. **Region VII Area Agency on Aging** supports coordinators and managers are all mandated reporters and any identified abuse, neglect or exploitation is immediately reported to APS or, in the event of an emergent situation, 911 or law enforcement are notified.
- Members, their allies, and service providers are all educated by **Region VII Area Agency on Aging** staff on identifying critical incidents and how to report them. Each member receives information in their **Region VII Area Agency on Aging** resource folder on critical incidents and abuse/neglect and this includes a card on how to contact central intake for APS.

Results:

- **Region VII Area Agency on Aging** reported 261 critical incidents in SFY 2021, and of those, 15 (5.7%) were related to abuse, neglect, exploitation, or use of restraints. In SFY 2020 **Region VII Area Agency on Aging** reported 225 critical incidents, and of those, 25 (11.0%) were related to abuse, neglect, exploitation, or use of restraints. From SFY 2020 to SFY 2021, **Region VII Area Agency on Aging** reduced the number of critical incidents reported that were related to abuse, neglect, exploitation, or use of restraints by 5.3%.
- In utilizing the quality indicator report through the COMPASS system to measure the number of **Region VII Area Agency on Aging** members who reported neglect or abuse, had poor hygiene, were fearful of a family member, or were restrained during SFY 2021 it was determined that:
  - Numerator: 50 (5.1%)
  - Denominator: 990 Total Members

Outcome:

- **Region VII Area Agency on Aging** members experienced an agency rate 0.1% higher than the statewide average goal of 5.0% for prevalence of neglect/abuse for SFY 2021.

QIP Topic	Goal	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Reduce the percentage of MI Choice Waiver participants who experience pain and experience inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain to a statewide average of 20% or less.	SFY 2019 = 28.1% SFY 2020 = 23.3% SFY 2021 = 22.2% ☒

Actions/Activities/Interventions:

According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks:

- **Region VII Area Agency on Aging** supports coordinators assess all MI Choice waiver members for adequate pain control during initial assessment, reassessment at least every 180 days, reassessment within 30 days of a hospitalization, and with monitoring contacts every 90 days or less.
- Supports coordinators educate members on pain management and medication regimens with regard to pain medication.
- Supports coordinators offer assistance to members in contacting their primary care physician for a referral to pain clinics.
- **Region VII Area Agency on Aging** also offers members assistance with medication reconciliation and occupational therapy referrals through a contracted pharmacist and physical therapist to assist with meeting their care needs.

The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following:

Improvement Projects and Strategies:

- **Region VII Area Agency on Aging** supports coordinators are trained to assess pain. They utilize a 0-10 Numerical Pain Rating Scale and for members who are unable to express themselves verbally due to physical or cognitive reasons. The FLACC [Face, Legs, Activity, Cry, Consolability] pain scale is used to assess pain. Supports coordinators assess pain at every assessment (initial, 90 day, and 180 day), and for any changes in medical condition at every monitoring contact (every 30-60 days). Members are contacted within five days of hospitalizations or emergency room visits to assess for change in condition or service needs, and they request a post-hospitalization assessment be completed within 30 days of discharge from the hospital per member choice. When a member experiences an unplanned transition to a nursing home for rehab, supports coordinators collaborate with both the member, their allies, and nursing home staff to prepare for discharge back to the community and a full reassessment is completed within seven days of discharge from the nursing home. Supports coordinators collaborate with skilled care staff and primary care physicians to assist members in addressing uncontrolled pain and educate members on asking their physician for a referral to a pain specialist. Supports coordinators also educate members with uncontrolled pain on palliative care options and make referrals to local advanced disease programs to provide additional assistance.
- Registered nurse supports coordinators complete a minimum of two continuing education contact hours focused on pain and pain management as part of the requirements for their nursing license in the State of Michigan. **Region VII Area Agency on Aging** offers resources to members and anyone in the community through their website www.region7aaa.org. This includes information on the Chronic Pain PATH and

QIP Topic	Goal	Measurement and Outcome
interactive workshop designed to help members with chronic pain improve their health and feel better through Living Well Programs, the Aging Mastery Program through the National Council on Aging, and the Arthritis Foundation Exercise Program among others. *Results:* • In utilizing the quality indicator report through the COMPASS system to measure the number of **Region VII Area Agency on Aging** members who experienced pain and experienced inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciating intense pain during SFY 2021 it was determined that: – Numerator: 218 (22.2%) – Denominator: 982 Total Members *Outcome:* • **Region VII Area Agency on Aging** members experienced an agency rate 2.2% higher than the statewide average goal of 20.0% for prevalence of pain with inadequate pain control.		
3. *Prevalence of Falls*	Reduce the percentage of MI Choice Waiver participants who record a fall on follow-up assessment to a statewide average of 25% or less.	SFY 2019 = 31.7% SFY 2020 = 32.7% SFY 2021 = 29.7% ☒
Actions/Activities/Interventions: According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks: • **Region VII Area Agency on Aging** supports coordinators assess all MI Choice waiver members for falls during initial assessment, reassessment at least every 180 days, reassessment within 30 days of a hospitalization, and with monitoring contacts every 90 days or less. • Supports coordinators educate members on fall prevention. • Supports coordinators offer assistance to members in contacting their primary care physician for referrals to skilled care for skilled nursing, physical therapy, or occupational therapy. • **Region VII Area Agency on Aging** also offers members assistance with medication reconciliation, occupational therapy, additional RN visits, and additional social worker visits to assist with meeting their care needs through the MICapable Program that is offered to all waiver members to improve their physical mobility and quality of life in community-based settings. • Any falls that result in injury requiring medical treatment are reported to MDHHS as critical incidents including resolution. • Assisted living and AFC [adult foster care] providers are required to submit an incident report to **Region VII Area Agency on Aging** for any falls that waiver members experience at their facility along with their resolution for fall prevention. • All in-home community living supports (CLS) providers are also required to notify **Region VII Area Agency on Aging** of any falls or health issues that members may experience under their care. • **Region VII Area Agency on Aging** also assists with any durable medical equipment needs that a member may have.		

QIP Topic	Goal	Measurement and Outcome

The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following:

Improvement Projects and Strategies:

- **Region VII Area Agency on Aging** supports coordinators assess all MI Choice waiver members for falls and risk for falls during each assessment (initial, 90 day, and 180 day) and at every monitoring contact (every 30-60 days). Supports coordinators collaborate with members and their allies, skilled care staff, primary care physicians, service providers, and **Region VII Area Agency on Aging**'s in-house pharmacist and occupational therapist to develop methods for fall prevention. **Region VII Area Agency on Aging** provides assistance with fall prevention to members by increasing caregiver hours during critical activity times, purchasing durable medical equipment to improve fall safety, and evaluating member environments in order to provide education on fall hazards. Supports coordinators contact members who experience an emergency room visit or hospitalization related to falls within five days to identify any health, safety or welfare issues and offer appropriate assistance. Contracted service providers are required by **Region VII Area Agency on Aging** to notify supports coordinators of any members who experience a fall so that follow-up may be completed with the member to determine the cause of the fall, whether any injuries occurred, and how to prevent future falls.
- The **Region VII Area Agency on Aging** local QMC meets once per quarter and several members also attend the statewide QMC meetings each quarter. Both the local and statewide QMC groups chose Prevalence of Falls as a primary goal throughout SFY 2021. At the 03/16/2021 local QMC meeting for **Region VII Area Agency on Aging** members, an occupational therapist provided a presentation on Fall Prevention. The local QMC felt the occupational therapist's presentation was a valuable tool for fall prevention. The information was forwarded to the statewide QMC and the occupational therapist was invited to provide the presentation to everyone at the May 2021 statewide QMC meeting and received many positive comments and thanks for providing a valuable fall prevention tool that could be passed on to other local QMC groups throughout the state. At their 09/14/2021 local QMC **Region VII Area Agency on Aging** members continued to collaborate on ways to prevent falls and all agreed strengthening chair exercises and being open to occupational and physical therapy was a good plan for future fall prevention.
- **Region VII Area Agency on Aging** provides access and information to fall prevention workshops on their website www.region7aaa.org that is available to all waiver members as well as anyone in the community. Workshop topics include: Silver Sneakers Stability – Become Stronger and Improve Balance; Arthritis Foundation Exercise Program; A Matter of Balance – Managing Concerns About Falls; among others.

Results:

- In utilizing the Quality Indicator Report through the COMPASS system to measure the number of **Region VII Area Agency on Aging** members who recorded a fall on follow-up assessment during SFY 2021 it was determined that:
  - Numerator: 273 (29.7%)
  - Denominator: 920 total members

Outcome:

- **Region VII Area Agency on Aging** members experienced an agency rate 4.7% higher than the statewide average goal of 25.0% for prevalence of falls.

QIP Topic	Goal	Measurement and Outcome
4. *Prevalence of Any Injuries*	Reduce the percentage of MI Choice Waiver participants with fractures or major skin problems, excluding current pressure or stasis ulcers to a statewide average of 5.0% or less.	SFY 2019 = 5.2% SFY 2020 = 5.4% SFY 2021 = 4.8% ☑

Actions/Activities/Interventions:

According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks:

- **Region VII Area Agency on Aging** supports coordinators assess all MI Choice waiver members for any injuries, including fractures or major skin problems during initial assessment, reassessment at least every 180 days, reassessment within 30 days of a hospitalization, and with monitoring contacts every 90 days or less.
- Supports coordinators educate members on fall prevention, skin care, nutrition, incontinence care, and pressure relief.
- Supports coordinators offer assistance to members in contacting their primary care physician for referrals to skilled care for skilled nursing, physical therapy, or occupational therapy.
- **Region VII Area Agency on Aging** also offers members assistance with medication reconciliation, occupational therapy, additional RN visits, and additional social worker visits to assist with meeting their care needs through the MICapable Program that is offered to all waiver members to improve their physical mobility and quality of life in community-based settings.
- Any injuries requiring medical treatment are reported to MDHHS as critical incidents including resolution.
- Assisted living and AFC providers are required to submit an incident report to **Region VII Area Agency on Aging** for any injuries that Waiver members experience at their facility along with their resolution to the incident.
- All in-home CLS providers are also required to notify **Region VII Area Agency on Aging** of any injuries or health issues that members may experience under their care.
- **Region VII Area Agency on Aging** also assists with any durable medical equipment needs that a member may have.

The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following:

Improvement Projects and Strategies:

- **Region VII Area Agency on Aging** supports coordinators assess all MI Choice waiver members for any injuries during each assessment (initial, 90 day, and 180 day) and at every monitoring contact (every 30-60 days). Supports coordinators collaborate with members and their allies, skilled care staff, primary care physicians, service providers, and **Region VII Area Agency on Aging**'s in-house pharmacist and occupational therapist to develop methods for preventing injuries. **Region VII Area Agency on Aging** provides assistance with preventing injuries to members by increasing caregiver hours during critical activity times, purchasing durable medical equipment to improve mobility and safety, and evaluating member environments in order to provide education on injury hazards. Supports coordinators contact members who experience an emergency room visit or hospitalization related to injuries within five days to identify any health, safety or welfare issues and offer appropriate assistance. Contracted service providers are required by **Region VII Area Agency on Aging** to notify supports coordinators of any members who experience an

QIP Topic	Goal	Measurement and Outcome
injury so that follow-up may be completed with the member to determine the cause of the injury, and how to prevent future injuries. In cases where a member chooses to continue with an activity or situation that presents an ongoing risk to health, safety or welfare, supports coordinators complete an Informed Risk Agreement that is reviewed with the member and their allies to ensure understanding for the risk they are assuming and make them aware of possible consequences to that risk. All injuries requiring medical treatment are reported as critical incidents to MDHHS through the Statewide Critical Incident Portal and the quality manager reviews each one for thorough documentation and appropriate resolution. • The quality support specialist reviews all ADT [admissions, discharges, transfers] notices for emergency room visits and hospitalizations each month via the Connected 2 Care System. Any injuries identified during this review are then audited for follow-up in COMPASS and, if no follow-up is identified or the injury was not reported to **Region VII Area Agency on Aging** then the waiver manager and supports coordinator are both notified so that appropriate follow up to ensure health, safety and welfare can be completed immediately. Findings are compiled in a log by the quality support specialist and analyzed by the quality manager to identify trends or repeat injuries to be reported to waiver managers so they can be addressed with the member in a timely manner and prevent future injuries. *Results:* • In utilizing the Quality Indicator Report through the COMPASS system to measure the number of **Region VII Area Agency on Aging** members who recorded a fall on follow-up assessment during FY2021 it was determined that: o Numerator: 47 (4.8%) o Denominator: 988 total members *Outcome:* • **Region VII Area Agency on Aging** members experienced an agency rate 0.2% lower than the statewide average goal of 5.0% for prevalence of any injuries, thereby meeting this goal for SFY 2021.		
5. *Prevalence of Dehydration*	Reduce the percentage of MI Choice Waiver participants who have insufficient fluid intake to a statewide average of 2.0% or less.	SFY 2019 = 3.6% SFY 2020 = 3.0% SFY 2021 = 2.9% ☒
Actions/Activities/Interventions: According to **Region VII Area Agency on Aging**'s MI Choice Waiver Quality Management Plan (QMP) FY 2020 – FY 2021 dated January 15, 2020, **Region VII Area Agency on Aging** planned to complete the following tasks: • **Region VII Area Agency on Aging** members are monitored for dehydration (insufficient fluid intake) by the supports coordinators at the initial assessment, and at reassessments at least every 180 days. • When dehydration is identified as an issue, supports coordinators educate members on fluid intake and signs/symptoms of dehydration and instruct them to contact their primary care physician when signs/symptoms of dehydration are present. • Supports coordinators who identify dehydration as a possible issue for members in an assisted living or AFC also educate the staff at that facility on dehydration and the need to monitor the member and offer fluids at regular intervals.		

QIP Topic	Goal	Measurement and Outcome

The **Region VII Area Agency on Aging** MI Choice Summary of Quality Management Plan (QMP) Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following:

Improvement Projects and Strategies:

- **Region VII Area Agency on Aging** Supports coordinators assess all MI Choice waiver members for dehydration and sufficient fluid intake during each assessment (initial, 90 day, and 180 day) and at every monitoring contact (every 30-60 days). Supports coordinators collaborate with members and their allies, skilled care staff, primary care physicians, and service providers to identify and prevent dehydration or insufficient fluid intake. Supports coordinators are trained to identify reasons for dehydration or insufficient fluid intake (cognitive or memory issues, mobility issues for access to liquids, health issues such as difficulty swallowing, etc.). This enables the supports coordinators to troubleshoot the situation and educate caregivers to provide reminders or make sure that the member always has liquids within their reach. Supports coordinators also educate members and their allies on signs or symptoms of dehydration and when to contact their primary care physician or seek emergency medical care.

Results:

- In utilizing the quality indicator report through the COMPASS system to measure the number of **Region VII Area Agency on Aging** members who experienced dehydration or insufficient fluid intake during SFY 2021 it was determined that:
  - Numerator: 29 (2.9%)
  - Denominator: 991 total members

Outcome:

- **Region VII Area Agency on Aging** members experienced an agency rate 0.9% higher than the statewide average goal of 2.0% for prevalence of dehydration.

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Region VII Area Agency on Aging measured each quality indicator against a baseline rate on an ongoing basis. [**Quality**]

Strength #2: Region VII Area Agency on Aging met its internal goal for the *Prevalence of Any Injuries* QIP and demonstrated a reduction in the prevalence rate compared to its baseline rate, indicating that **Region VII Area Agency on Aging**'s members experienced fewer injuries than the prior year. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The **Region VII Area Agency on Aging** goals indicated in the SFY 2020–2021 QMP did not specifically indicate the date by which the goal was to be achieved and did not align with the MDHHS goals associated with the QIPs. [**Quality**]

Why the weakness exists: The goals for each quality indicator were stated in the SFY 2020–2021 QMP dated January 15, 2020, under a header titled "FY 2021 Quality Improvement Projects, Goals, Strategies, and Results"; since the QMP was dated January 15, 2020, it was unclear if the goal was for SFY 2020, if the QMP was updated with a new goal for SFY 2021 but the date on the QMP was not revised, or if the goals were for SFY 2020 and 2021. Further, in comparing the rates against the goal, **Region VII Area Agency on Aging** indicated that the rate met the goal when it achieved a lower percentage than the statewide goal, but when the goal was not met, **Region VII Area Agency on Aging** only indicated that the rate was higher than the goal and did not state that the goal was not met.

Recommendation: HSAG recommends that **Region VII Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. Additionally, **Region VII Area Agency on Aging** should ensure that it evaluates the rates against the established goals.

Weakness #2: The interventions implemented by **Region VII Area Agency on Aging** for the *Prevalence of Neglect/Abuse* QIP did not appear to be effective as the prevalence rate increased. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. [**Quality**]

Why the weakness exists: **Region VII Area Agency on Aging** demonstrated an increase in prevalence rates for the *Prevalence of Neglect/Abuse* QIP. Additionally, documentation did not consistently support that a comprehensive causal/barrier analysis was conducted and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was logically linked to any identified barriers.

Recommendation: HSAG recommends that **Region VII Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Region VII Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Region VII Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region VII Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Region VII Area Agency on Aging**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and methodology followed by **Region VII Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Region VII Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region VII Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-50. Table 3-50 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Region VII Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region VII Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-50—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**95.83%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**97.38%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**97.41%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**94.64%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**97.66%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**95.83%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**100.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**95.59%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Region VII Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 8, 16, 20, 21, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included strategies to address health and safety risks; members received all the services and supports identified in the PCSP; waiver service choice was offered to members; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although **Region VII Area Agency on Aging** met or exceeded the statewide performance rate for all performance measures, HSAG recommends that **Region VII Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-51 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-51 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-51—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	98.53%	100.00%	**4.00**
Focus 2	Freedom of Choice	92.86%		**4.00**
Focus 3	Release of Information	100.00%		**4.00**
Focus 4	Status	96.67%		**4.00**
Focus 5	Pre-Planning	99.20%	100.00%	**4.00**
Focus 6	Assessment	97.22%	100.00%	**4.00**
Focus 7	Medication Record	90.45%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	98.06%	100.00%	**4.00**
Focus 9	MI Choice Services	96.88%	100.00%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 10	Linking and Coordinating	100.00%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	95.38%	100.00%	**4.00**
Focus 12	Service Provider	93.33%		**4.00**
Focus 13	Contingency Plan	96.00%	100.00%	**4.00**
Focus 14	Critical Incidents	75.00%	100.00%	**2.00**
Focus 15	Adverse Benefit Determination	87.50%		**4.00**
Focus 16	Complaints and Grievances	NA		**NA**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**96.62%**	**100.00%**	**3.91**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Fourteen home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. [**Quality**]

Strength #2: Region VII Area Agency on Aging achieved a substantial compliance rating in 15 of the applicable 16 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Region VII Area Agency on Aging did not consistently follow all Critical Incidents requirements—specifically, addressing the incident(s) with the member/guardian; taking appropriate action and discussing methods to prevent further occurrence with the member/guardian; and entering, reporting, and providing updates to the critical incident portal in accordance with MDHHS policy and contract requirements. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the four applicable records did not demonstrate evidence that the service coordinator addressed the incident with the member/guardian; one of the four applicable records did not demonstrate evidence that the supports coordinator took appropriate action and discussed methods to prevent further occurrence with the member/guardian; and two of the four applicable records did not demonstrate evidence that the supports coordinator entered, reported, and provided updates to the critical incident portal in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS required **Region VII Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Region VII Area Agency on Aging**'s CAP included, but was not limited to, staff training and education and a review of 12 records. While **Region VII Area Agency on Aging** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Region VII Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated percentage of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-52 presents **Region VII Area Agency on Aging**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-52—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	92.1%	91.5%
Recommendation Measures	96.5%	92.6%
Staff are Reliable and Helpful	94.7%	91.9%
Staff Listen and Communicate Well	97.5%	95.0%
Case Manager is Helpful	91.1%	95.2%
Choosing the Services that Matter to You	91.1%	92.7%
Transportation to Medical Appointments	95.3%	92.5%
Personal Safety and Respect	96.7%	97.2%
Planning Your Time and Activities	79.9%	75.4%
Met Need	95.3%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Region VII Area Agency on Aging achieved scores higher than or the same as the statewide results in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, *Met Need*, and *Physical Safety Measure* domains, indicating that **Region VII Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. It should be noted that while **Region VII Area Agency on Aging** achieved a higher score than the statewide results for *Planning Your Time and Activities*, this domain received the lowest statewide score across all domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Region VII Area Agency on Aging did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **Region VII Area Agency on Aging** scored below the statewide average on the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, and *Personal Safety and Respect* domains. Therefore, HSAG recommends that **Region VII Area Agency on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, and *Personal Safety and Respect* domains; conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, and *Personal Safety and Respect* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Region VII Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region VII Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region VII Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance

with their individualized health needs. Additionally, **Region VII Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Region VII Area Agency on Aging** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Region VII Area Agency on Aging** should focus its efforts on improving members' experiences with waiver agency staff and case manager effectiveness, as members reported lower satisfaction in the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, and *Personal Safety and Respect* domains. HSAG's assessment of **Region VII Area Agency on Aging** also identified continued opportunities for **Region VII Area Agency on Aging** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region VII Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Region VII Area Agency on Aging** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Region VII Area Agency on Aging**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Region 9 Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-53 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Region 9 Area Agency on Aging** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Region 9 Area Agency on Aging** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Region 9 Area Agency on Aging**'s QMP reports are also provided in Table 3-53. The results in Table 3-53 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-53—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Prevalence of neglect and abuse: Goal less than 5%	SFY 2019 = [No baseline data reported] SFY 2020* = [1.69%] SFY 2021* = [1.94%] ☑
Actions/Activities/Interventions: **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than SFY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are: • Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of members that fall within each indicator based on their assessment. The supports coordinators will be notified of these members to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences. According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2021 report dated January 13, 2022, **Region 9 Area Agency on Aging** identified that a robust ongoing education plan for abuse and neglect issues is employed. Additionally, staff monitored members monthly allowing for potential issues to be addressed quickly. **Region 9 Area Agency on Aging** was able to reduce prevalence in three quarters of SFY 2021.		

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Prevalence of pain with inadequate pain control: Goal less than 20%	SFY 2019 = [No baseline data reported] SFY 2020* = [13.69%] SFY 2021* = [15.22%] ☑
Actions/Activities/Interventions: **Region 9 Area Agency on Aging**'s Mi Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than SFY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are: • Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of members that fall within each indicator based on their assessment. The supports coordinators will be notified of these members to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences. According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2021 report dated January 13, 2022, **Region 9 Area Agency on Aging** identified that **Region 9 Area Agency on Aging** performance on pain control falls below the statewide goal and statewide average. No further activities than originally outlined were performed. Members are always encouraged to seek medical care for uncontrolled pain and encouraged to utilize non-pharmacological pain control methods approved by their primary care providers.		
3. *Prevalence of Falls*	Prevalence of falls: Goal less than 27%	SFY 2019 = [No baseline data reported] SFY 2020* = [29.24%] SFY 2021* [28.91%] ☒
Actions/Activities/Interventions: **Region 9 Area Agency on Aging**'s Mi Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than SFY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are: • Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of members that fall within each indicator based on their assessment. The supports coordinators will be notified of these members to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences.		

QIP Topic	Goal†	Measurement and Outcome
According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2021 report dated January 13, 2022, **Region 9 Area Agency on Aging** identified that **Region 9 Area Agency on Aging** had planned to focus significant efforts on reducing falls in SFY 2021. All staff received training through Capable, which addressed the issues of injuries and falls in the home. Further training was planned for SFY 2021 utilizing the CDC [Centers for Disease Control and Prevention] STEADI program; however, efforts were hampered by the effects of the Pandemic. The inability to perform in person and home environment assessments had hindered any further work on this measure during SFY 2021. This measure will be carried into SFY 2022 for further improvement efforts.		
4. *Prevalence of Any Injuries*	Prevalence of any injuries: Goal less than 5.5%	SFY 2019 = [No baseline data reported] SFY 2020* = [5.16%] SFY 2021* = [5.10%] ☑
Actions/Activities/Interventions: **Region 9 Area Agency on Aging**'s Mi Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on Aging** achieve better quality indicator scores than SFY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are: • Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of members that fall within each indicator based on their assessment. The supports coordinators will be notified of these members to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences. According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2021 report dated January 13, 2022, **Region 9 Area Agency on Aging** identified that in SFY 2021, **Region 9 Area Agency on Aging** planned to focus significant efforts on reducing injuries. All staff received training through Capable, which addressed the issues of injuries and falls in the home. Further training was planned for SFY 2021 utilizing the CDC STEADI program; however, efforts were hampered by the effects of the Pandemic. The inability to perform in person and home environment assessments had hindered any further work on this measure during SFY 2021. This measure will be carried into SFY 2022 for further improvement efforts.		
5. *Prevalence of Dehydration*	Prevalence of dehydration: Goal less than 2.5%	SFY 2019 = [No baseline data reported] SFY 2020* = [1.94%] SFY 2021* = [1.78%] ☑
Actions/Activities/Interventions: **Region 9 Area Agency on Aging**'s Mi Choice Quality Management Plan Fiscal Years 2020 and 2021 dated January 13, 2020, identified that **Region 9 Area Agency on Aging** determined a baseline set for the indicators. From this data, quality indicator goals were determined. The primary goal will be to **Region 9 Area Agency on**		

QIP Topic	Goal†	Measurement and Outcome
Aging achieve better quality indicator scores than SFY 2019. A secondary goal will be to ensure that **Region 9 Area Agency on Aging**'s quality scores maintain a rate lower than the statewide average. **Region 9 Area Agency on Aging**'s planned actions to achieve the goal are: • Review data obtained from the quality indicator reports and will act on any category which exceeds the statewide average • Quarterly reviews of quality reports provide a list of members that fall within each indicator based on their assessment. The supports coordinators will be notified of these members to ensure that ongoing monitoring specifically addresses the identified concern and that all available resources have been offered in attempts to mitigate future occurrences. According to **Region 9 Area Agency on Aging**'s MI Choice Quality Management Plan Activities and Outcomes Report Fiscal Year 2021 report dated January 13, 2022, **Region 9 Area Agency on Aging** identified that the **Region 9 Area Agency on Aging** reviews all members on this list and found instances of reporting that did not accurately describe the member's hydration status. **Region 9 Area Agency on Aging** has repeatedly advocated with the state for improvements to the measure data to no avail. The report does not exclude members who are on medically prescribed fluid restrictions or end of life care that results in NPO [nothing by mouth] status. The **Region 9 Area Agency on Aging** average consistently remains below the statewide average for this measure.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*HSAG calculated the overall SFY 2020 and 2021 performance rate for each QIP using the numerators and denominators provided by the waiver agency in the annual report.
†Goals in the QMP differed from the goals in the annual report. As the goals identified in the annual report did not include whether the goal was to be above or below the identified percentage, HSAG used the QMP goals to determine performance.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Region 9 Area Agency on Aging met its goals for four of the five QIPs, suggesting that **Region 9 Area Agency on Aging** had interventions in place to support goal attainment. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region 9 Area Agency on Aging's SFY 2020–2021 QMP and SFY 2021 annual report included conflicting goals, which created confusion as to the true goals established by **Region 9 Area Agency on Aging** when initiating the QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented and should not change through the measurement period of the QIP unless documentation is provided to support the rationale for the change. Additionally, although **Region 9 Area Agency on Aging** identified in the SFY 2020–2021 QMP that it had determined a baseline data set for the QIPs, the baseline data set was not included in the SFY 2020–2021 QMP or in the SFY 2021 annual report, which would allow for year-to-year comparative data. [**Quality**]

Why the weakness exists: Region 9 Area Agency on Aging's goals as identified in the SFY 2020–2021 QMP did not align with the statewide goals established by MDHHS. Additionally, **Region 9 Area Agency on Aging**'s SFY 2021 annual report did not include an analysis of whether **Region 9 Area Agency on Aging** met its SFY 2021 goals as established in the SFY 2020–2021 QMP.

Recommendation: HSAG recommends that **Region 9 Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should consistently align with the goals established by MDHHS. Additionally, **Region 9 Area Agency on Aging** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. Further, HSAG recommends that **Region 9 Area Agency on Aging** ensure its QMP and annual report include baseline data and the year-over-year comparative analysis.

Weakness #2: While **Region 9 Area Agency on Aging**'s SFY 2021 annual report was more robust than those submitted by most other waiver agencies, details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the development of relevant interventions to address identified barriers) of the QIPs were limited. **Region 9 Area Agency on Aging**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included minimal details on QIP design development, the methodology followed, and details into the specific interventions and implementation of those interventions.

Recommendation: HSAG recommends that **Region 9 Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 9 Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-54. Table 3-54 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Region 9 Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Region 9 Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-54—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**96.94%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**97.76%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**100.00%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**96.15%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**94.94%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**100.00%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**100.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**93.55%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Region 9 Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 8, 15, 16, 19, 20, 21, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included services and supports that aligned with members' assessed needs; PCSPs included strategies to address health and safety risks; PCSPs were updated according to MDHHS requirements; members received all of the services and supports identified in the PCSP; waiver service choice was offered to members; waiver provider choice was offered to members; members/guardians were provided with education

about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although **Region 9 Area Agency on Aging** met or exceeded the statewide performance rate for all performance measures, HSAG recommends that **Region 9 Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-55 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-55 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-55—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	76.92%		**1.00**
Focus 3	Release of Information	92.31%		**4.00**
Focus 4	Status	100.00%		**4.00**
Focus 5	Pre-Planning	97.39%	100.00%	**4.00**
Focus 6	Assessment	99.15%	100.00%	**4.00**
Focus 7	Medication Record	92.86%	100.00%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 8	Person-Centered Service Planning	90.63%	100.00%	**4.00**
Focus 9	MI Choice Services	100.00%	100.00%	**4.00**
Focus 10	Linking and Coordinating	100.00%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	96.43%	100.00%	**4.00**
Focus 12	Service Provider	100.00%		**4.00**
Focus 13	Contingency Plan	94.29%	100.00%	**4.00**
Focus 14	Critical Incidents	NA	100.00%	**NA**
Focus 15	Adverse Benefit Determination	95.45%		**4.00**
Focus 16	Complaints and Grievances	NA		**NA**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**95.54%**	**100.00%**	**3.98**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Seven home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and

member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. [**Quality**]

Strength #2: Region 9 Area Agency on Aging achieved a substantial compliance rating in 13 of the applicable 15 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Region 9 Area Agency on Aging did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid FOC form is on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three of the 10 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **Region 9 Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Region 9 Area Agency on Aging**'s CAP included, but was not limited to, staff training and education and a review of 13 records. While **Region 9 Area Agency on Aging** conducted internal monitoring until compliance of 90 percent is achieved, and measures failing to meet compliance within two quarters will be reevaluated, HSAG recommends that **Region 9 Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-56 presents **Region 9 Area Agency on Aging**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-56—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	90.4%	91.5%
Recommendation Measures	**87.4%**	92.6%
Staff are Reliable and Helpful	93.4%	91.9%
Staff Listen and Communicate Well	97.0%	95.0%
Case Manager is Helpful	**81.4%**	95.2%
Choosing the Services that Matter to You	90.6%	92.7%
Transportation to Medical Appointments	96.1%	92.5%
Personal Safety and Respect	97.5%	97.2%
Planning Your Time and Activities	76.1%	75.4%
Met Need	95.0%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Region 9 Area Agency on Aging achieved scores higher than the statewide results in the *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Physical Safety Measure* domains, indicating that **Region 9 Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. It should be noted that while **Region 9 Area Agency on Aging** achieved a higher score than the statewide results for *Planning Your Time*

and Activities, this domain received the lowest statewide score across all domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Region 9 Area Agency on Aging scored more than 5 percentage points below the statewide average on the *Recommendation Measures* domain at 87.4 percent compared to the statewide average of 92.6 percent. [**Quality**]

Why the weakness exists: The *Recommendation Measures* domain included *recommendation of personal assistance and behavioral health staff*, *recommendation of homemakers*, and *recommendation of case manager*. **Region 9 Area Agency on Aging** scored more than 5 percentage points below the statewide average for *recommendation of personal assistance and behavioral health staff* and *recommendation of homemakers.* Additionally, **Region 9 Area Agency on Aging** scored below the statewide average for *recommendation of case manager*.

Recommendation: HSAG recommends that **Region 9 Area Agency on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Recommendation Measures* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Recommendation Measures* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

Weakness #2: Region 9 Area Agency on Aging scored more than 5 percentage points below the statewide average on the *Case Manager is Helpful* domain at 81.4 percent compared to the statewide average of 95.2 percent. [**Quality**]

Why the weakness exists: Of the three questions within the *Case Manager is Helpful* domain, one of the questions had a denominator that was too small to calculate a percentage. Additionally, **Region 9 Area Agency on Aging** scored below the statewide average for the remaining two questions, one of which was 19 percentage points below the statewide average: *Case manager helped when asked for help with getting other changes to services*.

Recommendation: HSAG recommends that **Region 9 Area Agency on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Case Manager is Helpful* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Case Manager is Helpful* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Region 9 Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Region 9 Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Region 9 Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Region 9 Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Region 9 Area Agency on Aging** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Region 9 Area Agency on Aging** should focus its efforts on improving members' experiences with waiver agency staff, case manager effectiveness, and some waiver services, as members reported lower satisfaction in the *Global Ratings Measures*, *Recommendation Measures*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, and *Met Need* domains. HSAG's assessment of **Region 9 Area Agency on Aging** also identified continued opportunities for **Region 9 Area Agency on Aging** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Region 9 Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Region 9 Area Agency on Aging** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Region 9 Area Agency on Aging**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Reliance Community Care Partners

Validation of Performance Improvement Projects

Performance Results

Table 3-57 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Reliance Community Care Partners** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Reliance Community Care Partners** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Reliance Community Care Partners**' QMP reports are also provided in Table 3-57. The results in Table 3-57 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-57—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Lower the score by 0.50%	SFY 2019 = 5.07% [5.70%]* SFY 2020 = 4.12% SFY 2021† = 2.95% ☑
Actions/Activities/Interventions: According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks: • **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during SFY 2020. Additional goals and interventions will be established by the local quality councils. The **Reliance Community Care Partners** FY21 MI Choice Quality Management Outcome and Analysis Report dated January 10, 2022, identified the following: • Overall, the actions that **Reliance Community Care Partners** put in place during SFY 2020 made an overall score improvement for uncontrolled pain, neglect, and abuse. **Reliance Community Care Partners** was able to continue to improve these measures after providing additional training to staff on the quality indicators, how to ask the assessment questions and how to score the response. • Healthcare entities focused heavily on abuse and neglect during the pandemic as many felt that an increase in neglect and abuse during the COVID quarantines would occur. **Reliance Community Care Partners** provided training to staff and also asked as part of **Reliance Community Care Partners**' health status checks. The actions included: o Staff training on the quality indicators along with the assessment questions and responses o Staff training on the quality improvement initiatives for the five measures. o Reporting quarterly on the quality indicators and developing the next quarter action plan.		

QIP Topic	Goal	Measurement and Outcome
○ Sharing quarterly measures with **Reliance Community Care Partners** association members Quality Committee and completing root cause analysis. ○ Sharing of best practices and developing interventions to improve the measure. • Utilizing the continuous quality improvement framework, **Reliance Community Care Partners** is not looking for immediate improvement but looking at the lagging indicators that improvement is obtainable in six months. **Reliance Community Care Partners'** quarterly data is trending in the right direction for the quality indicators that will not be worked on in the SFY 2022-2023 Quality Management Plan. **Reliance Community Care Partners** elected to monitor and measure all of the quality indicators going into SFY 2022-2023 also.		
2. *Prevalence of Pain With Inadequate Pain Control*	Lower the score by 1%	SFY 2019 = 21.94% SFY 2020 = 21.53% SFY 2021† = 20.75% ☒
Actions/Activities/Interventions: According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks: • **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during SFY 2020. Additional goals and interventions will be established by the local quality councils. The **Reliance Community Care Partners** FY21 MI Choice Quality Management Outcome and Analysis Report dated January 10, 2022, identified the following: • Overall, the actions that **Reliance Community Care Partners** put in place during SFY 2020 made an overall score improvement for uncontrolled pain, neglect and abuse .**Reliance Community Care Partners** was able to continue to improve these measures after providing additional training to staff on the quality indicators, how to ask the assessment questions and how to score the response. • Utilizing the continuous quality improvement framework, **Reliance Community Care Partners** is not looking for immediate improvement but looking at the lagging indicators that improvement is obtainable in six months. **Reliance Community Care Partners'** quarterly data is trending in the right direction for the quality indicators that will not be worked on in the SFY 2022-2023 Quality Management Plan. **Reliance Community Care Partners** elected to monitor and measure all of the quality indicators going into SFY 2022-2023 also.		
3. *Prevalence of Falls*	Lower the score by 1%	SFY 2019 = 28.40% SFY 2020 = 24.59% SFY 2021† = 29.95% ☒
Actions/Activities/Interventions: According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks: • **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during SFY 2020. Additional goals and interventions will be established by the local quality councils.		

QIP Topic	Goal	Measurement and Outcome
The **Reliance Community Care Partners** FY21 MI Choice Quality Management Outcome and Analysis Report dated January 10, 2022, identified the following: • Dehydration, Falls and other injuries increased in SFY 2021. Falls may have increased as a result of ensuring that everyone was using the same definition of a fall and bringing more attention to the quality indicator. • Utilizing the continuous quality improvement framework, **Reliance Community Care Partners** is not looking for immediate improvement but looking at the lagging indicators that improvement is obtainable in six months. **Reliance Community Care Partners'** quarterly data is trending in the right direction for the quality indicators that will not be worked on in the SFY 2022-2023 Quality Management Plan. **Reliance Community Care Partners** elected to monitor and measure all of the quality indicators going into SFY 2022-2023 also. • Regional quality councils also worked on newsletters to program members on Falls and Dehydration. **Reliance Community Care Partners** is also working on the quality indicators with the association members (Michigan Home and Community Services Network (MHCSN)).		
4. *Prevalence of Any Injuries*	Lower the score by 0.50%	SFY 2019 = 6.08% SFY 2020 = 4.43% SFY 2021† = 4.91% ☒
Actions/Activities/Interventions: According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks: • **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during SFY 2020. Additional goals and interventions will be established by the local quality councils. The **Reliance Community Care Partners** FY21 MI Choice Quality Management Outcome and Analysis Report dated January 10, 2022, identified the following: • Dehydration, Falls and other injuries increased in SFY 2021. Falls may have increased as a result of ensuring that everyone was using the same definition of a fall and bringing more attention to the quality indicator. • Utilizing the continuous quality improvement framework, **Reliance Community Care Partners** is not looking for immediate improvement but looking at the lagging indicators that improvement is obtainable in six months. **Reliance Community Care Partners'** quarterly data is trending in the right direction for the quality indicators that will not be worked on in the SFY 2022-2023 Quality Management Plan. **Reliance Community Care Partners** elected to monitor and measure all of the quality indicators going into SFY 2022-2023 also.		

QIP Topic	Goal	Measurement and Outcome
5. *Prevalence of Dehydration*	Lower the score by 0.50%	SFY 2019 = 2.30% SFY 2020 = 2.21% SFY 2021† = 2.95% ☒

Actions/Activities/Interventions:

According to **Reliance Community Care Partners'** Continuous Quality Improvement Plan MI Choice Medicaid Waiver Program Fiscal Years 2020 & 2021 dated December 18, 2019, **Reliance Community Care Partners** planned to complete the following tasks:

- **Reliance Community Care Partners** will evaluate the data and conduct root cause analysis during SFY 2020. Additional goals and interventions will be established by the local quality councils.

The **Reliance Community Care Partners** FY21 MI Choice Quality Management Outcome and Analysis Report dated January 10, 2022, identified the following:

- Dehydration, Falls and other injuries increased in SFY 2021. Falls may have increased as a result of ensuring that everyone was using the same definition of a fall and bringing more attention to the quality indicator.
- Dehydration is being studied to determine why an increase is seen in SFY 2021. This quality indicator needs to be looked at to see if there should be an adjustment to the denominator to exclude diagnoses in which an individual is typically on fluid restrictions or the question needs to be revised.
- Utilizing the continuous quality improvement framework, **Reliance Community Care Partners** is not looking for immediate improvement but looking at the lagging indicators that improvement is obtainable in six months. **Reliance Community Care Partners'** quarterly data is trending in the right direction for the quality indicators that will not be worked on in the SFY 2022-2023 Quality Management Plan. **Reliance Community Care Partners** have elected to monitor and measure all of the quality indicators going into SFY 2022-2023 also.
- Regional quality councils also worked on newsletters to program members on Falls and Dehydration. **Reliance Community Care Partners** is also working on the quality indicators with the association members (MHCSN).

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*The waiver agency displayed a conflicting SFY 2019 baseline rate in its SFY 2020–2021 QMP and SFY 2020 annual report.
†Rates were provided by the agency; however, the numerator and denominators were the same as SFY 2020. Therefore, HSAG made the assumption that the numerators and denominators were incorrect and was unable to determine if the percentages reported were accurate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Reliance Community Care Partners met its established goal for *Prevalence of Neglect/Abuse*, suggesting that members experienced fewer incidents of neglect/abuse. Although the waiver agency reduced the rate for the *Prevalence of Pain With Inadequate Pain Control,* HSAG could not determine the waiver agency's goal for this QIP (i.e., 1 percent versus 1 percentage point); therefore, performance for this QIP was not considered a strength. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners' QMP did not include any specific planned interventions. The interventions included in the annual report were minimal. Additionally, the rates for the *Prevalence of Falls*, *Prevalence of Any Injuries*, and *Prevalence of Dehydration* QIPs increased, suggesting that the interventions implemented by **Reliance Community Care Partners** were not effective. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. **Reliance Community Care Partners**' choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential for the waiver agency's success in achieving the desired outcomes for the QIPs. [**Quality**]

Why the weakness exists: The QMP did not document the interventions that were initially implemented to reduce prevalence rates for the QIP. Although the annual report briefly connected interventions to results, the documentation was minimal. Additionally, the annual report did not support that a causal/barrier analysis was conducted for all QIPs and that an evaluation occurred for each intervention to determine its effectiveness and ensure each intervention was plausibly linked to any identified barriers.

Recommendation: HSAG recommends that **Reliance Community Care Partners** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Reliance Community Care Partners** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Reliance Community Care Partners** should analyze and interpret results at multiple points in time and test for statistical significance. **Reliance Community Care Partners** should also evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #2: Reliance Community Care Partners' SFY 2020–2021 QMP and SFY 2021 annual report included conflicting goals, which created confusion as to the true goals established by **Reliance Community Care Partners** when initiating the QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented and should not change through the measurement

period of the QIP unless documentation is provided to support the rationale for the change. Additionally, the goals indicated in the SFY 2020–2021 QMP were to "lower the score by X percent;" however, it was unclear if **Reliance Community Care Partners** intended the goal to be decreased by a percentage or percentage points. Decreasing rates by a percentage or by percentage points are two different calculations (e.g., if 25 is the starting percentage and 10 is the percent/percentage points by which to decrease, to decrease by a specified percentage, the calculation would be 25% − 10% [i.e., 25 × .10 = 2.5], then the result should be subtracted from the starting percentage [i.e., 25 − 2.5 = 22.5]. The calculation to decrease by percentage points would be 25 − 10 = 15%). [**Quality**]

Why the weakness exists: **Reliance Community Care Partners**' goals as identified in the SFY 2020–2021 QMP did not align with the statewide goals established by MDHHS. Additionally, the goals in the SFY 2020–2021 QMP were unclear.

Recommendation: HSAG recommends that **Reliance Community Care Partners** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals, and that they are consistent in its annual report. These goals should consistently align with the goals established by MDHHS.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Reliance Community Care Partners**' QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and methodology followed by **Reliance Community Care Partners** when implementing its QIPs.

Recommendation: HSAG recommends that **Reliance Community Care Partners** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Reliance Community Care Partners** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-58. Table 3-58 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Reliance Community Care Partners**' percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Reliance Community Care Partners**' impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-58—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**87.43%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**94.68%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**97.94%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**93.75%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**95.49%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**83.87%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**86.84%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**95.83%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**80.00%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Reliance Community Care Partners received a 100 percent performance rating for Performance Measures 4, 8, 16, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included strategies to address health and safety risks; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners performed substantially worse than other waiver agencies on Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, as indicated by a

performance rate of more than 5 percentage points below the statewide rate. This demonstrated that services provided were not always consistent with the PCSP. [**Quality** and **Access**]

Why the weakness exists: Reliance Community Care Partners' performance rate for Performance Measure 20 fell 6.34 percentage points below the statewide rate. Through the CQAR, of the 24 records reviewed, MPHI determined that four of the 13 applicable records did not demonstrate evidence that the supports coordinator contacted newly enrolled members to ensure service delivery in accordance with MDHHS policy and contract requirements; and one of the applicable eight records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with the member's backup plan or an out-of-network provider.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies associated with Performance Measure 20. **Reliance Community Care Partners**' CAP included, but was not limited to, staff training and a review of 10 records. Although **Reliance Community Care Partners** identified that it had an internal compliance monitoring threshold of 90 percent, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Reliance Community Care Partners performed substantially worse than other waiver agencies on Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies,* as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always ensure members had an individualized contingency plan for emergencies. [**Quality** and **Access**]

Why the weakness exists: Reliance Community Care Partners' performance rate for Performance Measure 30 fell 10.29 percentage points below the statewide rate. Through the CQAR, of the 24 records reviewed, MPHI determined that five of the 24 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan; three of the applicable 24 records did not demonstrate evidence that the member/guardian received a copy of the contingency plan; and three of the applicable seven records did not demonstrate evidence that the other allies included in the plan received a copy of the contingency plan as preferred by the member/guardian.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies associated with Performance Measure 30. **Reliance Community Care Partners**' CAP included, but was not limited to, staff training and a review of 10 records. Although **Reliance Community Care Partners** identified that it had an internal compliance monitoring threshold of 80 percent, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-59 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-59 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-59—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	98.36%	100.00%	**4.00**
Focus 2	Freedom of Choice	54.17%		**1.00**
Focus 3	Release of Information	33.33%		**1.00**
Focus 4	Status	100.00%		**4.00**
Focus 5	Pre-Planning	99.53%	100.00%	**4.00**
Focus 6	Assessment	98.61%	100.00%	**4.00**
Focus 7	Medication Record	92.74%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	92.76%	100.00%	**4.00**
Focus 9	MI Choice Services	97.64%	100.00%	**4.00**
Focus 10	Linking and Coordinating	96.61%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	72.58%	100.00%	**2.00**
Focus 12	Service Provider	80.00%		**4.00**
Focus 13	Contingency Plan	81.36%	100.00%	**4.00**
Focus 14	Critical Incidents	87.50%	100.00%	**3.33**
Focus 15	Adverse Benefit Determination	81.82%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**92.70%**	**100.00%**	**3.84**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Twelve home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the area of Follow-Up and Monitoring as the overall rating for this program area was less than full compliance. [**Quality**]

Strength #2: Reliance Community Care Partners achieved a substantial compliance rating in 14 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member;

therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid FOC form is on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 11 of the 24 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, staff training and a review of 10 records. Although **Reliance Community Care Partners** identified that it had an internal compliance monitoring threshold of 90 percent, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: Reliance Community Care Partners did not consistently follow all Release of Information requirements; specifically, ensuring a valid ROI form is on file. Waiver agencies are required to ensure the member record includes a valid ROI form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 16 of the 24 applicable records did not demonstrate evidence that the waiver agency ensured a valid ROI form was included in the member record.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, staff training and a review of 10 records. Although **Reliance Community Care Partners** identified that it had an internal compliance monitoring threshold of 85 percent, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: Reliance Community Care Partners did not consistently adhere to all Follow-Up and Monitoring requirements; specifically, contacting new members to ensure service delivery in accordance with MDHHS policy and contract requirements, contacting members for follow-up and monitoring as specified in the member's PCSP, and ensuring service delivery in accordance with the use of the member's backup plan or out-of-network provider. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not

implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that four of the 13 applicable records did not demonstrate evidence that the waiver agency contacted new members/guardians to ensure service delivery in accordance with MDHHS policy and contract requirements, 12 of the 24 applicable records did not demonstrate evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP, and one of the eight applicable records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with the use of the member's backup plan or out-of-network provider.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, staff training and a review of 10 records. Although **Reliance Community Care Partners** identified that it had an internal compliance monitoring threshold of 80 or 90 percent (depending on the requirements), HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **Reliance Community Care Partners** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-60 presents **Reliance Community Care Partners**' domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-60—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	93.2%	91.5%
Recommendation Measures	92.3%	92.6%
Staff are Reliable and Helpful	91.5%	91.9%

Domain	Waiver Agency Score	Statewide Average Score
Staff Listen and Communicate Well	95.5%	95.0%
Case Manager is Helpful	100.0%	95.2%
Choosing the Services that Matter to You	88.8%	92.7%
Transportation to Medical Appointments	92.5%	92.5%
Personal Safety and Respect	**92.1%**	97.2%
Planning Your Time and Activities	74.7%	75.4%
Met Need	97.2%	95.3%
Physical Safety Measure	97.5%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Reliance Community Care Partners achieved scores higher than the statewide results in the *Global Ratings Measures*, *Staff Listen and Communicate Well*, *Case Manager is Helpful*, and *Met Need* domains, indicating that **Reliance Community Care Partners** provides services in a manner that meets or exceeds members' expectations in some domains. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners scored more than 5 percentage points below the statewide average on the *Personal Safety and Respect* domain at 92.1 percent compared to the statewide average of 97.2 percent. [**Quality**]

Why the weakness exists: Of the three questions within the *Personal Safety and Respect* domain, **Reliance Community Care Partners** scored below the statewide average for all three questions and

more than 5 percentage points below the statewide average for the question: *Have someone to talk to if someone hurts you or does something to you that you don't like*.

Recommendation: HSAG recommends that **Reliance Community Care Partners** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Personal Safety and Respect* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Personal Safety and Respect* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Reliance Community Care Partners**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Reliance Community Care Partners** across all EQR activities. The overarching aggregated findings showed that **Reliance Community Care Partners**' quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Reliance Community Care Partners** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Reliance Community Care Partners** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Reliance Community Care Partners** should focus its efforts on improving members' experiences with waiver agency staff and case manager effectiveness, as members reported lower satisfaction in the *Recommendation Measures*, *Staff are Reliable and Helpful*, *Choosing the Services that Matter to You*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Physical Safety Measure* domains. HSAG's assessment of **Reliance Community Care Partners** also identified continued opportunities for **Reliance Community Care Partners** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Reliance Community Care Partners** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Reliance Community Care Partners** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR

findings, **Reliance Community Care Partners**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Senior Resources

Validation of Performance Improvement Projects

Performance Results

Table 3-61 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Senior Resources** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Senior Resources** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Senior Resources**' QMP reports are also provided in Table 3-61. The results in Table 3-61 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-61—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Reduce the number of participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained [3%]	SFY 2019 = [No baseline data reported] SFY 2020 = 2.15% SFY 2021 = 3.2% ☒
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources**' QI Committee will review the biannual reports and make recommendations. • Education will continue to be provided to supports coordinators regarding this QMP goal, the importance of monitoring these members and making referrals for services as necessary. If percentages increase further training with supports coordinators will take place. • Supports coordinators will be actively involved in the QMP process during SFY 2020 and 2021 to increase buy-in re: the importance of gathering good data and achieving this goal. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2021 dated January 11, 2022, identified the following: • **Senior Resources** staff is aware of the signs of neglect and abuse. Staff regularly discuss with the QI Coordinator, supervisors and other supports coordinators possible cases of neglect and abuse in all realms-physical, emotional, and financial. **Senior Resources** has an "At Risk Participants Policy and Procedure" that is reviewed annually and revised, as necessary.		

QIP Topic	Goal†	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	Decrease the percent of participants reporting pain with inadequate control [20%]	SFY 2019 = [No baseline data reported] SFY 2020 = 16.4% SFY 2021 = 16.5% ☑
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources** will monitor issues, goals and interventions that are identified via the PCSP which is completed at every assessment. • Supports coordinators will be educated annually about the importance of updating this information in COMPASS at every assessment so that accurate data is available for analysis. Additionally, refresher training will be provided to supports coordinators regarding the usefulness of "Next Assessment" in COMPASS and appropriately updating the COMPASS assessment. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2021 dated January 11, 2022, identified the following: • All Waiver supports coordinators are required to receive continuing education in pain. Trainings are offered regularly on site and through web-based programs. The staff educator tracks all trainings for individual supports coordinators to be certain education has been completed.		
3. *Prevalence of Falls*	Reduce the percentage of MI Choice participants who have had a fall in the past 6 months (excluding those participants totally dependent with bed mobility) [23%]	SFY 2019 = [No baseline data reported] SFY 2020 = 28.05% SFY 2021 = 27.05% ☒
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources** will obtain and analyze data biannually via their QI Committee. Dependent on, and in response to the data obtained, **Senior Resources** will institute processes designed to impact those risk factors. Supports coordinators will be instructed to ensure that informal and MI Choice supports are adequately meeting the needs of the member through reassessments and monthly monitoring contacts. Effectiveness of interventions will be tracked biannually and revisions made as appropriate. • Supports coordinators will be actively involved in the QMP process during SFY 2020 and 2021 to increase buy-in on the importance of gathering good data and achieving this goal. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2021 dated January 11, 2022, identified the following: • **Senior Resources** recognizes that this is an area that requires improvement. At the 5/19/21 staff meeting, supports coordinators participated in a brainstorming session regarding ideas on how to impact the reduction of falls and reduce the occurrence of injury. Prevalence of falls increased during the second half of SFY 2021. Possibilities discussed were lack of exercise, and difficulty finding caregivers, due to the pandemic. See attachment titled: Ideas to reduce falls, injuries. The topic of falls/injuries was discussed, and education		

QIP Topic	Goal†	Measurement and Outcome
provided during the local Consumer Quality Collaborative on 5/19/21. PT and OT [physical therapy and occupational therapy representatives] from a home care agency attended to provide the education.		
4. *Prevalence of Any Injuries*	Decrease the percentage of participants who experience/report an injury [3%]	SFY 2019 = [No baseline data reported] SFY 2020 = 3.65% SFY 2021 = 5.4% ☒
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources** will obtain and analyze data biannually via their QI Committee. Dependent on, and in response to the data obtained, **Senior Resources** will institute processes designed to impact those risk factors. Supports coordinators will be instructed to ensure that informal and MI Choice supports are adequately meeting the needs of the member through reassessments and monthly monitoring contacts. Effectiveness of interventions will be tracked biannually and revisions made as appropriate. • Supports coordinators will be actively involved in the QMP process during SFY 2020 and 2021 to increase buy-in on the importance of gathering good data and achieving this goal. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2021 dated January 11, 2022, identified the following: • This Quality Indicator is tied very closely with #3. The topic of falls/injuries was discussed, and education provided during the local Consumer Quality Collaborative on 5/19/21. PT and OT [physical therapy and occupational therapy representatives] from a home care agency attended to provide the education.		
5. *Prevalence of Dehydration*	Reduce the prevalence of participants who were dehydrated due to insufficient fluid intake [1.5%]	SFY 2019 = [No baseline data reported] SFY 2020 = 1.75% SFY 2021 = 1.6% ☒
Actions/Activities/Interventions: According to **Senior Resources**' MI Choice Quality Management Plan Fiscal Years 2020-2021 report dated December 16, 2019, **Senior Resources** planned to complete the following tasks: • **Senior Resources** will provide training to supports coordinators regarding their responsibilities in this area: determining reason(s) for findings of dehydration and institute appropriate solutions, providing education about community resources, making physician/APS referrals as needed, and collaborating with CLS providers to ensure member hydration needs are met. • Supports coordinators will be actively involved in the QMP process during SFY 2020 and 2021 to increase buy-in on the importance of gathering good data and achieving this goal. Progress toward reaching this goal will be monitored continuously and processes revised as necessary. The **Senior Resources**' Summary of Quality Management Plan Activities & Outcomes for FY 2021 dated January 11, 2022, identified the following: • **Senior Resources** staff is aware of the need for hydration for all members. Food boxes are available for any member that needs help in securing food. Members are contacted minimally every 30 days to determine if		

QIP Topic	Goal†	Measurement and Outcome
they are experiencing any COVID symptoms. During this contact members are asked if they have any food or supply needs. The topic of dehydration was also discussed at the 11/19/20 Local Collaborative Meeting with members and staff.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*Goals in the QMP differed from the goals in the annual report. As the goals identified in the annual report were more stringent, HSAG used these goals to determine performance.
†The goals within the QMP did not consistently include a specific percentage rate and, when available, were less stringent than the goals identified in the annual report. Therefore, HSAG assessed performance outcomes using the goals identified in the annual report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Senior Resources met its goal for the *Prevalence of Pain With Inadequate Pain Control* QIP, suggesting that **Senior Resources**' members experienced few incidents of uncontrolled pain. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Senior Resources' SFY 2020–2021 QMP and SFY 2021 annual report included conflicting goals, which created confusion as to the true goals established by **Senior Resources** when initiating the QIPs. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: Senior Resources' SFY 2020–2021 QMP identified different goals for each QIP than the SFY 2021 annual report. The SFY 2021 goal within the annual report aligned with MDHHS' established statewide goals. Additionally, some goals identified in the SFY 2020–2021 QMP did not include a specific measurable performance goal (i.e., percentage rate).

Recommendation: HSAG recommends that **Senior Resources** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Senior Resources** should ensure that

its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #2: Senior Resources' interventions appeared to be ineffective as **Senior Resources** did not meet the statewide goals for four QIPs. Additionally, the prevalence rates for the *Prevalence of Neglect/Abuse* and *Prevalence of Any Injuries* QIPs increased, suggesting that interventions implemented by **Senior Resources** were not effective. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. [**Quality**]

Why the weakness exists: Senior Resources' SFY 2021 annual report listed some activities that were conducted; however, the SFY 2021 annual report did not include an assessment of whether a specific intervention(s) was/were successful or unsuccessful in achieving increased performance. Additionally, no conclusions were drawn regarding whether the interventions had an impact on the rate.

Recommendation: HSAG recommends that **Senior Resources** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Senior Resources** should analyze and interpret results at multiple points in time and test for statistical significance. **Senior Resources** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #3: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Senior Resources**' QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and the methodology followed by **Senior Resources** when implementing its QIPs.

Recommendation: HSAG recommends that **Senior Resources** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Senior Resources** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-62. Table 3-62 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Senior Resources**' percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Senior Resources**' impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-62—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**95.06%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**93.48%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**98.81%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**95.24%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**95.24%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**96.51%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**97.22%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**96.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**95.24%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**96.23%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Senior Resources received a 100 percent performance rating for Performance Measures 4, 8, 22, 24, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 2 and 16 did not meet the statewide performance rate, neither performance measure fell below the statewide rate by more than 5 percentage points. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: MDHHS required **Senior Resources** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 2 and 16. **Senior Resources**' CAP included, but was not limited to, staff training, including one-on-one training for staff members not achieving 100 percent compliance; and a review of 12 or 28 member records monthly (depending on the standards being reviewed). Although **Senior Resources** identified that it had an internal compliance monitoring threshold of 90 percent, HSAG recommends that **Senior Resources** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-63 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-63 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-63—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	90.20%	100.00%	**4.00**
Focus 2	Freedom of Choice	85.71%		**3.00**
Focus 3	Release of Information	100.00%		**4.00**
Focus 4	Status	90.28%		**4.00**
Focus 5	Pre-Planning	98.40%	100.00%	**4.00**
Focus 6	Assessment	97.35%	100.00%	**4.00**
Focus 7	Medication Record	90.27%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	95.77%	100.00%	**4.00**
Focus 9	MI Choice Services	97.50%	100.00%	**4.00**
Focus 10	Linking and Coordinating	100.00%	100.00%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 11	Follow-Up and Monitoring	93.48%	100.00%	**4.00**
Focus 12	Service Provider	85.71%		**4.00**
Focus 13	Contingency Plan	96.36%	100.00%	**4.00**
Focus 14	Critical Incidents	88.46%	100.00%	**3.34**
Focus 15	Adverse Benefit Determination	97.14%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**95.35%**	**100.00%**	**3.96**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Eleven home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. [**Quality**]

Strength #2: Senior Resources achieved a substantial compliance rating in 16 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Senior Resources did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified. [**Quality**]
Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.
Recommendation: No substantial weaknesses were identified within any of the program areas under review; however, HSAG recommends **Senior Resources** implement an ongoing and robust internal auditing process of individual supports coordinators to ensure all program requirements are being met, specifically one that supports coordinators take appropriate action and discuss methods to prevent further occurrence with the member/guardian.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-64 presents **Senior Resources**' domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-64—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	91.3%	91.5%
Recommendation Measures	92.4%	92.6%
Staff are Reliable and Helpful	**86.9%**	91.9%
Staff Listen and Communicate Well	93.9%	95.0%
Case Manager is Helpful	98.1%	95.2%
Choosing the Services that Matter to You	94.0%	92.7%
Transportation to Medical Appointments	94.7%	92.5%
Personal Safety and Respect	98.3%	97.2%
Planning Your Time and Activities	74.3%	75.4%
Met Need	94.5%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Senior Resources achieved scores higher than the statewide results in the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, and *Physical Safety Measure* domains, indicating that **Senior Resources** provides services in a manner that meets or exceeds members' expectations in many domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Senior Resources scored at least 5 percentage points below the statewide average on the *Staff are Reliable and Helpful* domain at 86.9 percent compared to the statewide average of 91.9 percent. [**Quality**]

Why the weakness exists: Of the six questions within the *Staff are Reliable and Helpful* domain, two of the questions had denominators that were too small to calculate a percentage. Although **Senior Resources** scored higher than the statewide average for all remaining questions in this domain, two of the questions were only within two-tenths of a percentage point of the statewide average.

Recommendation: HSAG recommends that **Senior Resources** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Staff are Reliable and Helpful* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Staff are Reliable and Helpful* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Senior Resources**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Senior Resources** across all EQR activities. The overarching aggregated findings showed that **Senior Resources**' quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Senior Resources** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Senior Resources** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Senior Resources** should focus its efforts on improving members' experiences with waiver agency staff and some waiver services, as members reported lower satisfaction in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Planning Your Time and Activities*, and *Met Need* domains. HSAG's assessment of **Senior Resources** also identified continued opportunities for **Senior Resources** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Senior Resources** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Senior Resources** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Senior Resources**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

The Information Center

Validation of Performance Improvement Projects

Performance Results

Table 3-65 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **The Information Center** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **The Information Center** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **The Information Center**'s QMP reports are also provided in Table 3-65. The results in Table 3-65 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-65—QIP Results

QIP Topic	Goal‡	Measurement and Outcome‡
1. *Prevalence of Neglect/Abuse*	Statewide goal of 3%	SFY 2019 = [No baseline data reported] SFY 2020* = [0.54%] SFY 2021[1] = 0.033% [0.00%] ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center**'s MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • **The Information Center** will continue to work with members on reporting Neglect/Abuse.		
2. *Prevalence of Pain With Inadequate Pain Control*	TIC will work to decrease the percentage of participant's with inadequate pain control to the statewide goal of 20%	SFY 2019 = [No baseline data reported] SFY 2020* = [35.37%] SFY 2021 = 37.23% ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center**'s MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • **The Information Center** did not meet the statewide goal of 20%. • Supports coordinators will continue to educate members regarding pain control and coordinate with the member's PCP. • Resources on pain identification and management will be provided as part of the intervention process.		

QIP Topic	Goal‡	Measurement and Outcome‡
3. *Prevalence of Falls*	TIC will work to reduce the percentage of MI Choice participants who have had a fall on a follow-up assessment to the Statewide goal of 23%.	SFY 2019 = [No baseline data reported] SFY 2020* = [28.88%] SFY 2021[1] = 25.31% ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center**'s MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • Supports coordinators will, on an ongoing basis, educate members on fall risks/how to avoid falls. • Service providers will be educated on fall prevention and identification of issues within the home that can create a fall risk. • **The Information Center** did not meet the goal of reducing falls based on the statewide guideline of 23%.		
4. *Prevalence of Any Injuries*	TIC will meet the state wide goal of 3%.	SFY 2019 = [No baseline data reported] SFY 2020* = [4.31%] SFY 2021 = 5% ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center**'s MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • **The Information Center** did not meet the statewide goal of 3%. • Service providers will be educated on the type and scope of injury to assist supports coordinators with providing additional information and interventions strategies to prevent injuries.		

QIP Topic	Goal‡	Measurement and Outcome‡
5. *Prevalence of Dehydration*	TIC will work with participants to decrease the prevalence of participants who were dehydrated due to insufficient fluid intake to less than the State wide goal of 2.7%.	SFY 2019 = [No baseline data reported] SFY 2020* = [10.77%] SFY 2021 = 7.6% ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Information Center**. **The Information Center**'s MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report FY 2021 dated January 15, 2022, identified the following: • **The Information Center** did not meet the statewide goal of 2.7%. • **The Information Center** via, QI summary and detailed reports, will identify members with nutritional and hydration issues. Supports coordinators will continue educate and inform members of the importance of adequate fluid intake to prevent dehydration.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
‡ MDHHS provided a document labeled "FY 2020 QMP Plan Final" for this waiver agency; however, this document was the SFY 2020 annual report. Therefore, information included as part of the QIP documentation, including the QIP goals and outcomes, were obtained through the SFY 2021 annual report. Where a specific goal was not identified, HSAG evaluated outcomes using the statewide goal percentage rates. Additionally, some of the goals indicated did not align with the statewide goal.
*HSAG calculated the SFY 2020 performance rates using the numerators and denominators provided by the waiver agency in the annual report.
[1]Percentage rates displayed as reported by the waiver agency; however, the rates reported do not align with HSAG's calculation using the numerators and denominators reported by the waiver agency.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: The Information Center met the statewide goal for the *Prevalence of Neglect/Abuse* QIP, suggesting members experienced few incidents of neglect/abuse. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There was no SFY 2020–2021 QMP available for **The Information Center**. [**Quality**]

Why the weakness exists: Although MDHHS provided a document labeled "FY 2020 QMP Plan Final" for **The Information Center**, this document was actually the SFY 2020 annual report. Therefore, it appears that **The Information Center** did not provide MDHHS with a QMP as required by the MDHHS contract requirements.

Recommendation: HSAG recommends that **The Information Center** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report.

Weakness #2: The Information Center did not measure improvements to the quality indicators on an ongoing basis. To effectively measure improvement in the quality indicators, it is important to identify and measure against a baseline rate. [**Quality**]

Why the weakness exists: The Information Center did not indicate the baseline rate for each quality indicator within its QMP reports.

Recommendation: HSAG recommends **The Information Center** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective.

Weakness #3: The interventions implemented by **The Information Center** to meet performance goals were very limited and non-specific. Additionally, the prevalence rates for the *Prevalence of Pain With Inadequate Pain Control* and *Prevalence of Any Injuries* QIPs increased, suggesting that the interventions implemented by **The Information Center** were not effective. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be specific, measurable, and actionable. [**Quality**]

Why the weakness exists: The Information Center's SFY 2021 annual report did not include specific and measurable interventions for the state-required QIPs or an assessment of whether a specific intervention(s) was/were successful or unsuccessful in achieving increased performance. Additionally, no conclusions were drawn regarding whether the interventions had an impact on the rate.

Recommendation: HSAG recommends that **The Information Center** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **The Information Center** should analyze and interpret results at multiple points in time and test for statistical significance. **The Information Center** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #4: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **The Information Center**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2021 annual report included limited details on the design developed and methodology followed by **The Information Center** when implementing its QIPs.

Recommendation: HSAG recommends that **The Information Center** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **The Information Center** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-66. Table 3-66 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **The Information Center**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **The Information Center**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-66—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**81.82%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**100.00%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**100.00%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**90.00%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**93.00%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**82.35%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**92.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**80.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**95.45%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: The Information Center received a 100 percent performance rating for Performance Measures 2, 4, 8, 15, 16, 22, 24, and 38, indicating that qualified members were enrolled consistent with MDHHS policies; appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included services and supports that aligned with members' assessed needs; PCSPs included strategies to address health and safety risks; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: The Information Center performed substantially worse than other waiver agencies on Performance Measure 1, *number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always comply with the service plan completion time frames. [**Timeliness**]

Why the weakness exists: The Information Center's performance rate for Performance Measure 1 fell 6.63 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that one of the 10 applicable records did not demonstrate evidence that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements; two of the 10 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member; two of the 10 applicable records did not demonstrate evidence that the PCSP included the provider, type, amount, frequency, and duration of services and supports; one of the 10 applicable records did not demonstrate evidence that the PCSP included outcome evaluations for each goal; six of the 10 applicable records did not demonstrate evidence that the person responsible for monitoring the PCSP was identified in the plan; and two of the seven applicable records did not demonstrate evidence that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements or provided the member/guardian with appropriate alternatives.

Recommendation: MDHHS required **The Information Center** to submit a CAP to remediate the deficiencies associated with Performance Measure 1. **The Information Center**'s CAP included, but was not limited to, training for all staff and a review of one record per month. While **The Information Center** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **The Information Center** continue conducting a specific number

of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: The Information Center performed substantially worse than other waiver agencies on Performance Measure 19, *number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always update the PCSP according to MDHHS requirements. [**Quality**]

Why the weakness exists: The Information Center's performance rate for Performance Measure 19 fell 6.10 percentage points below the statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that one of the 10 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and two of the seven applicable records did not demonstrate evidence that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements or provided the member/guardian with appropriate alternatives.

Recommendation: MDHHS required **The Information Center** to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **The Information Center**'s CAP included, but was not limited to, training for all staff and a review of one record per month. While **The Information Center** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **The Information Center** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: The Information Center performed substantially worse than other waiver agencies on Performance Measure 21, *number and percent of waiver participants whose records indicate choice was offered among waiver services,* as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that members were not always offered a choice among waiver services.

Why the weakness exists: The Information Center's performance rate for Performance Measure 21 fell 15.01 percentage points below HSAG's calculated statewide rate. Through the CQAR, of the 10 records reviewed, MPHI determined that two of the 10 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian a choice of appropriate MI Choice program services.

Recommendation: MDHHS required **The Information Center** to submit a CAP to remediate the deficiencies associated with Performance Measure 21. **The Information Center**'s CAP included, but was not limited to, training for all staff and a review of one record per month. While **The Information Center** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **The Information Center** continue conducting a specific number

of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-67 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-67 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-67—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	100.00%		**4.00**
Focus 3	Release of Information	100.00%		**4.00**
Focus 4	Status	100.00%		**4.00**
Focus 5	Pre-Planning	98.85%	100.00%	**4.00**
Focus 6	Assessment	98.89%	100.00%	**4.00**
Focus 7	Medication Record	83.64%	100.00%	**3.33**
Focus 8	Person-Centered Service Planning	88.44%	100.00%	**4.00**
Focus 9	MI Choice Services	92.98%	97.14%	**4.00**
Focus 10	Linking and Coordinating	90.63%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	86.96%	100.00%	**4.00**
Focus 12	Service Provider	83.33%		**4.00**
Focus 13	Contingency Plan	95.83%	100.00%	**4.00**
Focus 14	Critical Incidents	87.50%	92.31%	**3.33**
Focus 15	Adverse Benefit Determination	90.00%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**93.13%**	**99.22%**	**3.92**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: The Information Center achieved a substantial compliance rating in all 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: The Information Center did not receive any compliance determinations that were in the *not full or substantial compliance* or *compliance not demonstrated* rating categories; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: No substantial weaknesses were identified within any of the program areas under review; however, HSAG recommends **The Information Center** implement an ongoing and robust internal auditing process of individual supports coordinators as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-68 presents **The Information Center**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-68—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	92.3%	91.5%
Recommendation Measures	91.7%	92.6%
Staff are Reliable and Helpful	90.2%	91.9%
Staff Listen and Communicate Well	96.3%	95.0%
Case Manager is Helpful	90.7%	95.2%
Choosing the Services that Matter to You	89.0%	92.7%
Transportation to Medical Appointments	92.9%	92.5%
Personal Safety and Respect	99.1%	97.2%
Planning Your Time and Activities	74.9%	75.4%
Met Need	94.9%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: The Information Center achieved scores higher than the statewide results in the *Global Ratings Measures*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, and *Physical Safety Measure* domains, indicating that **The Information Center** provides services in a manner that meets or exceeds members' expectations in many domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: The Information Center did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **The Information Center** scored below the statewide average on the *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains. Therefore, HSAG recommends that **The Information Center** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains; conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary. The CAHPS survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. However, the waiver agency should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agency should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.

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

To identify strengths and weaknesses and draw conclusions for **The Information Center**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **The Information Center** across all EQR activities. The overarching aggregated findings showed that **The Information Center**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **The Information Center** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **The Information Center** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **The Information Center** should focus its efforts on improving members' experiences with waiver agency staff, case manager effectiveness, and some waiver services, as members reported lower satisfaction in the *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains. HSAG's assessment of **The Information Center** also identified continued opportunities for **The Information Center** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **The Information Center** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **The Information Center** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **The Information Center**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

The Senior Alliance

Validation of Performance Improvement Projects

Performance Results

Table 3-69 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **The Senior Alliance** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **The Senior Alliance** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **The Senior Alliance**'s QMP reports are also provided in Table 3-69. The results in Table 3-69 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-69—QIP Results

QIP Topic	Goal‡	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	Participants who have been neglected/abused, have poor hygiene, are fearful of family member, or have been restrained (3%)	SFY 2019 = [No baseline data reported] SFY 2020* = [7.20%] SFY 2021* = [5.06%] ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Senior Alliance**. **The Senior Alliance** Activities & Outcomes Report For FY 2021 The Senior Alliance 1-C, dated January 15, 2022 identified the following: • Included reminders in the January and July 2021 waiver newsletters to report any neglect/abuse to supports coordinators. • Provided training on neglect/abuse during annual critical incident training with all waiver staff.		
2. *Prevalence of Pain With Inadequate Pain Control*	Participants who experience pain -AND- experience inadequate pain control on regimen or breakthrough pain or sometimes severe or excruciatingly intense pain (20%)	SFY 2019 = [No baseline data reported] SFY 2020* = [23.92%] SFY 2021* = [19.82%] ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Senior Alliance**. **The Senior Alliance** Activities & Outcomes Report For FY 2021 The Senior Alliance 1-C, dated January 15, 2022 identified the following: • Added information on PATH classes to the agenda for March 2021 Local Quality Collaborative Meeting. • Sent out quarterly quality indicator report to supports coordinators to review members that had pain with inadequate control and ensure that adequate interventions were in place.		

QIP Topic	Goal‡	Measurement and Outcome
3. *Prevalence of Falls*	Participants who recorded a fall on follow-up assessment (23%)	SFY 2019 = [No baseline data reported] SFY 2020* = [26.59%] SFY 2021* [28.77%] ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Senior Alliance**. **The Senior Alliance** Activities & Outcomes Report For FY 2021 The Senior Alliance 1-C, dated January 15, 2022 identified the following: • Sent out quarterly quality indicator report to supports coordinators to review members that had reported falls and ensure adequate interventions were in place. • Added information on PATH classes to the agenda for March 2021 Local Quality Collaborative Meeting. • January and July 2021 Waiver Newsletter included information on fall prevention. • Conducted fall prevention training in September 2021 Local Quality Collaborative Meeting. • Included reminders in the January and July 2021 waiver newsletters to report any falls or injuries to their supports coordinator.		
4. *Prevalence of Any Injuries*	Participants with fractures or major skin problems, excluding current pressure or stasis ulcers (3%)	SFY 2019 = [No baseline data reported] SFY 2020* = [4.76%] SFY 2021* [3.46%] ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Senior Alliance**. **The Senior Alliance** Activities & Outcomes Report For FY 2021 The Senior Alliance 1-C, dated January 15, 2022 identified the following: • Sent out quarterly Quality Indicator report to supports coordinators to review members that had reported injuries and ensure adequate interventions were in place. • Included reminders in the January and July 2021 waiver newsletters to report any falls or injuries to their supports coordinator.		

QIP Topic	Goal‡	Measurement and Outcome
5. *Prevalence of Dehydration*	Insufficient fluid intake (1.5%)	SFY 2019 = [No baseline data reported] SFY 2020* = [1.00%] SFY 2021* [1.04%] ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **The Senior Alliance**. **The Senior Alliance** Activities & Outcomes Report For FY 2021 The Senior Alliance 1-C, dated January 15, 2022 identified the following: • Sent out quarterly quality indicator report to supports coordinators to review members that had reported insufficient fluid intake and ensure adequate interventions were in place.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
‡MDHHS provided a document labeled "FY 2020 Quality Management Plan" for this waiver agency; however, this document was the SFY 2020 annual report. Therefore, information included as part of the QIP documentation, including the QIP goals and outcomes, were obtained through the SFY 2021 annual report. Where a specific goal was not identified, HSAG evaluated outcomes using the statewide goal percentage rates.
*HSAG calculated the SFY 2020 and SFY 2021 performance rates using the numerators and denominators provided by the waiver agency in the annual report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: The Senior Alliance met its internal QIP goals for the *Prevalence of Pain With Inadequate Pain Control* and *Prevalence of Dehydration* QIPs, suggesting **The Senior Alliance** implemented effective interventions and members experienced few incidents of uncontrolled pain and dehydration. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There was no SFY 2020–2021 QMP available for **The Senior Alliance**. [**Quality**]

Why the weakness exists: Although MDHHS provided a document labeled "FY 2020 Quality Management Plan" for **The Senior Alliance**, this document was actually the SFY 2020 annual report. Therefore, it appeared that **The Senior Alliance** did not provide MDHHS with a QMP as required by the MDHHS contract requirements.

Recommendation: HSAG recommends that **The Senior Alliance** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report.

Weakness #2: In the SFY 2021 annual report, **The Senior Alliance** reported the numerator and denominator, and the percentage rates for each quarter of SFY 2021 for each QIP; however, **The Senior Alliance** did not provide an overall performance rate for SFY 2021 or compare performance against a baseline rate to determine performance outcomes. It is important to monitor not only the numerator and denominator on an ongoing basis, but also the annual percentage to monitor performance over time, including any significant improvements or declines in annual outcomes. [**Quality**]

Why the weakness exists: **The Senior Alliance** did not calculate a percentage rate for the entire state fiscal year and compare those overall state fiscal year results to an identified baseline rate to determine the QIPs' performance outcomes.

Recommendation: HSAG recommends that **The Senior Alliance** calculate QIP performance rates at the end of the specified measurement period (i.e., conclusion of the state fiscal year) using the numerators and denominators applicable for the entire state fiscal year. These performance rates should then be assessed against a specified baseline rate to determine whether performance in each QIP improved or declined over time. **The Senior Alliance** should use the results of this assessment to determine whether its implemented interventions should continue or be discontinued, be revised, or whether new interventions need to be developed.

Weakness #3: The interventions implemented by **The Senior Alliance** to meet performance goals were identified in the SFY 2021 annual report; however, there was no evaluation of each intervention to determine its effectiveness. Additionally, the prevalence rate for the *Prevalence of Falls* QIP increased, suggesting that the interventions implemented by **The Senior Alliance** were not effective. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly evaluated. [**Quality**]

Why the weakness exists: **The Senior Alliance**'s SFY 2021 annual report did not clearly include an assessment of whether a specific intervention(s) was/were successful or unsuccessful in achieving increased performance.

Recommendation: HSAG recommends that **The Senior Alliance** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test

of change would be likely to lead to the desired improvement in processes or outcomes). **The Senior Alliance** should analyze and interpret results at multiple points in time and test for statistical significance. **The Senior Alliance** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #4: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **The Senior Alliance**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and methodology followed by **The Senior Alliance** when implementing its QIPs.

Recommendation: HSAG recommends that **The Senior Alliance** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **The Senior Alliance** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-70. Table 3-70 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **The Senior Alliance**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **The Senior Alliance**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-70—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**91.74%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**96.61%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**93.75%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**96.97%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**84.38%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**95.18%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**92.00%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**94.74%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**93.75%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**97.30%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: The Senior Alliance received a 100 percent performance rating for Performance Measures 8, 16, 22, 24, and 38, indicating that LOC criteria were accurately applied on initial determination; PCSPs included strategies to address health and safety risks; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: The Senior Alliance performed substantially worse than other waiver agencies on Performance Measure 4, *number and percent of appropriate LOC determinations found after MDHHS review*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that the waiver agency did not always ensure the appropriate LOCDs were made. [**Quality**]

Why the weakness exists: The Senior Alliance's performance rate for Performance Measure 4 fell 5.46 percentage points below the statewide rate. Through the CQAR, of the 16 records reviewed, MPHI determined that one of the 16 applicable records did not demonstrate evidence that the waiver agency validated the accuracy of the NFLOCD enrollment Door, thus ensuring the validity of the NFLOCDs in CHAMPS.

Recommendation: MDHHS did not require **The Senior Alliance** to submit a CAP to remediate the one deficiency associated with Performance Measure 4. However, HSAG recommends that **The Senior Alliance** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: The Senior Alliance performed substantially worse than other waiver agencies on Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always include the goals and preferences desired by the member in the PCSP. [**Quality**]

Why the weakness exists: **The Senior Alliance**'s performance rate for Performance Measure 17 fell 6.96 percentage points below the statewide rate. Through the CQAR, of the 16 records reviewed, MPHI determined that five of the 16 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member.

Recommendation: MDHHS required **The Senior Alliance** to submit a CAP to remediate the deficiencies associated with Performance Measure 17. **The Senior Alliance**'s CAP included, but was not limited to, education and training for all staff and a review of 12 records. However, **The Senior Alliance** also indicated that individual staff meetings may result based on the review findings and, while **The Senior Alliance** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **The Senior Alliance** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-71 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-71 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-71—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	97.30%	100.00%	**4.00**
Focus 2	Freedom of Choice	87.50%		**3.00**
Focus 3	Release of Information	100.00%		**4.00**
Focus 4	Status	97.96%		**4.00**
Focus 5	Pre-Planning	97.93%	100.00%	**4.00**
Focus 6	Assessment	94.37%	100.00%	**4.00**
Focus 7	Medication Record	86.21%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	93.94%	100.00%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 9	MI Choice Services	97.75%	100.00%	**4.00**
Focus 10	Linking and Coordinating	100.00%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	82.86%	100.00%	**3.33**
Focus 12	Service Provider	91.67%		**4.00**
Focus 13	Contingency Plan	97.78%	100.00%	**4.00**
Focus 14	Critical Incidents	90.00%	100.00%	**2.00**
Focus 15	Adverse Benefit Determination	81.82%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**94.28%**	**100.00%**	**3.88**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Eight home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences

and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the area of Critical Incidents as the overall rating for this program area was less than full compliance. [**Quality**]

Strength #2: The Senior Alliance achieved a substantial compliance rating in 15 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: The Senior Alliance did not consistently follow all Critical Incidents requirements; specifically, entering, reporting, and providing updates to the critical incident portal in accordance with MDHHS policy and contract requirements. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the five applicable records did not demonstrate evidence that the supports coordinator entered, reported, and provided updates to the critical incident portal in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS required **The Senior Alliance** to submit a CAP to remediate the deficiencies. **The Senior Alliance**'s CAP included, but was not limited to, education and training for all staff and a review of 10 records. **The Senior Alliance** also indicated that individual staff meetings may result based on the review findings. However, while **The Senior Alliance** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **The Senior Alliance** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-72 presents **The Senior Alliance**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-72—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	90.4%	91.5%
Recommendation Measures	89.8%	92.6%
Staff are Reliable and Helpful	87.2%	91.9%
Staff Listen and Communicate Well	94.5%	95.0%
Case Manager is Helpful	95.8%	95.2%
Choosing the Services that Matter to You	90.2%	92.7%
Transportation to Medical Appointments	94.9%	92.5%
Personal Safety and Respect	98.3%	97.2%
Planning Your Time and Activities	72.0%	75.4%
Met Need	91.1%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: The Senior Alliance achieved scores higher than the statewide results in the *Case Manager is Helpful*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, and *Physical Safety Measure* domains, indicating that **The Senior Alliance** provides services in a manner that meets or exceeds members' expectations in some domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: The Senior Alliance did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **The Senior Alliance** scored below the statewide average on the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains. Therefore, HSAG recommends that **The Senior Alliance** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains; conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary. The CAHPS survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. However, the waiver agency should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agency should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.

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

To identify strengths and weaknesses and draw conclusions for **The Senior Alliance**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **The Senior Alliance** across all EQR activities. The overarching aggregated findings showed that **The Senior Alliance**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **The Senior Alliance** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **The Senior Alliance** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **The Senior Alliance** should focus its efforts on improving members' experiences with waiver agency staff, case manager effectiveness, and some waiver services, as members reported lower satisfaction in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicates Well*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains. HSAG's assessment of **The Senior Alliance** also identified continued opportunities for **The Senior Alliance** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **The Senior Alliance** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **The Senior Alliance** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **The Senior Alliance**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Tri-County Office on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-73 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Tri-County Office on Aging** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Tri-County Office on Aging** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Tri-County Office on Aging**'s QMP reports are also provided in Table 3-73. The results in Table 3-73 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-73—QIP Results

QIP Topic	Goal†	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 3.2% SFY 2021[1] = 3.8% ☒
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s SFY 2020-2021 QMP dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified] **Tri-County Office on Aging**'s Summary of 2020-2021 Quality Management Plan dated January 11, 2022, identified the following: • **Tri-County Office on Aging** implemented a training plan for supports coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to the prevention and reporting of abuse and neglect. Additionally, **Tri-County Office on Aging** coordinated the implementation of training regarding abuse and neglect at all staff meetings in SFY 2020 and 2021. **Tri-County Office on Aging**'s consumer quality collaborative, CSI [Choice, Satisfaction, and Independence], also began the initial planning process for a guide outlining common financial scams targeted at older adults that could be distributed and/or reviewed with members and community members.		
2. *Prevalence of Pain With Inadequate Pain Control*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 27.3% SFY 2021[1] = 30.8% ☒

QIP Topic	Goal†	Measurement and Outcome
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s Summary of QA Plan Activities and Outcomes dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified] **Tri-County Office on Aging**'s Summary of 2020-2021 Quality Management Plan dated January 11, 2022, identified the following: • **Tri-County Office on Aging** implemented a training plan for supports coordinators and professional support staff using the web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to pain management. Additionally, **Tri-County Office on Aging** utilized the MI Capable Tool-Kit to provide education and resources for supports coordinators related to the efficacy of alternative pain relief strategies. Adequate pain control also continues to be an ongoing topic of discussion at CSI, the local consumer quality collaborative group.		
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 32% SFY 2021[1] = 30% ☒
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s Summary of QA Plan Activities and Outcomes dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified] **Tri-County Office on Aging**'s Summary of 2020-2021 Quality Management Plan dated January 11, 2022, identified the following: • **Tri-County Office on Aging** implemented a training plan for supports coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to reducing the risk of falls. Additionally, **Tri-County Office on Aging** utilized the MI Capable Toolkit to provide education and resources for supports coordinators related to the most current evidence-based assessment tools and prevention strategies for falls. The reduction of risk and prevention of falls also continues to be an ongoing topic of discussion at CSI, the local consumer quality collaborative group.		
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 4.7% SFY 2021[1] = 6.7% ☒
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s Summary of QA Plan Activities and Outcomes dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified]		

QIP Topic	Goal†	Measurement and Outcome
Tri-County Office on Aging's Summary of 2020-2021 Quality Management Plan dated January 11, 2022, identified the following: • **Tri-County Office on Aging** implemented a training plan for supports coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to reducing the risk of injury for members, including abuse or neglect. Additionally, **Tri-County Office on Aging** utilized the MI Capable Toolkit to provide education and resources for supports coordinators related to the most current evidence-based assessment tools and prevention strategies for risk reduction and intervention planning. Reduction of risk and prevention of injury continues to be discussed and addressed by CSI, the local consumer quality collaborative group, who recently updated a document previously developed by the committee to prompt members of what may be required or helpful for emergency professionals in case of injury that results in a hospitalization.		
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 1.6% SFY 2021[1] = 1.4% ☑
Actions/Activities/Interventions: According to **Tri-County Office on Aging**'s Summary of QA Plan Activities and Outcomes dated January 8, 2020, **Tri-County Office on Aging** planned to complete the following tasks: • [None identified] **Tri-County Office on Aging**'s Summary of 2020-2021 Quality Management Plan dated January 11, 2022, identified the following: • **Tri-County Office on Aging** implemented a training plan for supports coordinators and professional support staff using web-based training platform, Relias. The trainings within the training plan highlight the latest research and evidence-based knowledge related to proper nutrition and hydration. Additionally, **Tri-County Office on Aging** utilized the MI Capable Toolkit to provide education and resources for supports coordinators related to the most current evidence-based assessment tools and prevention strategies for reducing risk for dehydration. Access to proper nutrition and hydration continues to be discussed and addressed by CSI, the local consumer quality collaborative group.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
*HSAG determined performance outcomes using the most current percentage rate identified by the waiver agency within the FY 2020 annual report. HSAG cannot determine whether the most current percentage rates identified by the waiver agency within the report were reflective of the rates at the end of SFY 2020.
†The waiver agency did not identify goals in its QMP reports; therefore, HSAG measured performance outcomes using the statewide goal.
[1] HSAG determined performance outcomes using the most current percentage rate identified by the waiver agency within the FY 2021 annual report. HSAG cannot determine whether the most current percentage rates identified by the waiver agency within the report were reflective of the rates at the end of SFY 2021.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Tri-County Office on Aging met the statewide goal for the *Prevalence of Dehydration* QIP, suggesting that **Tri-County Office on Aging** implemented interventions that had a positive effect on prevalence rates, and members experienced few incidents of dehydration. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Tri-County Office on Aging did not meet statewide goals for four of the five QIPs and also demonstrated worse year-over-year performance in three of the five QIPs as indicated in the SFY 2021 annual report. [**Quality**]

Why the weakness exists: Based on **Tri-County Office on Aging**'s outcomes analysis within the SFY 2021 annual report, prevalence rates for neglect/abuse, inadequate pain control, and injuries increased throughout the measurement period, suggesting the implemented activities did not support improvement.

Recommendation: HSAG recommends that **Tri-County Office on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Tri-County Office on Aging** should ensure that its annual report includes a more comprehensive analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. Further, HSAG recommends that **Tri-County Office on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Tri-County Office on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Tri-County Office on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #2: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Tri-County Office on Aging**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and the methodology followed by **Tri-County Office on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Tri-County Office on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Tri-County Office on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-74. Table 3-74 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Tri-County Office on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Tri-County Office on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-74—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	88.45%	90.67%
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	96.06%	97.18%
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	99.21%	100.00%

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**92.31%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**97.12%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**90.00%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**93.21%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**86.05%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**94.59%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**92.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**88.89%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Tri-County Office on Aging received a 100 percent performance rating for Performance Measures 4, 16, 22, 24, and 38, indicating that appropriate LOCDs were made; PCSPs included strategies to address health and safety risks; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Tri-County Office on Aging performed substantially worse than other waiver agencies on Performance Measure 8, *number and percent of participants who had initial LOCDs where the NFLOC criteria were accurately applied*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that the waiver agency did not always ensure that the members met NFLOC criteria prior to waiver enrollment. [**Quality**]

Why the weakness exists: Tri-County Office on Aging's performance rate for Performance Measure 8 fell 6.83 percentage points below the statewide rate. Through the CQAR, of the 25 records reviewed, MPHI determined that one of the 13 applicable records did not demonstrate evidence that the NFLOCD was adopted or conducted prior to initial enrollment.

Recommendation: MDHHS did not require **Tri-County Office on Aging** to submit a CAP to remediate the one deficiency associated with Performance Measure 8. However, HSAG recommends that **Tri-County Office on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-75 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-75 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-75—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	98.46%	100.00%	**4.00**
Focus 2	Freedom of Choice	96.00%		**4.00**
Focus 3	Release of Information	96.00%		**4.00**
Focus 4	Status	97.70%		**4.00**
Focus 5	Pre-Planning	97.76%	100.00%	**4.00**
Focus 6	Assessment	95.56%	100.00%	**4.00**
Focus 7	Medication Record	72.31%	100.00%	**2.03**
Focus 8	Person-Centered Service Planning	90.96%	100.00%	**4.00**
Focus 9	MI Choice Services	95.80%	98.90%	**4.00**
Focus 10	Linking and Coordinating	92.19%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	82.26%	100.00%	**3.34**
Focus 12	Service Provider	83.33%		**4.00**
Focus 13	Contingency Plan	90.32%	100.00%	**4.00**
Focus 14	Critical Incidents	91.67%	100.00%	**4.00**
Focus 15	Adverse Benefit Determination	85.00%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**91.92%**	**99.85%**	**3.82**

	Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.
	Indicates substantial compliance: 3.26 or higher.
	Indicates some compliance, needs improvement: 2.51 to 3.25.
	Indicates not full or substantial compliance: 1.76 to 2.50.
	Indicates compliance not demonstrated: 1.00 to 1.75.
	NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Tri-County Office on Aging achieved a substantial compliance rating in 16 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Tri-County Office on Aging did not consistently follow all Medication Record requirements—specifically, inclusion of all prescribed medications; the name, prescribing physician name, purpose, strength/dose, frequency, and route for all medications; and identification of the member's known pharmaceutical, environmental, and food allergies or that the member had no known allergies. If a member's medication record does not include all prescribed medications and

information related to medication and the member's allergies, medication errors can occur, such as adverse drug-to-drug interactions or allergic reactions. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that nine of the 25 applicable medication records did not include all prescribed medications; three of the 25 applicable records did not include the name, prescribing physician name, purpose, strength/dose, frequency, and route for all medications; and 23 of the 25 applicable medication records did not include the member's known allergies.

Recommendation: MDHHS required **Tri-County Office on Aging** to submit a CAP to remediate the deficiencies. **Tri-County Office on Aging**'s CAP included, but was not limited to, updated protocol, staff training, and a review of 12 records, including specific individual action for supports coordinators not meeting 90 percent on this focus area. However, HSAG recommends that **Tri-County Office on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-76 presents **Tri-County Office on Aging**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-76—CAHPS Domain Scores

Domain	PAHP	Statewide
Global Ratings Measures	**96.7%**	91.5%
Recommendation Measures	**97.7%**	92.6%
Staff are Reliable and Helpful	96.1%	91.9%
Staff Listen and Communicate Well	95.8%	95.0%
Case Manager is Helpful	100.0%	95.2%
Choosing the Services that Matter to You	93.1%	92.7%
Transportation to Medical Appointments	92.7%	92.5%
Personal Safety and Respect	94.1%	97.2%

Domain	PAHP	Statewide
Planning Your Time and Activities	73.3%	75.4%
Met Need	92.4%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the PAHP scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Tri-County Office on Aging achieved scores higher than the statewide results in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, and *Physical Safety Measure* domains, indicating that **Tri-County Office on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. Additionally, **Tri-County Office on Aging** scored more than 5 percentage points higher than the statewide average on the *Global Ratings Measures* and *Recommendation Measures* domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Tri-County Office on Aging did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **Tri-County Office on Aging** scored below the statewide average on the *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains. Therefore, HSAG recommends that **Tri-County Office on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains; conduct a root cause

analysis to determine potential reasons for the expressed dissatisfaction; develop interventions to improve the *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains; evaluate the effectiveness of the interventions regularly; and make changes as necessary. It should be noted that the *Planning Your Time and Activities* domain received the lowest statewide score across all domains. The CAHPS survey was conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. However, the waiver agency should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agency should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.

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

To identify strengths and weaknesses and draw conclusions for **Tri-County Office on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Tri-County Office on Aging** across all EQR activities. The overarching aggregated findings showed that **Tri-County Office on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Tri-County Office on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Tri-County Office on Aging** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Tri-County Office on Aging** should focus its efforts on improving members' experiences with waiver agency staff, case manager effectiveness, and some waiver services, as members reported lower satisfaction in the *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains. HSAG's assessment of **Tri-County Office on Aging** also identified continued opportunities for **Tri-County Office on Aging** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Tri-County Office on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Tri-County Office on Aging** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Tri-County Office on Aging**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

UPCAP Care Management, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 3-77 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **UPCAP Care Management, Inc.** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **UPCAP Care Management, Inc.** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **UPCAP Care Management, Inc.**'s QMP reports are also provided in Table 3-77. The results in Table 3-77 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-77—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 12.1% SFY 2021†[2] = 5.8% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019[1], **UPCAP Care Management, Inc.** planned to complete the following tasks: • **UPCAP Care Management, Inc.** will make no significant changes to its current response to incidences of neglect/abuse. • Care managers receive training on this issue that includes signs to look for and reporting responsibilities. • Care managers provide information to members and families on how to report and make appropriate referrals. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 202 dated January 14, 2022, identified the following: • **UPCAP Care Management, Inc.** will make no significant changes to its current response to incidences of neglect/abuse. Supports coordinators receive training on this issue that includes signs to look for and reporting responsibilities. Supports coordinators provide information and education to members and families on how to report and make appropriate referrals.		

QIP Topic	Goal	Measurement and Outcome
2. *Prevalence of Pain With Inadequate Pain Control*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 38.8% SFY 2021†2 = 30.8% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019, **UPCAP Care Management, Inc.** planned to complete the following tasks: • Care managers have reported members telling them that their physicians are reluctant to prescribe adequate pain medications due to the opioid crisis. • Care managers review medications and try to intervene by talking to physicians but that does not always result in a change to pain medications. • Care managers review medication management plan to assure member is taking meds as prescribed and on time. • Care managers encourage the use of pain clinics, and offer information on alternative pain treatments. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 202 dated January 14, 2022, identified the following: • Supports coordinators have reported members telling them that their physicians are reluctant to prescribe adequate pain medications due to the opioid crisis. Supports coordinators review medications and try to intervene by talking to physicians but that does not always result in a change to pain medications. Supports coordinators review medication management plan to assure member is taking meds as prescribed and on time. Supports coordinators encourage the use of pain clinics, and offer information on alternative pain treatments. Supports coordinators also encourage members to participate in evidence-based programs offered by **UPCAP Care Management, Inc.** such as "Chronic Pain Self-Management".		
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 50.9% SFY 2021† = 39.0% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019, **UPCAP Care Management, Inc.** planned to complete the following tasks: • In 2019 all **UPCAP Care Management, Inc.** Care managers completed the training for the MI CAPABLE model of care. **UPCAP Care Management, Inc.** is in the process of implementing the model for SFY 2020. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 202 dated January 14, 2022, identified the following: • In 2021 all **UPCAP Care Management, Inc.** supports coordinators completed the refresher training for the CAPABLE model of care, which educated supports coordinators on ways to improve the safety of members		

QIP Topic	Goal	Measurement and Outcome
in their home, working with an Occupational Therapist to determine what DME or home modifications are needed. Supports coordinators also encourage members to participate in evidence-based programs offered by **UPCAP Care Management, Inc.** such as "A Matter of Balance" and "Walk with Ease".		
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = 6.9% SFY 2020* = 13% SFY 2021† = 10.5% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019, **UPCAP Care Management, Inc.** planned to complete the following tasks: • In 2019 all **UPCAP Care Management, Inc.** Care managers completed the training for the MI CAPABLE model of care. • **UPCAP Care Management, Inc.** is in the process of implementing the model for SFY 2020. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 202 dated January 14, 2022, identified the following: • In 2021 all **UPCAP Care Management, Inc.** supports coordinators completed the refresher training for the CAPABLE model of care, which educated supports coordinators on ways to improve the safety of members in their home, working with an Occupational Therapist to determine what DME or home modifications are needed. Supports coordinators also encourage members to participate in evidence-based programs offered by **UPCAP Care Management, Inc.** such as "A Matter of Balance" and "Walk with Ease". • Due to this increase staff will be required to provide education to members utilizing materials from the CAPABLE toolkit and encouraging them to participate in online educational seminars regarding injury prevention.		
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data reported] SFY 2020* = 9.5% SFY 2021†2 = 3.8% ☒
Actions/Activities/Interventions: According to **UPCAP Care Management, Inc.**'s MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 2020–FY 2021 dated February 7, 2019, **UPCAP Care Management, Inc.** planned to complete the following tasks: • Care managers see members two times per year and assessing dehydrations in any specific period are difficult. • Provider agencies are reminded on work orders to push fluids and care managers educate members on the importance of drinking enough fluids. The **UPCAP Care Management, Inc.** MI Choice Summary of Quality Management Plan Activities & Outcomes Report FY 202 dated January 14, 2022, identified the following:		

QIP Topic	Goal	Measurement and Outcome
• Supports coordinators only see members two times per year so assessing dehydration in any specific period is difficult. Provider agencies are reminded on work orders to push fluids and supports coordinators educate members on the importance of drinking enough fluids.		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
[1]HSAG made the assumption that the QMP dated February 7, 2019, was a typographical error as the QMP included the QIPs required for SFY 2020.
[2]Percentage rates displayed as reported by the waiver agency; however, the rates reported do not align with HSAG's calculation using the numerators and denominators reported by the waiver agency.
*As reported by the waiver agency, the percentage rates were calculated from numerators and denominators applicable during the time period of April 2020 through September 2020.
†As reported by the waiver agency, the percentage rates were calculated from numerators and denominators applicable during the time period of April 2021 through September 2021.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: HSAG did not identify any substantial strengths for **UPCAP Care Management, Inc.** as none of the statewide goals for the QIPs were met.

Weaknesses and Recommendations

Weakness #1: The document with the file name "Quality Management Plan 2020" for **UPCAP Care Management, Inc.** had a title of "MI Choice Summary of Quality Management Plan Activities & Outcomes Report"; however, the information in the document appeared to be the SFY 2020–2021 QMP and was dated February 7, 2019. [**Quality**]

Why the weakness exists: The title of the document was incorrect.

Recommendation: HSAG recommends **UPCAP Care Management, Inc.** ensure that it completes and submits to MDHHS an updated QMP every two years that includes an appropriate title and date.

Weakness #2: UPCAP Care Management, Inc.'s QIP performance results reported in the SFY 2021 annual report were not comparable across all waiver agencies. [**Quality**]

Why the weakness exists: The performance rates, numerators, and denominators in the SFY 2021 annual report identified the data time frame of April 2021 to September 2021 for all QIPs. It is unknown why **UPCAP Care Management, Inc.** only reported data for a six-month period for the SFY 2021 annual results.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.**'s annual report includes an evaluation of the entire state fiscal year's performance results for each QIP quality indicator.

Weakness #3: UPCAP Care Management, Inc. did not identify goals in the SFY 2020–2021 QMP or in the SFY 2021 annual report. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: UPCAP Care Management, Inc. did not identify goals within its SFY 2020–2021 QMP or SFY 2021 annual report; therefore, there was no analysis indicating whether **UPCAP Care Management** met its goals.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **UPCAP Care Management, Inc.** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #4: The interventions implemented by **UPCAP Care Management, Inc.** to meet performance goals were not specific and measurable. Additionally, there was no evaluation of each intervention to determine its effectiveness. Further, **UPCAP Care Management, Inc.** did not meet any of the five statewide goals for the QIPs, suggesting that the interventions implemented did not have a positive effect on the outcomes of the QIPs. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly evaluated. [**Quality**]

Why the weakness exists: UPCAP Care Management, Inc.'s SFY 2021 annual report did not include a comprehensive assessment of whether a specific intervention(s) was/were successful or unsuccessful in achieving increased performance.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **UPCAP Care Management, Inc.** should analyze and interpret results at multiple points in time and test for statistical significance. **UPCAP Care Management, Inc.** should evaluate the effectiveness

of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #5: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **UPCAP Care Management, Inc.**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2020–2021 QMP and SFY 2021 annual report included limited details on the design developed and methodology followed by **UPCAP Care Management, Inc.** when implementing its QIPs.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **UPCAP Care Management, Inc.** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-78. Table 3-78 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **UPCAP Care Management, Inc.**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **UPCAP Care Management, Inc.**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-78—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**84.47%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**94.29%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**92.31%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**94.34%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**84.62%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**88.25%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**80.00%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**100.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**94.87%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**66.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: UPCAP Care Management, Inc. received a 100 percent performance rating for Performance Measures 8, 16, 20, 21, 22, and 38, indicating that LOC criteria were accurately applied on initial determinations; PCSPs included strategies to address health and safety risks; members received all of the services and supports identified in the PCSP; waiver service choice was offered to members; waiver provider choice was offered to members; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: UPCAP Care Management, Inc. performed substantially worse than other waiver agencies on Performance Measure 4, *number and percent of appropriate LOC determinations found after MDHHS review*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that the waiver agency did not always ensure the appropriate LOCDs were made. [**Quality**]

Why the weakness exists: UPCAP Care Management, Inc.'s performance rate for Performance Measure 4 fell 6.90 percentage points below the statewide rate. Through the CQAR, of the 13 records reviewed, MPHI determined that one of the 13 applicable records did not demonstrate evidence that the waiver agency validated the accuracy of the NFLOCD enrollment Door, thus ensuring the validity of the NFLOCDs in CHAMPS.

Recommendation: MDHHS did not require **UPCAP Care Management, Inc.** to submit a CAP to remediate the one deficiency associated with Performance Measure 4. However, HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: UPCAP Care Management, Inc. performed substantially worse than other waiver agencies on Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always include the goals and preferences desired by the member in the PCSP. [**Quality**]

Why the weakness exists: UPCAP Care Management, Inc.'s performance rate for Performance Measure 17 fell 6.72 percentage points below the statewide rate. Through the CQAR, of the 13 records reviewed, MPHI determined that four of the 13 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member.

Recommendation: MDHHS required **UPCAP Care Management, Inc.** to submit a CAP to remediate the deficiencies associated with Performance Measure 17. **UPCAP Care Management, Inc.**'s CAP included, but was not limited to, education and training for all staff and a review of 20 records per month. However, **UPCAP Care Management, Inc.** also indicated that that once standards show a compliance rate of 85 percent, no further reporting will be required. Therefore, HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #3: UPCAP Care Management, Inc. performed substantially worse than other waiver agencies on Performance Measure 18, *number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always develop service plans according to MDHHS policies. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: UPCAP Care Management, Inc.'s performance rate for Performance Measure 18 fell 6.50 percentage points below the statewide rate. Through the CQAR, of the 13 records reviewed, MPHI determined that four of the 13 applicable records did not demonstrate evidence that the supports coordinator contacted the member/guardian prior to assessments, home visits, and/or planning meetings to ensure the dates/times/locations were convenient for the member/guardian; five of the 13 applicable records did not demonstrate evidence that the supports coordinator assessed the member for risks, educated the member/guardian on assessed/identified risks, offered modifications to promote safety and independence, and provided the member/guardian the opportunity to manage risk throughout care planning and service delivery; one of the 13 applicable records did not demonstrate evidence that the information in the assessment was consistent, providing a clear picture of the member's strengths, needs, and abilities, and contained relevant information and explanations; four of the 13 applicable records did not demonstrate evidence that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements; four of the 13 applicable records did not demonstrate evidence that the PCSP included the process for minimizing risk factors, planning, and supporting the member; one of the 13 applicable records did not demonstrate evidence that the services and supports on the PCSP included the provider, type, amount, frequency, and duration; one of the 13 applicable records did not demonstrate evidence that the PCSP included an acknowledgment that the member's informal supports agreed to provide uncompensated services and supports; three of the 13 applicable records did not demonstrate evidence that the PCSP included outcome evaluations for each goal; one of the 13 applicable records did not demonstrate evidence that the person responsible for monitoring the

PCSP was identified in the plan; 12 of the 13 applicable records did not demonstrate evidence that the PCSP was understandable, written in plain language, and offered in a manner that was accessible to the member/guardian; and three of the 13 applicable records did not demonstrate evidence that the authorized services met service standard requirements.

Recommendation: MDHHS required **UPCAP Care Management, Inc.** to submit a CAP to remediate the deficiencies associated with Performance Measure 18. **UPCAP Care Management, Inc.**'s CAP included, but was not limited to, education and training for all staff and a review of 20 records per month. However, **UPCAP Care Management, Inc.** also indicated that that once standards show a compliance rate of 85 or 90 percent (depending on the requirements), no further reporting will be required. Therefore, HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #4: UPCAP Care Management, Inc. performed substantially worse than other waiver agencies on Performance Measure 19, *number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that supports coordinators did not always update the PCSP according to MDHHS requirements. [**Quality**]

Why the weakness exists: UPCAP Care Management, Inc.'s performance rate for Performance Measure 19 fell 8.45 percentage points below the statewide rate. Through the CQAR, of the 13 records reviewed, MPHI determined that four of the 13 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and one of the 12 applicable records did not demonstrate evidence that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements or provided the member/guardian with appropriate alternatives.

Recommendation: MDHHS required **UPCAP Care Management, Inc.** to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **UPCAP Care Management, Inc.**'s CAP included, but was not limited to, education and training for all staff and a review of 20 records per month. However, **UPCAP Care Management, Inc.** also indicated that that once standards show a compliance rate of 85 percent, no further reporting will be required. Therefore, HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #5: UPCAP Care Management, Inc. performed substantially worse than other waiver agencies on Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies*, as indicated by a performance rate of more than 5 percentage

points below the statewide rate. This demonstrated that supports coordinators did not always ensure members had an individualized contingency plan for emergencies. [**Quality** and **Access**]

Why the weakness exists: **UPCAP Care Management, Inc.**'s performance rate for Performance Measure 30 fell 23.62 percentage points below the statewide rate. Through the CQAR, of the 13 records reviewed, MPHI determined that 10 of the 13 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan.

Recommendation: MDHHS required **UPCAP Care Management, Inc.** to submit a CAP to remediate the deficiencies associated with Performance Measure 30. **UPCAP Care Management, Inc.**'s CAP included, but was not limited to, education and training for all staff and a review of 20 records per month. However, **UPCAP Care Management, Inc.** also indicated that that once standards show a compliance rate of 90 percent, no further reporting will be required. Therefore, HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-79 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-79 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-79—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	96.77%	100.00%	**4.00**
Focus 2	Freedom of Choice	61.54%		**1.00**
Focus 3	Release of Information	100.00%		**4.00**
Focus 4	Status	100.00%		**4.00**
Focus 5	Pre-Planning	94.64%	100.00%	**4.00**
Focus 6	Assessment	93.10%	100.00%	**4.00**

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 7	Medication Record	95.52%	100.00%	**3.34**
Focus 8	Person-Centered Service Planning	85.71%	100.00%	**4.00**
Focus 9	MI Choice Services	94.81%	100.00%	**4.00**
Focus 10	Linking and Coordinating	92.86%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	65.52%	100.00%	**2.05**
Focus 12	Service Provider	85.71%		**4.00**
Focus 13	Contingency Plan	71.43%	100.00%	**2.70**
Focus 14	Critical Incidents	NA	100.00%	
Focus 15	Adverse Benefit Determination	94.44%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		90.00%	**4.00**
	Totals	**89.99%**	**99.71%**	**3.84**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Seven home visit reviews were conducted and nearly all reviews achieved full compliance, with one deficiency. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the areas of Follow-Up and Monitoring and Contingency Plan as the overall ratings for these program areas were less than full compliance. [**Quality**]

Strength #2: UPCAP Care Management, Inc. achieved a substantial compliance rating in 13 of the applicable 16 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: UPCAP Care Management, Inc. did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid FOC form was on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that five of the 13 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **UPCAP Care Management, Inc.** to submit a CAP to remediate the deficiencies. **UPCAP Care Management, Inc.**'s CAP included, but was not limited to, education and training for all staff and a review of up to 20 records per month. However, **UPCAP Care Management, Inc.** also indicated that once a standard shows a compliance rate of 90 percent, no further reporting will be required. Therefore, HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) per

supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Weakness #2: UPCAP Care Management, Inc. did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting members for follow-up and monitoring as specified in the member's PCSP. Waiver agencies are required to contact each member to ensure services are implemented as planned. When services are not implemented as planned or when the planned services require adjustments, waiver agencies should implement corrective actions to resolve problems and issues. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 of the 13 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP.

Recommendation: MDHHS required **UPCAP Care Management, Inc.** to submit a CAP to remediate the deficiencies. **UPCAP Care Management, Inc.**'s CAP included, but was not limited to, education and training for all staff and a review of 20 records per month. However, **UPCAP Care Management, Inc.** also indicated that that once standards show a compliance rate of 90 percent, no further reporting will be required. Therefore, HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. Additionally, HSAG recommends that **UPCAP Care Management, Inc.** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-80 presents **UPCAP Care Management, Inc.**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-80—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	95.8%	91.5%
Recommendation Measures	**98.6%**	92.6%
Staff are Reliable and Helpful	92.6%	91.9%
Staff Listen and Communicate Well	97.6%	95.0%
Case Manager is Helpful	96.4%	95.2%
Choosing the Services that Matter to You	97.4%	92.7%
Transportation to Medical Appointments	91.8%	92.5%
Personal Safety and Respect	97.4%	97.2%
Planning Your Time and Activities	80.0%	75.4%
Met Need	98.3%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: UPCAP Care Management, Inc. achieved scores higher than the statewide results in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Personal Safety and Respect*, *Planning Your Time and Activities*, *Met Need*, and *Physical Safety Measure* domains, indicating that **UPCAP Care Management, Inc.** provides services in a manner that meets or exceeds members' expectations in many domains. It should be noted that while

UPCAP Care Management, Inc. achieved a higher score than the statewide results for *Planning Your Time and Activities*, this domain received the lowest statewide score across all domains. [**Quality**]

Weaknesses and Recommendations

Weakness #1: UPCAP Care Management, Inc. did not score more than 5 percentage points lower than the statewide average in any of the CAHPS domains; therefore, no substantial weaknesses were identified. [**Quality** and **Access**]

Why the weakness exists: This section is not applicable as no substantial weaknesses were identified.

Recommendation: Although no substantial weaknesses were identified within any of the CAHPS domains, **UPCAP Care Management, Inc.** scored below the statewide average on the *Transportation to Medical Appointments* domain; therefore, HSAG recommends that **UPCAP Care Management, Inc.** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Transportation to Medical Appointments* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Transportation to Medical Appointments* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **UPCAP Care Management, Inc.**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **UPCAP Care Management, Inc.** across all EQR activities. The overarching aggregated findings showed that **UPCAP Care Management, Inc.**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **UPCAP Care Management, Inc.** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **UPCAP Care Management, Inc.** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **UPCAP Care Management, Inc.** should focus its efforts on improving members' experiences with waiver agency staff, access to transportation, and some waiver services, as members reported lower satisfaction in the *Transportation to Medical Appointments* domain. HSAG's assessment of **UPCAP Care Management, Inc.** also identified continued opportunities for **UPCAP Care Management, Inc.** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **UPCAP Care Management, Inc.** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **UPCAP Care Management, Inc.** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **UPCAP Care Management, Inc.**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

Valley Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-81 displays the SFY 2019 baseline rate and the results for each QIP implemented during SFY 2021. For each QIP, the topic, goal, and measurement and outcome are identified. The outcome for each QIP is designated with a check mark (☑), signifying that **Valley Area Agency on Aging** met its internal SFY 2021 QIP goal or the statewide goal (if the internal goal was not identified); or with an x mark (☒), signifying that **Valley Area Agency on Aging** did not meet its internal SFY 2021 QIP goal or the statewide goal. Any interventions described within **Valley Area Agency on Aging**'s QMP reports are also provided in Table 3-81. The results in Table 3-81 are displayed as reported by the waiver agency and were not validated by HSAG.

Table 3-81—QIP Results

QIP Topic	Goal	Measurement and Outcome
1. *Prevalence of Neglect/Abuse*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 0.9% [1.3]* SFY 2021 = 3.1% ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** FY 2021 Outcomes & Activities Summary QM Report dated January 15, 2022, identified the following: • [None identified]		
2. *Prevalence of Pain With Inadequate Pain Control*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 15.2% [15.3]* SFY 2021 = 14.4% ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** FY 2021 Outcomes & Activities Summary QM Report dated January 15, 2022, identified the following: • [None identified]		
3. *Prevalence of Falls*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 29.1% [28.6]* SFY 2021 = 22.4% ☒

QIP Topic	Goal	Measurement and Outcome
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** FY 2021 Outcomes & Activities Summary QM Report dated January 15, 2022, identified the following: • All members were mailed a Fall Prevention handout that contained detailed education on preventing falls in the home on 11/25/2020. Supports coordinators were informed of this finding to provide individual education to members who report falls during assessments or monitoring contacts. A presentation on Falls/Injuries was also given at the local 10/18/21 Quality Collaborative meeting.		
4. *Prevalence of Any Injuries*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 6.1% [5.7]* SFY 2021 = 4.9% ☒
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** FY 2021 Outcomes & Activities Summary QM Report dated January 15, 2022, identified the following: • **Valley Area Agency on Aging** staff collaborated with a local skilled care agency to provide education to an individual member on self-catheter care.		
5. *Prevalence of Dehydration*	[Goal not identified by the waiver agency in the QMP reports]	SFY 2019 = [No baseline data not reported] SFY 2020 = 0.6% SFY 2021 = 0.9% ☑
Actions/Activities/Interventions: A SFY 2020-2021 QMP was not available for **Valley Area Agency on Aging**[1]. The **Valley Area Agency on Aging** FY 2021 Outcomes & Activities Summary QM Report dated January 15, 2022, identified the following: • [None identified]		

SFY 2019 = Waiver agency baseline results.
☑ Waiver agency met its QIP study goal or the statewide goal.
☒ Waiver agency did not meet its QIP study goal or the statewide goal.
Actions/Activities/Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
[1]The QMP provided by MDHHS for SFY 2020–2021 was not dated by the waiver agency and included QIP results for SFY 2020. Since the QMP for SFY 2020–2021 was due to MDHHS by January 2020, this suggests that the document was not the SFY 2020–2021 QMP. Therefore, the information contained within the document was not reliable for this EQR.
*The SFY 2020 annual report included a performance rate that did not align with the performance rate calculated by HSAG based on the reported numerator and denominator. The HSAG calculated performance rate, when applicable, was used to determine the outcome.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the QIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the QIP activity 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: Valley Area Agency on Aging met the statewide goal for the *Prevalence of Pain With Inadequate Pain Control* and *Prevalence of Dehydration* QIPs, suggesting there were few reports of uncontrolled pain and dehydration. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There was no SFY 2020–2021 QMP available for **Valley Area Agency on Aging**. [**Quality**]

Why the weakness exists: The QMP provided by MDHHS for SFY 2020–2021 was not dated by the waiver agency and included QIP results for SFY 2020. Since the QMP for SFY 2020–2021 was due to MDHHS by January 2020, this suggests that the document was not the SFY 2020–2021 QMP. Therefore, the information contained within the document was not reliable for this EQR.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report.

Weakness #2: Valley Area Agency on Aging did not identify goals in the SFY 2021 annual report. As performance measures (i.e., quality indicators) are used to monitor the performance of individual waiver agencies at a point in time, track waiver agency performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the goal for each measure needs to be clearly and consistently documented. [**Quality**]

Why the weakness exists: Valley Area Agency on Aging's SFY 2021 annual report did not include specific and measurable goals for the five state-required QIPs; therefore, there was no analysis indicating whether **Valley Area Agency on Aging** met its goals.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Valley Area Agency on Aging** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers.

Weakness #3: The interventions implemented by **Valley Area Agency on Aging** to meet performance goals were not specified for three of the five QIPs. Additionally, the statewide goals were not met for three of the five QIPs, and the prevalence rate for the *Prevalence of Neglect/Abuse* QIP increased, suggesting that the interventions were not effective. Further, there was no evaluation of each intervention to determine its effectiveness. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly specified and subsequently evaluated. [**Quality**]

Why the weakness exists: **Valley Area Agency on Aging**'s SFY 2021 annual report did not include an assessment of whether a specific intervention(s) was/were successful or unsuccessful in achieving increased performance.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Valley Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Valley Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.

Weakness #4: Details into the design (i.e., study question, population, sampling techniques, data collection methodology) and implementation (i.e., data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions) of the QIPs were unclear. **Valley Area Agency on Aging**'s QIPs must be designed in a methodologically sound manner for projects to achieve, through ongoing measurement and interventions, real improvements in care and outcomes. Effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. [**Quality**]

Why the weakness exists: The SFY 2021 annual report included limited details on the design developed and methodology followed by **Valley Area Agency on Aging** when implementing its QIPs.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Valley Area Agency on Aging** in a methodologically sound manner.

Performance Measure Validation

Performance Results

In SFY 2021, MDHHS collected CQAR record review results to calculate the statewide percentage rates for performance measures in which CQAR record review results were the source for the performance measure data. For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 3-82. Table 3-82 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Valley Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate **Valley Area Agency on Aging**'s impact to the overall statewide rate. Performance rates shaded in green indicate that performance is better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 3-82—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.45%**	**93.75%**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.* 1.1, 1.2, 1.3, 1.4, 2.1, 4.1, 4.2, 4.3, 4.4, 4.5, 6.1, 6.2, 6.3, 6.8, 10.1	**96.06%**	**97.27%**
4	*Number and percent of appropriate LOC determinations found after MDHHS review.* 1.3	**99.21%**	**100.00%**
8	*Number and percent of participants who had level of care initial determinations where the level of care criteria was accurately applied.* 1.1	**99.14%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* 5.3, 9.1, 9.2, 9.3, 9.6	**97.11%**	**100.00%**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* 8.3, 8.4	**98.69%**	**100.00%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.34%**	**90.91%**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.* 5.1, 5.2, 5.3, 5.8, 5.9, 5.10, 5.11, 6.6, 6.8, 6.9, 6.10, 8.1, 8.2, 8.4, 8.5, 8.7, 8.8, 8.10, 8.12, 8.13, 8.14, 8.15, 9.1, 9.2, 9.3, 9.4, 9.6	**94.75%**	**96.82%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.45%**	**100.00%**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.* 11.1, 11.3, 11.4	**93.18%**	**75.00%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**100.00%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**99.74%**	**100.00%**

Performance Measures and Applicable CQAR Standards*		CMS-372 Statewide % Rate**	Waiver Agency % Rate*
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.* 5.5, 5.6, 5.7	**99.74%**	**100.00%**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver).* 13.1, 13.2, 13.3	**90.29%**	**100.00%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100.00%**

* The individual waiver agency performance measure rates calculated by HSAG were derived from the standards outlined in the MDHHS-provided FY 2021 Performance Measures.01272022 spreadsheet under "FY 2021 Source," which contributed to the aggregated performance measure rates reported through the CMS-372 report. While MDHHS calculated the statewide rates for the CMS-372 report according to whether a particular record reviewed was fully compliant in all standards included as part of each performance measure, HSAG's calculation for the individual waiver agency performance measure rate considered each standard for every record reviewed independently. Therefore, caution should be used when comparing the CMS-372 statewide rate to the waiver agency rate percentages.

**Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is higher than the statewide rate.

Indicates the performance measure rate is lower than the statewide rate.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV activity 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: Valley Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 8, 15, 16, 19, 21, 22, 24, 30, and 38, indicating that appropriate LOCDs were made; LOC criteria were accurately applied on initial determinations; PCSPs included services and supports that align with members' assessed needs; PCSPs included strategies to address health and safety risks; PCSPs were updated according to MDHHS requirements; waiver service choice was offered to members; waiver provider choice was offered to members; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents;

members had an individualized contingency plan for emergencies; and service plans supported paid services. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Valley Area Agency on Aging performed substantially worse than other waiver agencies on Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, as indicated by a performance rate of more than 5 percentage points below the statewide rate. This demonstrated that services provided were not always consistent with the person-centered service plan. [**Access**]

Why the weakness exists: Valley Area Agency on Aging's performance rate for Performance Measure 20 fell 18.18 percentage points below the statewide rate. Through the CQAR, of the 11 records reviewed, MPHI determined that the one applicable record did not demonstrate evidence that the supports coordinator contacted newly enrolled members to ensure service delivery in accordance with MDHHS policy and contract requirements; and two of the four applicable records did not demonstrate that the supports coordinator ensured service delivery in accordance with the member's backup plan or an out-of-network provider.

Recommendation: MDHHS required **Valley Area Agency on Aging** to submit a CAP to remediate the deficiencies associated with Performance Measure 20. **Valley Area Agency on Aging**'s CAP included, but was not limited to, a review of 11 records monthly and creation of a new improvement plan if findings continue to be deficient. While **Valley Area Agency on Aging** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Valley Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Compliance Review

Performance Results

Table 3-83 presents the standards included as part of the annual CQAR and the percentage of standards determined to be compliant (*Evident*) through the record review process and home visit interviews. Table 3-83 also identifies the compliance determination for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination. The overall rating is determined based on a compliance level determination matrix that is derived from the overall importance and harm risk levels for each standard. For additional details on the matrix, refer to Appendix A. HSAG's assessment of performance was determined from the MDHHS rating for compliance.

Table 3-83—CQARs and Overall Compliance Determination

Standard		Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**
Focus 2	Freedom of Choice	81.82%		**2.00**
Focus 3	Release of Information	81.82%		**3.00**
Focus 4	Status	96.15%		**4.00**
Focus 5	Pre-Planning	100.00%	100.00%	**4.00**
Focus 6	Assessment	97.96%	100.00%	**4.00**
Focus 7	Medication Record	88.71%	100.00%	**4.00**
Focus 8	Person-Centered Service Planning	94.30%	100.00%	**4.00**
Focus 9	MI Choice Services	100.00%	100.00%	**4.00**
Focus 10	Linking and Coordinating	96.67%	100.00%	**4.00**
Focus 11	Follow-Up and Monitoring	82.61%	100.00%	**3.35**
Focus 12	Service Provider	100.00%		**4.00**
Focus 13	Contingency Plan	100.00%	100.00%	**4.00**
Focus 14	Critical Incidents	83.33%	100.00%	**2.71**
Focus 15	Adverse Benefit Determination	100.00%		**4.00**
Focus 16	Complaints and Grievances	100.00%		**4.00**
Focus 17	Home and Community Based		100.00%	**4.00**
	Totals	**95.33%**	**100.00%**	**3.89**

Indicates the standard was not reviewed as part of the record review or home visit for SFY 2021.

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

NA indicates the requirements within the standard were not applicable to the samples selected for the record review and/or home visit.

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: Six home visit reviews were conducted and all reviews achieved full compliance. The purpose of the home visits is to confirm that providers furnish services according to the PCSP and member preferences, and to determine member satisfaction with those services; therefore, the findings suggested that members are receiving services in accordance with their service plans and preferences and are satisfied with those services. It should be noted that while the home visit reviews achieved full compliance, the record review identified conflicting results in the area of Critical Incidents as the overall rating for this program area was less than full compliance. [**Quality**]

Strength #2: Valley Area Agency on Aging achieved a substantial compliance rating in 14 of the 17 record review standards reviewed as part of the CQAR, which includes the results of the medical record reviews and home visit reviews as applicable. The purpose of the record reviews and home visit reviews, as applicable, is to gauge the level of compliance with program standards (e.g., waiver member enrollment, assessment data, NFLOC eligibility, the PCSP and care planning process, reassessment data) and to assess the quality of waiver agency services for each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Valley Area Agency on Aging did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid FOC form is on file. Waiver agencies are required to ensure the member record includes a valid FOC form during the review period. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the 11 applicable records did not demonstrate evidence that the waiver agency ensured a valid FOC form was included in the member record.

Recommendation: MDHHS required **Valley Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Valley Area Agency on Aging**'s CAP included, but was not limited to, a review of 11 records monthly and creation of a new improvement plan if findings continue to be deficient. While **Valley Area Agency on Aging** was required to conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Valley Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) per supports coordinator on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved,

as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In SFY 2021, CAHPS surveys were conducted which asked adult members to report on and evaluate their experiences with their waiver services and providers. Table 3-84 presents **Valley Area Agency on Aging**'s domain scores based on a 100-point scale as compared to the statewide domain scores. Performance rates shaded in green indicate that performance is better than the statewide score, while performance rates shaded in red indicate that performance is worse than the statewide score. **Bold** font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Table 3-84—CAHPS Domain Scores

Domain	Waiver Agency Score	Statewide Average Score
Global Ratings Measures	90.9%	91.5%
Recommendation Measures	92.3%	92.6%
Staff are Reliable and Helpful	91.7%	91.9%
Staff Listen and Communicate Well	95.2%	95.0%
Case Manager is Helpful	**88.4%**	95.2%
Choosing the Services that Matter to You	92.0%	92.7%
Transportation to Medical Appointments	94.8%	92.5%
Personal Safety and Respect	95.8%	97.2%
Planning Your Time and Activities	72.9%	75.4%
Met Need	94.4%	95.3%
Physical Safety Measure	100.0%	99.6%

Bold font indicates the waiver agency scored more than 5 percentage points above or below the statewide percentage.

Indicates the performance measure rate is higher than the statewide rate

Indicates the performance measure rate is lower than the statewide rate

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 of the CAHPS activity 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: Valley Area Agency on Aging achieved scores higher than the statewide results in the *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, and *Physical Safety Measure* domains, indicating that **Valley Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in some domains. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Valley Area Agency on Aging scored more than 5 percentage points below the statewide average on the *Case Manager is Helpful* domain at 88.4 percent compared to the statewide average of 95.2 percent. [**Quality**]

Why the weakness exists: Of the three questions within the *Case Manager is Helpful* domain, one question had a denominator that was too small to calculate a percentage. Additionally, **Valley Area Agency on Aging** scored below the statewide average for the remaining two questions and more than 5 percentage points below the statewide average for the question: *Case manager helped when asked for help with getting other changes to services*.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** review the results of the member satisfaction survey to determine which questions contributed to the low satisfaction score within the *Case Manager is Helpful* domain, conduct a root cause analysis to determine potential reasons for the expressed dissatisfaction, develop interventions to improve the *Case Manager is Helpful* domain, evaluate the effectiveness of the interventions regularly, and make changes as necessary.

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

To identify strengths and weaknesses and draw conclusions for **Valley Area Agency on Aging**, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Valley Area Agency on Aging** across all EQR activities. The overarching aggregated findings showed that **Valley Area Agency on Aging**'s quality improvement efforts are focused on care management processes and person-centered planning to support members' **access** to **timely** services in accordance with their individualized health needs. Additionally, **Valley Area Agency on Aging** is focusing strategies on **quality** of care by implementing initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.

The overarching aggregated findings also indicated that **Valley Area Agency on Aging** has several opportunities for improvement in the areas reviewed that are likely to impact the quality, timeliness, and accessibility of care and services. The results from the CAHPS survey demonstrated **Valley Area Agency on Aging** should focus its efforts on improving members' experiences with waiver agency staff, case manager effectiveness, and some waiver services, as members reported lower satisfaction in the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains. HSAG's assessment of **Valley Area Agency on Aging** also identified continued opportunities for **Valley Area Agency on Aging** to enhance its QAPI program to ensure agency-wide, evidence-based quality improvement processes are effectuated and have the greatest probability to impact **quality** of care and the services being provided to waiver members. While **Valley Area Agency on Aging** had a QMP that included brief descriptions of its quality management activities, its QMP should be enhanced to more comprehensively align with the requirements and best practices for a QAPI program as outlined in 42 CFR §438.330(b), including the following components:

- PIPs that focus on both clinical and nonclinical areas.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care furnished to waiver members with special health care needs, including those receiving LTSS as described in 42 CFR §438.330(b)(5)(i-ii).

Additionally, although **Valley Area Agency on Aging** generally meets the expectations under the MI Choice Waiver Program as indicated through the MDHHS Rating for Compliance overall CQAR findings, **Valley Area Agency on Aging**, as an MCE, must also ensure that it has policies and practices in place to support compliance with all Medicaid requirements outlined in 42 CFR Part 438—Managed Care as they apply to the MI Choice Waiver Program.

Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. Therefore, in most of the EQR activities evaluated, the opportunities for improvement remained consistent between SFY 2020 and SFY 2021.

4. Follow-Up on Prior EQR Recommendations for Waiver Agencies

From the findings of each waiver agency's performance for the SFY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the MI Choice Waiver Program. The recommendations provided to each waiver agency for the EQR activities in the *State Fiscal Year 2020 External Quality Review Technical Report for the MI Choice Waiver Program* are summarized in Table 4-1 through Table 4-20. The waiver agency'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 4-20.

A&D Home Health Care

Table 4-1—Prior Year Recommendations and Responses for A&D Home Health Care

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **A&D Home Health Care** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports and should not change through the measurement period of the QIP unless documentation is provided to support the rationale for the change. Additionally, **A&D Home Health Care** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. • HSAG recommends that **A&D Home Health Care** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **A&D Home Health Care** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **A&D Home Health Care** should analyze and interpret results at multiple points in time and test for statistical significance. **A&D Home Health Care** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **A&D Home Health Care** follow *CMS EQR Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **A&D Home Health Care** in a methodologically sound manner.
MCE's Response
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. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:

Upon review of the prior year recommendations, it is noted that the following activities were implemented as of SFY 2021:
• Quarterly reviews of iHC data from locked assessments to ensure accurate reporting on the established goals. All quarterly reviews are completed by Quality Assurance (QA) and the process is as follows:
  ○ QA runs the iHC (interRAI Home Care) detail report for the quarter prior. (Example: Quarter 2 review information would be obtained by April 15)
  ○ QA then converts the information to a computerized workbook (such as Excel).
  ○ QA completes individual reviews on each member triggering the specific goal with results being kept in the computerized workbook.
  ○ The computerized workbook then indicates how many individual members triggered the goal incorrectly (outlier).
  ○ New numerator is then identified on the Corrected Numbers review for the SFY and information is provided in the SFY Activities and Outcomes report.
• Internal monitoring tools have been updated to reflect the current QMP percentage goal to ensure consistency throughout the monitoring and reporting process.
• Current status of goals and percentages are reported quarterly to the Management Team for additional oversight and monitoring.
• QMP goals are formulated based on recommendations from the Statewide Consumer Quality group. The numerator is based on the number of individual responses to specific questions within locked assessments. The denominator is based upon the number of locked assessments during the review period.
• When concerns were noted regarding the percentages, QA completed a comprehensive review of where data came from. During the review it was noted that the questions did not "re-set" after an assessment was locked. "Re-set" refers to the response bubble changing from yes to no selection. To remedy the issue, the response bubbles are manually re-set following assessment lock downs.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Current monitoring and review methods have noted a marked improvement within the review periods. Improvements have indicated a decrease in numerator which has decreased the reporting percentage which indicated an increase in agency compliance. The noted changes have been incorporated into **A&D Home Health Care**'s normal practice.
c. Identify any barriers to implementing initiatives: No noted barriers to implementing the initiatives.
HSAG's Assessment: HSAG determined that **A&D Home Health Care** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **A&D Home Health Care** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **A&D Home Health Care** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **A&D Home Health Care** should analyze and interpret results at multiple points

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
in time and test for statistical significance. **A&D Home Health Care** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **A&D Home Health Care** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **A&D Home Health Care** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **A&D Home Health Care** to submit a CAP to remediate the deficiencies associated with Performance Measure 15. **A&D Home Health Care**'s CAP included, but was not limited to, updates to its person-centered plan of care and self-determination policies; individual education for each supports coordinator out of compliance; education to all staff members on policy change; a process change where service summaries are printed and signed by the member/legal representative; a plan to reformat the self-determination program to streamline the process; and a review of 12 records per month by the management team. However, **A&D Home Health Care** also indicated that once standards show compliance of 90 percent, no further reporting will be required. Therefore, HSAG recommends that **A&D Home Health Care** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **A&D Home Health Care** continues to review PCSPs on a monthly basis for staff compliance. Education and corrections completed when elements or PCSPs are not in compliance. The CAP indicates: following the demonstration of compliance, that no further reporting is required. Statement should have indicated that reviews will continue on an ongoing basis. However, the reporting of the results to CQAR team stops once compliance is attained. In addition, PCSP training was provided to all clinical staff members to improve competency and execution of a PCSP. Training included: • Training where data is pulled from in the assessment and moved into the PCSP. • How to accurately identify risks, assess needs, and evaluate goals, outcomes, and interventions. Execution of the PCSP includes: • How to apply the balance of "important to" and "important for" in each PCSP. • Partner with stakeholders to create innovative and sustainable solutions to support. Stakeholders include non-waiver services and the member's natural supports. Non-Waiver services can include but are not limited to: Food Assistance, Faith/Religion Based Services & Supports, Skilled Care, Hospice or Palliative Care, Mental Health Assistance, Transportation, Housing, Durable Medical Equipment, Medical Providers, etc.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Currently, aggregating data following the most recent training for application to individual PCSPs. Performance data will be reviewed for compliance. Education provided to individual staff during: chart review, pod meetings, etc. Needed adjustments or corrections will be made at that time as well.
c. Identify any barriers to implementing initiatives: Noted barriers to the improvement, appears to be individual clinical staff comprehension and ability to consistently maintain employee performance changes. In addition, health literacy has been assessed for several years. However, the assessed literacy level has not always been applied to the creation of the PCSP. To address this, clinical staff will be assigned additional self-audits, peer reviews, and QA audits. Completion of audits provides clinical staff repeated exposure to standards and how those standards are attained. **A&D Home Health Care** Leadership is utilizing a "practice makes perfect" approach.
HSAG's Assessment: HSAG determined that **A&D Home Health Care** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • MDHHS required **A&D Home Health Care** to submit a CAP to remediate the deficiencies. **A&D Home Health Care**'s CAP included, but was not limited to, updates to its notification of ABD policy; individual education for each supports coordinator out of compliance; education to all staff members on policy change; dissemination of an updated process manual to all staff members; updates to the ABD notice; management team review of all ABD notices prior to mailing; and a review of 12 records per month by the management team. However, **A&D Home Health Care** also indicated that once standards show compliance of 80 percent, no further reporting will be required. Therefore, HSAG recommends that **A&D Home Health Care** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **A&D Home Health Care** management continues to review ABDs on a monthly basis for staff compliance. Education and staff correction provided as needed. Following the demonstration of compliance, no further reporting is required. Statement should have indicated that reviews continue on an ongoing basis. However, the reporting of the results to CQAR team stops once noted compliance is attained. In addition, **A&D Home Health Care** did update the process for Performance Measure 15 (Adverse Benefit Determination): • No services are placed on hold without a copy of the ABD provided. • All Adverse Benefit Letters are reviewed by a member of the Management Team prior to mailing to ensure accuracy. • Copies of all ABDs are uploaded to the member's chart.

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): With the noted process change, Performance Measure 15 (Adverse Benefit Determination) results went from 67.65% in SFY 2020 to 100% in SFY 2021. As the interventions were successful, they have been incorporated into normal practice.
c. Identify any barriers to implementing initiatives: No noted barriers to implementing the initiatives.
HSAG's Assessment: HSAG determined that **A&D Home Health Care** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Agency on Aging of Northwest Michigan

Table 4-2—Prior Year Recommendations and Responses for Agency on Aging of Northwest Michigan

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Agency on Aging of Northwest Michigan** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Agency on Aging of Northwest Michigan** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. • HSAG recommends that **Agency on Aging of Northwest Michigan**'s annual SFY report, include an evaluation of the full year's performance results for each QIP quality indicator. • HSAG recommends that **Agency on Aging of Northwest Michigan** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Agency on Aging of Northwest Michigan** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address the identified barriers to improve outcomes. **Agency on Aging of Northwest Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Agency on Aging of Northwest Michigan** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Agency on Aging of Northwest Michigan** follow CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Agency on Aging of Northwest Michigan** in a methodologically sound manner.
MCE's Response
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. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
• Improvement interventions based on recommendations for SFY2021 performance outcomes limited due to date of receipt of recommendations beyond SFY2021. • **Agency on Aging of Northwest Michigan** focused targeted improvement efforts on two main goals in SFY 2021 (prevalence of falls and prevalence of pain with inadequate pain control), as it was identified that focus on five goals was not resulting in adequate improvements. • Barriers to implementing plans were included in the state QMP report for SFY 2022 with additional detail. • **Agency on Aging of Northwest Michigan** updated its internal organizational QAPI plan to include goals and objectives aligned with MDHHS and similar to those in the state required QMP, to include reduction of prevalence of falls and injury for the SFY 2022. • Evaluation of full year's performance to be included for SFY 2022 monitoring plans. • **Agency on Aging of Northwest Michigan**'s SFY 2022 quality plan includes goals and objectives that align with MDHHS, including reduction in prevalence of falls and injury. Additionally, specific planned activities to achieve goals were included, including evidence-based interventions, descriptions of metrics, quality control methods, and assessing for improvement.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Agency on Aging of Northwest Michigan** focused targeted interventions on two quality improvement projects (prevalence of falls and prevalence of pain with inadequate pain control) and identified improvements. • **Agency on Aging of Northwest Michigan** identified an improvement in prevalence of pain with inadequate pain control in SFY 2021, decreased to 21.9%. • **Agency on Aging of Northwest Michigan** identified an improvement in prevalence of falls in SFY 2021, decreased to 28%.
c. Identify any barriers to implementing initiatives: • Limited interventions initiated in SFY 2021 due to timing of receipt of recommendations beyond SFY 2021. • **Agency on Aging of Northwest Michigan** was unable to focus targeted interventions across five different quality improvement projects and see meaningful change due to environment of shifting organizational priorities with limited resources available who are dedicated to quality improvement work, data collection and monitoring processes. • **Agency on Aging of Northwest Michigan** has allocated additional resources for a full-time employee to assist with quality improvement efforts as a result of identified barrier of limited resources to focus on targeted improvement interventions. Position created May 2022. In hiring process as of June 2022.
HSAG's Assessment: HSAG determined that **Agency on Aging of Northwest Michigan** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Agency on Aging of Northwest Michigan** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Agency on Aging of Northwest**

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Michigan should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address the identified barriers to improve outcomes. **Agency on Aging of Northwest Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Agency on Aging of Northwest Michigan** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Agency on Aging of Northwest Michigan** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Agency on Aging of Northwest Michigan** in a methodologically sound manner.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 15. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, staff training and one-to-one training with supports coordinators if necessary; a review of 12 member records through peer reviews and supervisory reviews; and additional or modified staff training, if necessary, based on the results of the review. However, the CAP also indicated internal monitoring is required by **Agency on Aging of Northwest Michigan** until compliance in excess of 90 percent is achieved. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. • MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 16. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, staff training and one-to-one training with supports coordinators if necessary; a review of 12 member records through peer reviews and supervisory reviews; and additional or modified staff training if necessary based on the results of the review. However, the CAP also indicated internal monitoring is required by **Agency on Aging of Northwest Michigan** until compliance in excess of 90 percent is achieved. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: • Limited interventions initiated in SFY 2021 due to timing of receipt of recommendations beyond SFY 2021. • **Agency on Aging of Northwest Michigan** has identified five standards that equate to Performance Measure 15 for SFY 2022 via the CQAR SFY 2022 audit tool (standard 5.3, 9.1, 9.2, 9.3, & 9.6). • **Agency on Aging of Northwest Michigan** has identified two standards that equate to Performance Measure 16 for SFY 2022 via the CQAR SFY 2022 audit tool (standard 8.3 & 8.4). • Seven total standards added to **Agency on Aging of Northwest Michigan**'s chart review process for routine monitoring and data collection of standards included as part of Performance Measure 15 and

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Performance Measure 16 to regularly monitor staff members to ensure performance stays consistent and requirements are met at rates above 90 percent compliance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Limited interventions initiated in SFY 2021 due to timing of receipt of recommendations beyond SFY 2021.
c. Identify any barriers to implementing initiatives: • Limited interventions initiated in SFY 2021 due to timing of receipt of recommendations beyond SFY 2021. • **Agency on Aging of Northwest Michigan** was unable to focus detailed monitoring of seven total standards with routine feedback and monitoring of individual staff members due to environment of shifting organizational priorities with limited resources available who are dedicated to quality improvement work, data collection, and monitoring processes. • **Agency on Aging of Northwest Michigan** has allocated additional resources for a full-time employee to assist with quality improvement efforts as a result of identified barrier of limited resources to focus on data collection and monitoring processes. Position created May 2022. In hiring process as of June 2022.
HSAG's Assessment: HSAG determined that **Agency on Aging of Northwest Michigan** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • MDHHS required **Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Agency on Aging of Northwest Michigan**'s CAP included, but was not limited to, staff training and one-to-one training with supports coordinators, if necessary; a review of 12 member records through peer reviews and supervisory reviews; and additional or modified staff training if necessary based on the results of the review. However, the CAP also indicated internal monitoring is required by **Agency on Aging of Northwest Michigan** until compliance in excess of 80 percent is achieved. Therefore, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: • **Agency on Aging of Northwest Michigan** added Follow-up and Monitoring requirements to its internal organizational SFY 2020-2021 QAPI and has continued with inclusion of Follow-up and Monitoring requirements into its SFY 2022-2023 QAPI plan. • Routine data collection, monitoring, and staff feedback have been added in SFY 2021 and SFY 2022 routine chart review process for Follow-up and Monitoring requirements.

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): • Limited targeted interventions focused on improvement of Follow-up and Monitoring requirements in SFY 2021. • **Agency on Aging of Northwest Michigan** focused improvement efforts in SFY 2021 on prevalence of fall reduction and prevalence of pain with inadequate pain control reduction, as it was identified that focusing improvement efforts on multiple standards and quality improvement projects was unable to be attained and see meaningful changes with available resources within the organization.
c. Identify any barriers to implementing initiatives: • **Agency on Aging of Northwest Michigan** was unable to focus targeted efforts on improvement strategies due to environment of shifting priorities with limited resources. • **Agency on Aging of Northwest Michigan** has allocated additional resources for a full-time employee to assist with quality improvement efforts as a result of identified barrier of limited resources to focus on data collection and staff monitoring processes. Position created May 2022. In hiring process as of June 2022.
HSAG's Assessment: HSAG determined that **Agency on Aging of Northwest Michigan** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Area Agency on Aging 1B

Table 4-3—Prior Year Recommendations and Responses for Area Agency on Aging 1B

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Area Agency on Aging 1B** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Area Agency on Aging 1B** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. • HSAG recommends that **Area Agency on Aging 1B** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Area Agency on Aging 1B** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Area Agency on Aging 1B** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging 1B** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. HSAG further recommends that **Area Agency on Aging 1B** conduct an analysis of the data to determine if the prevalence rate is being appropriately calculated to determine the percentage of members being reported as abused and/or neglected. • HSAG recommends that **Area Agency on Aging 1B** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Area Agency on Aging 1B** in a methodologically sound manner.
MCE's Response

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)***:
 	
<u>SFY 2021:</u>
• The MDHHS Quality Management Collaboration selected 5 quality indicator (QI) measures for all Waiver Agencies to monitor and address in SFY 2021. **Area Agency on Aging 1B**'s Activities and Outcome report identified whether each goal was met, the success and barriers in achieving its goals, and strategies for eliminating identified barriers.
  ○ These goals were monitored every quarter by the QI workgroup and the MI Choice Quality Assurance Team.
• **Area Agency on Aging 1B** is working on implementing supplemental questions into the interRAI Home Care (iHC) assessment that will provide additional information regarding a triggered QI; this information will ensure the most appropriate interventions are implemented to improve member outcomes.
  ○ **Area Agency on Aging 1B** conducted a thorough analysis of the data related to the prevalence of abuse/neglect. One of the metrics factored into the QI, is the use/presence of a restraint. The iHC assessment user's manual states the following regarding coding restraints: *a restraint must be coded <u>regardless of its intent</u> (i.e., seatbelt, bedrail, etc.).*

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:

- MDHHS has instructed Waiver Agencies to code restraints based on intent, which is inaccurate based on the iHC assessment user's manual.
- The iHC assessment user's manual must be adhered to in order to ensure the validity and reliability of the tool.

  - **Area Agency on Aging 1B** codes restraints based on the directions in the iHC assessment user's manual.
    Further analysis of SFY 2021 data: Restraints account for 345 unique members or 91.27% (345/378) who trigger to the Abuse/Neglect QI report. There was only one instance where a restraint was not being utilized for safety purposes.
    - If **Area Agency on Aging 1B** were to code based on MDHHS' instructions (vs. the iHC user's manual definition) **Area Agency on Aging 1B**'s Prevalence of neglect/abuse would be 2.10% (33/1578).
      - Of the 33 identified cases: 28 members reported poor hygiene; three members reported being neglected, abused, or mistreated; one member was fearful of family member(s); and one member was restrained against their will (reported to MDHHS as a Critical Incident).

- **Area Agency on Aging 1B** created their Quality Management Plan based on the outline and guidance provided by MDHHS for SFY 2020-2021, as well as the MDHHS outline for our Activities and Outcome report for SFY 2020/2021.
  - HSAG recommendation report was not provided to waiver agencies until 12/01/21, **Area Agency on Aging 1B**'s SFY 2020/2021 QMP was due 01/15/20.

Note: The waiver agency provided the interventions that were initiated in SFY 2022; however, HSAG removed those interventions from this report, since they were not implemented during the time period of review of this EQR.

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

- Prevalence of falls: 21.10%, Goal Met (<23.0%)
  - Post-iHC training, supports coordinators improved their accuracy with coding 'Falls' resulting in a more accurate representation of member issues and needs.
  - Supports coordinators all received MI Capable training and were able to provide education and resources to reduce falls, using evidence-based practices.
    - Members received assistance with:
      - physical and occupational therapy referrals
      - Medication reconciliation resources and referrals
      - Durable Medical Equipment resources and referrals
      - Received a verbal review of the Aging in Place Toolkit and/or received the Toolkit
- Prevalence of any injuries: 2.92%, Goal Met (<3.0%)
  - Post-iHC training, supports coordinators improved their accuracy with coding 'Major Skin Issues' resulting in a more accurate representation of members' needs.

c. Identify any barriers to implementing initiatives:

<u>SFY 2021:</u>
Overarching barriers affecting all measures/goals:

- **Area Agency on Aging 1B** has been unable to implement the supplemental iHC questions due to unforeseen issues with our electronic medical record (EMR) platform, WellSky.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
• MDHHS EMR COMPASS QI reports were written incorrectly and negatively impacted the state's QI measurements by inflating the numerator and including data from assessments that should have been omitted. o Prevalence of neglect/abuse: 30.16%, Goal not met (<3.0%). ▪ Continued conflict between MDHHS' directive and the iHC assessment user's manual on the coding of a 'restraint'. o Prevalence of pain with inadequate pain control: 30.35%, Goal not met (<20.0%). o Prevalence of dehydration: 2.60%, Goal not met (<1.5%).
HSAG's Assessment: HSAG determined that **Area Agency on Aging 1B** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Area Agency on Aging 1B** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Area Agency on Aging 1B** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Area Agency on Aging 1B** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging 1B** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. HSAG further recommends that **Area Agency on Aging 1B** conduct an analysis of the data to determine if the prevalence rate is being appropriately calculated to determine the percentage of members being reported as abused and/or neglected. Additionally, HSAG recommends that **Area Agency on Aging 1B** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Area Agency on Aging 1B** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • This section is not applicable (N/A) as no weaknesses were identified; therefore, HSAG has no recommendations for improvement.
MCE's Response
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)***: N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
c. Identify any barriers to implementing initiatives: N/A
HSAG's Assessment: HSAG did not identify any weaknesses; therefore, no recommendations were made to **Area Agency on Aging 1B** for the PMV activity.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • MDHHS required **Area Agency on Aging 1B** to submit a CAP to remediate the deficiencies. **Area Agency on Aging 1B**'s CAP included, but was not limited to, reviewing each finding with and providing one-on-one training with the responsible supports coordinator; providing additional training to all supports coordinators; and a random record review of each supports coordinator an average of five times per year. However, the CAP also indicated that internal monitoring was required by **Area Agency on Aging 1B** until compliance in excess of 80 percent is achieved. While the CAP also indicated that monthly audits are completed and continual monitoring occurs throughout the year, HSAG recommends that **Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: <u>SFY 2021:</u> • **Area Agency on Aging 1B** audited a minimum of 13 member records per month utilizing a targeted Clinical Quality Assurance Review audit tool (provided by MDHHS). • The Quality Department also completed 332 new enrollment chart audits and 166 partial new enrollment chart audits; 55.01% (498/904) of **Area Agency on Aging 1B**'s average MI Choice population was audited.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Aggregated data does not show performance improvement; rather the need for additional training and supervisory support for supports coordinators.
c. Identify any barriers to implementing initiatives: • No barriers with implementing a standard auditing practice and schedule.
HSAG's Assessment: HSAG determined that **Area Agency on Aging 1B** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Area Agency on Aging of Western Michigan

Table 4-4—Prior Year Recommendations and Responses for Area Agency on Aging of Western Michigan

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Area Agency on Aging of Western Michigan** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Area Agency on Aging of Western Michigan** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. • HSAG recommends that **Area Agency on Aging of Western Michigan** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Area Agency on Aging of Western Michigan** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Area Agency on Aging of Western Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging of Western Michigan** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Area Agency on Aging of Western Michigan** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Area Agency on Aging of Western Michigan** in a methodologically sound manner. • HSAG recommends that **Area Agency on Aging of Western Michigan** re-evaluate the data reported to MDHHS in the SFY 2020 annual report. Further, **Area Agency on Aging of Western Michigan** should enhance internal validation processes to ensure data reported to MDHHS are valid and accurate.
MCE's Response
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)***: **Area Agency on Aging of Western Michigan** will be reviewing all recommendations regarding improvement of the QMP. This will include reviewing all quality indicators and established goals and ensuring evidence-based interventions with routine review. Quality/Compliance staff will also review CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, in order to assure each Quality Improvement Project is methodologically sound. Both the Compliance Manager and the Assistant Director of Care Management Services have joined a new statewide quality group which will focus on improving QMPs and implementing HSAG recommendations.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): [None identified by the waiver agency]
c. Identify any barriers to implementing initiatives: HSAG recommendations coming after the 2021 fiscal year, staff turnover in the Compliance Manager position, as well as a staff person taking on a new role related to the oversight of the Compliance Manager and the need

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
to fill a vacant Compliance Specialist position have all contributed to the delay in implementing HSAG recommendations.
HSAG's Assessment: HSAG determined that **Area Agency on Aging of Western Michigan** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Area Agency on Aging of Western Michigan** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Area Agency on Aging of Western Michigan** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Area Agency on Aging of Western Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging of Western Michigan** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. HSAG also continues to recommend that **Area Agency on Aging of Western Michigan** reevaluate the data reported to MDHHS in the SFY 2020 annual report. Further, **Area Agency on Aging of Western Michigan** should enhance internal validation processes to ensure data reported to MDHHS are valid and accurate. Lastly, HSAG recommends that **Area Agency on Aging of Western Michigan** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Area Agency on Aging of Western Michigan** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Area Agency on Aging of Western Michigan** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 2 and 20. **Area Agency on Aging of Western Michigan**'s CAP included, but was not limited to, staff training and one-to-one training with supports coordinators if necessary; a review of 11 member records per month by quality staff members; and the implementation of additional performance improvement strategies, if necessary, based on the results of the review. However, the CAP also indicated internal monitoring is required by **Area Agency on Aging of Western Michigan** until compliance in excess of 80 or 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Area Agency on Aging of Western Michigan** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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:
Area Agency on Aging of Western Michigan completed 11 member record reviews every month for the entire fiscal year. Regular group staff training occurred. One-on-one training of supports coordinators occurred when applicable.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): 13 standards were reviewed monthly for 11 records. At the end of the fiscal year, staff had achieved compliance with 10 of the 13 standards.
c. Identify any barriers to implementing initiatives: [None identified by waiver agency]
HSAG's Assessment: HSAG determined that **Area Agency on Aging of Western Michigan** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • Although no substantial weaknesses were identified within any of the program areas under review, **Area Agency on Aging of Western Michigan** had noted deficiencies in multiple program standards, indicating there are opportunities for improvement related to these performance areas. MDHHS required a CAP for the noted areas of deficiency; however, HSAG recommends **Area Agency on Aging of Western Michigan** implement an ongoing and robust internal auditing process of individual supports coordinators to ensure all program requirements are being met, assuring **Area Agency on Aging of Western Michigan**'s waiver members are afforded all rights under Medicaid and waiver requirements, and are able to access timely and quality services as indicated in their person-centered service plans.
MCE's Response
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)***: **Area Agency on Aging of Western Michigan** reviews 100% of new member records as well as a monthly Peer Review of 11 member records. Every service plan is reviewed and approved by the Services Manager to ensure members are afforded the full array of MI Choice services. Two Support Specialist positions were created to assist supports coordinators with finding select MI Choice services in a timely and efficient manner. Quality staff run a weekly report to ensure members are given appropriate notice when services are held or terminated. Weekly staff meetings are required for all supports coordinators to attend which allows management staff to educate and reinforce opportunities for improvement.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Reviewing 100% of new member records allowed Quality staff to identify trends which in turn has resulted in education and improved compliance measures for staff.
c. Identify any barriers to implementing initiatives: [None identified by waiver agency]
HSAG's Assessment: HSAG determined that **Area Agency on Aging of Western Michigan** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Detroit Area Agency on Aging

Table 4-5—Prior Year Recommendations and Responses for Detroit Area Agency on Aging

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Detroit Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals that include baseline data, and these goals should specifically be identified as the state-required QIP indicators. Additionally, **Detroit Area Agency on Aging** should ensure that its annual report identifies the QIP goals and performance benchmarks, and an analysis on whether **Detroit Area Agency on Aging** met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating any identified barriers. • HSAG recommends that **Detroit Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Detroit Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Detroit Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Detroit Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Detroit Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Detroit Area Agency on Aging** in a methodologically sound manner.
MCE's Response
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)***: **Detroit Area Agency on Aging** implemented a monthly report that highlights the targeted goals and objectives of the QMP and measures the outcomes based on the data that is abstracted and analyzed. This report helps identify barriers, trends, and patterns, and helps determine any adjustments that may be needed with the quality metrics.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Detroit Area Agency on Aging** has been able to maintain and reduce the number of falls based on evidence-based training that has been provided to the members in a variety of ways and based on the number of activities available on fall prevention.
c. Identify any barriers to implementing initiatives: During the year 2020-2021 there were barriers with live classes due to COVID-19 that helped with fall prevention, in order to continue educating our members virtual meetings and classes were provided.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG's Assessment: HSAG determined that **Detroit Area Agency on Aging** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Detroit Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Detroit Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Detroit Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Detroit Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Detroit Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Detroit Area Agency on Aging** in a methodologically sound manner.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Detroit Area Agency on Aging** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Detroit Area Agency on Aging** would conduct education and training for staff members and the quality department would use reports to audit compliance to determine if individual CAPs need to be developed. HSAG recommends **Detroit Area Agency on Aging** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **Detroit Area Agency on Aging** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required. • MDHHS required **Detroit Area Agency on Aging** to develop a CAP to remediate the deficiencies that were associated with Performance Measure 19. The completed CAP indicated that **Detroit Area Agency on Aging** would conduct education and training for staff members and audit a select number of records until the compliance threshold was met; however, HSAG recommends **Detroit Area Agency on Aging** continue to conduct audits of individual supports coordinators on an ongoing basis to ensure all person-centered service planning requirements are adhered to and compliance is maintained. • MDHHS required **Detroit Area Agency on Aging** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Detroit Area Agency on Aging** would conduct education and training for staff members and the quality department would use reports to audit compliance to determine if individual CAPs need to be developed. HSAG recommends **Detroit Area Agency on Aging** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **Detroit Area Agency on Aging** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
MCE's Response
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)***: Upon review of audits completed, **Detroit Area Agency on Aging**'s quality department and the Long Term Care (LTC) department determined that all staff needed additional training and support due to non-compliance with timely completion of the PCSP as required. Staff have been put through new training, coaching and education that includes a review of their audits, peer review, and training that requires a passing of the training exam with a 90% or higher. Staff that do not pass, will be identified for additional coaching and support. New audits are currently taking place by the quality department as part of the corrective action plan and to determine if additional training is needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): [None identified by the waiver agency]
c. Identify any barriers to implementing initiatives: [None identified by the waiver agency]
HSAG's Assessment: HSAG determined that **Detroit Area Agency on Aging** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend **Detroit Area Agency on Aging** continue to conduct audits of individual supports coordinators on an ongoing basis to ensure all person-centered service planning requirements are adhered to and compliance is maintained.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **Detroit Area Agency on Aging** was required to submit a CAP to address these findings, which was approved by MDHHS; however, HSAG recommends that **Detroit Area Agency on Aging** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members. • MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. **Detroit Area Agency on Aging**'s CAP indicated that further education and training would be provided to all supports coordinators, and quality staff members would conduct weekly audits, in addition to peer-to-peer and self-audits. HSAG recommends that **Detroit Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. HSAG further recommends that **Detroit Area Agency on Aging** implement a quality assurance process of its ABD notices before they are sent to members to ensure the notices contain all required federal and state-specific content and comply with the language and format requirements under 42 CFR §438.10(d).

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
MCE's Response
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)***: **Detroit Area Agency on Aging** has been conducting regular record reviews, 12 per month and has put a process improvement in place that has been implemented for the last 30 days to improve the ABD process. Quality has reviewed ABD records for March, April and May and preliminary findings show further improvement efforts are needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): There was an increase in individual staff having no citations during the ABD audit **Detroit Area Agency on Aging** conducted for the last three months.
c. Identify any barriers to implementing initiatives: While there was individual improvement by staff, **Detroit Area Agency on Aging** would like to see an increase in the ABD score overall, barriers to this appear to have been staff training and lack of consistency. Staff are being in-serviced and individual staff identified during the audit process will be provided 1:1 coaching.
HSAG's Assessment: HSAG determined that **Detroit Area Agency on Aging** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Detroit Area Agency on Aging** develop a mechanism to monitor for underutilization of services on an ongoing basis and use this information to determine whether additional service providers are necessary to support the membership and needs of the enrolled waiver members.

Milestone Senior Services

Table 4-6—Prior Year Recommendations and Responses for Milestone Senior Services

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Milestone Senior Services** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports (i.e., QMP, annual report). Additionally, **Milestone Senior Services** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. This analysis should be conducted based on **Milestone Senior Services**' baseline data included within its QMP. • HSAG recommends that **Milestone Senior Services** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Milestone Senior Services** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Milestone Senior Services** should analyze and interpret results at multiple points in time and test for statistical significance. **Milestone Senior Services** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Milestone Senior Services** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Milestone Senior Services** in a methodologically sound manner.
MCE's Response
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)***: **Milestone Senior Services** in collaboration with MHCSN reviewed QI goals and adopted the State recommended goals for each of the 5 QI's [QIPs]. **Milestone Senior Services** collected data from Compass and Clear Access monthly and reported Quarterly thru MHCSN. **Milestone Senior Services** has determined 2 focus QI's for QMP 2022-2023 along with PDSA vehicles to ensure analysis of results, successes and/or barriers and RCA for barriers and obstacles will be conducted. **Milestone Senior Services** QMP has identified two PIPs, one clinical and one non-clinical. Each has clear goals and strategies with baselines identified and CQI [continuous quality improvement] frameworks. Results will be compiled Quarterly, and evaluation will utilize CQAR review standards. CAPs will be developed as necessary based on analysis.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): SFY 2021 Prevalence of Neglect and Abuse posted improvement of 37% Prevalence of uncontrollable pain posted improvement of 23%

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
c. Identify any barriers to implementing initiatives: **Milestone Senior Services** had a major turnover in staffing at end of SFY 2020 and beginning of SFY 2021 and a new Quality Department was established as a result.
HSAG's Assessment: HSAG determined that **Milestone Senior Services** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Milestone Senior Services** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Milestone Senior Services** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Milestone Senior Services** should analyze and interpret results at multiple points in time and test for statistical significance. **Milestone Senior Services** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rate for Performance Measure 15. The CAP indicated **Milestone Senior Services** would conduct education and training, and random chart reviews would be conducted until a 95 percent compliance threshold is achieved for three months. However, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements remain compliant. • MDHHS required **Milestone Senior Services** to develop a CAP to remediate the deficiencies that were associated with Performance Measure 19. The CAP indicated **Milestone Senior Services** would conduct education and training, and random chart reviews would be conducted until a 95 percent compliance threshold is achieved for three months. However, HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements remain compliant.
MCE's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Based on the recommendations, beginning in SFY 2022 chart audits were started and continue to be conducted monthly; Ten random charts are pulled and reviewed each month with suggested changes by the Quality

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Department. Feedback is given to supports coordinators in a one-on-one meeting with the Waiver Program Supervisor and/or Waiver Program Manager to go over results and provide remediation. These audits will be a continuous improvement to ensure quality content in member charts, as well as compliance with MDHHS contract requirements and **Milestone Senior Services** policies and procedures.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): [None identified by the waiver agency]
c. Identify any barriers to implementing initiatives: [None identified by the waiver agency]
HSAG's Assessment: HSAG determined that **Milestone Senior Services** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. **Milestone Senior Services**' CAP included, but was not limited to, education of staff members centered around ensuring the frequency of monitoring and a review of 20 records per month by the quality improvement department until a 90 percent threshold is achieved. HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. • MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. **Milestone Senior Services**' CAP included, but was not limited to, education of staff members and a review of 20 records per month by the quality improvement department until a 90 percent threshold is achieved for three consecutive months. HSAG recommends that **Milestone Senior Services** continue conducting a specific number of record reviews on an ongoing basis, regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Based on the recommendations, beginning in SFY 2022 chart audits were started and continue to be conducted monthly; Ten random charts are pulled and reviewed each month with suggested changes by the Quality Department. Feedback is given to supports coordinators in a one-on-one meeting with the Waiver Program Supervisor and/or Waiver Program Manager to go over results and provide remediation. These audits will be a continuous improvement to ensure quality content in member charts, as well as compliance with MDHHS contract requirements and **Milestone Senior Services** policies and procedures.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): [None identified by the waiver agency]
c. Identify any barriers to implementing initiatives: [None identified by the waiver agency]
HSAG's Assessment: HSAG determined that **Milestone Senior Services** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

MORC Home Care

Table 4-7—Prior Year Recommendations and Responses for MORC Home Care

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **MORC Home Care** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **MORC Home Care** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. • HSAG recommends that **MORC Home Care** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **MORC Home Care** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **MORC Home Care** should analyze and interpret results at multiple points in time and test for statistical significance. **MORC Home Care** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **MORC Home Care**'s annual report include the full year's performance results for each QIP quality indicator. • HSAG recommends that **MORC Home Care** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **MORC Home Care** in a methodologically sound manner.
MCE's Response
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)***: **MORC Home Care** updated the QMP to clearly define objectives, establish goals, evaluate outcomes and eliminate barriers using evidence based practices. Quality Indicators have been updated to be measurable as established by MDHHS. The QMP was updated to include measurable interventions to improve outcomes. **MORC Home Care** will include the full years' performance results for each Quality Indicator.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **MORC Home Care** tracked the QMP goals and objectives but lacked evidence-based practices when analyzing and reporting the data.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
c. Identify any barriers to implementing initiatives: This was the first year **MORC Home Care** received the EQR Technical Report and is unable to identify barrier to initiatives. **MORC Home Care** will begin to monitor measurable goals and objectives as written in the QMP for the coming year.
HSAG's Assessment: HSAG determined that **MORC Home Care** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **MORC Home Care** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **MORC Home Care** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **MORC Home Care** should analyze and interpret results at multiple points in time and test for statistical significance. **MORC Home Care** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **MORC Home Care** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **MORC Home Care** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **MORC Home Care** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **MORC Home Care** would conduct education and training for staff members and four case audits would be conducted by the clinical supervisor for each support coordinator. HSAG recommends **MORC Home Care** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **MORC Home Care** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required.
MCE's Response
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)***: **MORC Home Care** Clinical Supervisor will continue to complete audits utilizing the Compass Support Coordinator (SC) Monthly Monitoring reports. PCSPs will be monitored during this time to ensure it occurs within the MDHHS Timelines.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): The SC Monthly Monitoring Report that was analyzed and reviewed with clinical staff was successful and has been incorporated into standard business practices.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
c. Identify any barriers to implementing initiatives: Identified Staff shortages for Support Coordination which have potential to affect the ability to train consistently and maintain goals and objectives. Training requires at least six months to have an impact on the initiatives and to ensure understanding of all requirements.
HSAG's Assessment: HSAG determined that **MORC Home Care** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend **MORC Home Care** continue to conduct audits of individual supports coordinators on an ongoing basis to ensure PCSPs are completed within the required 10 days of enrollment. Additionally, HSAG continues to recommend that **MORC Home Care** ensure mechanisms are in place that verify timely completion of the PCSP as required.
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **MORC Home Care** was required to submit a CAP to address the noted deficiencies, which included updating language in the ABD notice, providing staff training, and auditing records until an 80 percent compliance threshold is achieved. HSAG recommends that **MORC Home Care** continue conducting a specific number of record reviews (for example, 10 records) on an ongoing basis (e.g., monthly) regardless if the designated percent (e.g., 80 percent) of compliance is achieved as it is important to regularly monitor staff to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: **MORC Home Care** reviewed the ABD Notice [template] and made several revisions. Staff members received training per the CAP. The Quality Analyst will begin to conduct six case audits on a quarterly basis. Cases will be reviewed with supports coordinators and training will be provided as indicated.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **MORC Home Care** has not been cited following the CAP for ABDs which demonstrates training was successful.
c. Identify any barriers to implementing initiatives: **MORC Home Care** has not identified any barriers to maintain compliance with this recommendation.
HSAG's Assessment: HSAG determined that **MORC Home Care** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Northern Healthcare Management

Table 4-8—Prior Year Recommendations and Responses for Northern Healthcare Management

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Northern Healthcare Management** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should consistently align with the goals established by MDHHS. Additionally, **Northern Healthcare Management** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. Further, **Northern Healthcare Management** should develop a mechanism to validate QIP performance and present performance rates for the entire state fiscal year. • HSAG recommends that **Northern Healthcare Management** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Northern Healthcare Management** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Northern Healthcare Management** should analyze and interpret results at multiple points in time and test for statistical significance. **Northern Healthcare Management** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Northern Healthcare Management** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Northern Healthcare Management** in a methodologically sound manner.
MCE's Response
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)***: • **Northern Healthcare Management** is a participating MI Choice Waiver Agency, in the MDHHS sponsored "Quality Focus Group", that is meeting to define, objective, and measurable quality indicators. **Northern Healthcare Management**'s new initiative to review and ensure future QMPs include clearly defined, objective, and measurable quality indicators and established goals that align with MDHHS' goals with validation of performance and presented rates for the fiscal year. QMPs will include goal analysis, success or barriers, and strategies for eliminating identified barriers. • **Northern Healthcare Management** has assigned a new staff role with a focus to include review and documentation of evidence-based interventions that would likely lead to the desired improvement in processes and or outcomes. This will include an analysis of interventions, to assess if successful or not, which may result in a revision of interventions as necessary or appropriate. • **Northern Healthcare Management**'s Quality Management Team (QMT) will meet beginning Tuesday June 7, 2022, to discuss, and develop processes that align with *CMS EQR Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
QIPs to ensure the technical structure of each QIP is designed, conducted, and reported in a methodologically sound manner.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • New initiative will be implemented when gathering data/information and creating QMP to include recommendation regarding the analysis of goals, outcomes, barriers, and strategies for improvement. • In the process of creating new position with role to focus on quality indicator performance improvement projects. • Initiative to review and learn *CMS EQR Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*. Working with MDHHS to establish performance improvement projects.
c. Identify any barriers to implementing initiatives: • Barrier #1 SFY 2020 QMP included five quality indicators to focus improvement initiatives and since has been decreased to two indicators. • Barrier #2 quality staff had decreased knowledge of what data and documentation to include in QMP. • Potential barrier #1 to implementing initiatives include decreased knowledge of *CMS EQR Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*. • Potential barrier #2 is decreased implementation timeframe between current time and start of next SFY.
HSAG's Assessment: HSAG determined that **Northern Healthcare Management** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Northern Healthcare Management** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Northern Healthcare Management** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Northern Healthcare Management** should analyze and interpret results at multiple points in time and test for statistical significance. **Northern Healthcare Management** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Northern Healthcare Management** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Northern Healthcare Management** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Northern Healthcare Management** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 1, 15, and 20. **Northern Healthcare Management**'s CAP included, but was not limited to, staff training and

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
education; a review of 10 to 12 participant records per month by quality staff members; and the implementation of additional performance improvement strategies, if necessary, based on the results of the review. However, the CAP also indicated internal monitoring is required by **Northern Healthcare Management** until compliance is evident (percent compliance not noted). Therefore, HSAG recommends that **Northern Healthcare Management** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: • **Northern Healthcare Management** will review each Performance Measure identified by CQAR that require a CAP and will include that **Northern Healthcare Management** will continue conducting internal monitoring of a specific number of record reviews on a quarterly based on the most recent SFY CQAR audit review.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Currently aggregating data being reported to CQAR for SFY 2021 CAPs. Performance data will be reviewed for increase in performance during subsequent quarterly audits.
c. Identify any barriers to implementing initiatives: • CQAR CAPs occur during part of the next SFY timeframe, delaying implementation of new initiatives prior to the next CQAR audit.
HSAG's Assessment: HSAG determined that **Northern Healthcare Management** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Northern Healthcare Management** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • Although no substantial weaknesses were identified within any of the program areas under review, **Northern Healthcare Management** had noted deficiencies in the Complaints and Grievances standard, indicating there are opportunities for improvement related to resolving complaints or grievances at the supports coordinator level. MDHHS required a CAP for the noted area of deficiency. Although **Northern Healthcare Management** identified that the deficiency was an isolated incident and traced to one supports coordinator who had been on extended leave, HSAG recommends **Northern Healthcare Management** implement an ongoing and robust internal auditing process of individual supports coordinators to ensure all

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
program requirements are being met, assuring that complaints and grievances received by **Northern Healthcare Management** are resolved timely and at the supports coordinator level.
MCE's Response
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)***: • Noted deficiencies in Complaints and Grievances standard have concluded prior to receiving recommendation. **Northern Healthcare Management** will review each standard identified by CQAR that require a CAP and will include that **Northern Healthcare Management** will continue conducting internal monitoring of a specific number of record reviews on a quarterly based on the most recent SFY CQAR audit review.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Northern Healthcare Management** had no deficiencies in the CQAR FY 2021 audit regarding Complaints and Grievances.
c. Identify any barriers to implementing initiatives: • CQAR CAPs occur during part of the next SFY timeframe, delaying implementation of new initiatives prior to the next CQAR audit.
HSAG's Assessment: HSAG determined that **Northern Healthcare Management** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend **Northern Healthcare Management** implement an ongoing and robust internal auditing process of individual supports coordinators to ensure all program requirements are being met, assuring that complaints and grievances received by **Northern Healthcare Management** are resolved timely and at the supports coordinator level.

Region 2 Area Agency on Aging

Table 4-9—Prior Year Recommendations and Responses for Region 2 Area Agency on Aging

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Region 2 Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP. Additionally, the goals should include a static performance measurement and the measurement should not change through the QIP measurement period unless documentation is provided to support the rationale for the change (the statewide average will continually change; therefore, this fluid measurement may not lead to improvement). • HSAG recommends **Region 2 Area Agency on Aging** identify the baseline period and rate for each quality indicator and measure them frequently to determine if interventions implemented are effective. • HSAG recommends that **Region 2 Area Agency on Aging** monitor the percentage results for each quality indicator on an ongoing basis to determine if interventions are successful throughout the time period of the QIP. • HSAG recommends that **Region 2 Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Region 2 Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 2 Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Region 2 Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 2 Area Agency on Aging** in a methodologically sound manner.
MCE's Response
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)***: **Region 2 Area Agency on Aging** received the HSAG recommendations for SFY 2021 in December 2021 at the time of the Quality Management Plan Activities and Outcomes Report was initiated. Therefore, the above suggestions were not implemented during SFY 2021. Data is collected and analyzed under similar or identical conditions for each goal. Data is collected annually through the InterRAI HC Assessment by supports coordinators during routine meetings with members, as required by MDHHS. Starting in May 2022, specific InteRAI HC Assessment questions targeting specific Quality Indicators were also asked at Person-Centered Planning Meetings, which occur 6 months following each assessment. The data collected is maintained by Quality Improvement staff to allow for data analysis. Thus, the identified population for each month will include the total number of members enrolled in the MI Choice Waiver Program who were administered the applicable InterRAI HC questions. Only members in this population will be considered when identifying those who meet the criteria listed below for each goal. Based on

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
the HSAG recommendations, the following describes a consistent baseline that could be used to replace the fluid baseline originally identified. Based on HSAG recommendations, the baseline for each of the following goals would have been the **Region 2 Area Agency on Aging** average for the six months prior to the fiscal year. Thus, the baseline would be **Region 2 Area Agency on Aging** average monthly rate from April, 2020 to September, 2020 for each individual indicator. The rate this time period would then be compared against the same rate for SFY 2021, which runs from October, 2020 through September, 2021. For Prevalence of Neglect/Abuse, the baseline was 2.5% (**Region 2 Area Agency on Aging** average monthly rate from April, 2020 to September, 2020). The SFY 2021 annual average for **Region 2 Area Agency on Aging** was 1.8%, which was an absolute decrease of less than one percentage point. For Prevalence of inadequate pain management, the baseline was 28.4%, and the SFY 2021 annual average for **Region 2 Area Agency on Aging** was 16.0%. This is an absolute decrease of 12.4 points. For prevalence of falls, the baseline and SFY 2021 annual average for **Region 2 Area Agency on Aging** were both 30.9%. For prevalence of injuries, the baseline was 5.0%, and the SFY 2021 annual average for **Region 2 Area Agency on Aging** was 5.8%. This was an absolute increase of less than one percentage point. For prevalence of dehydration, the baseline was 0.6%, and the SFY 2021 annual average for **Region 2 Area Agency on Aging** was 1.7%. This was an absolute increase of less than one percentage point. **Region 2 Area Agency on Aging** monitored the quality indicators at every other month Quality Improvement Risk Management (QIRM) meetings. Trends are identified and education for staff is developed and provided to supports coordinators to work towards our quality goals. Supports coordinators offer various interventions that include Evidence Based Programs such as Matter of Balance and other Living Well Programs. Interventions are monitored by supports coordinators at monthly member contact calls and at subsequent Reassessments and Person Centered Planning meetings. **Region 2 Area Agency on Aging** followed the CMS EQR protocol for validation of *Performance Improvement Projects: A Mandatory EQR Activity* for SFY 2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): In SFY 2021, **Region 2 Area Agency on Aging** was unable to make improvements as indicated in the HSAG findings due to receiving the document in early SFY 2022. **Region 2 Area Agency on Aging** has implemented the above recommendations for SFY 2022.
c. Identify any barriers to implementing initiatives: **Region 2 Area Agency on Aging** Received the *CMS EQR Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* in December 2022 when preparing to write the 2022-2023 QMP. In addition, our data for this time period (SFY 2020 and SFY2021) was too limited to allow for a test of statistical significance. This is a significant flaw in the methodology utilized and is being addressed for future QMPs.
HSAG's Assessment: HSAG determined that **Region 2 Area Agency on Aging** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG continues to recommend that **Region 2 Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Region 2 Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 2 Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Region 2 Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 2 Area Agency on Aging** in a methodologically sound manner.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Region 2 Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 17, 18, and 20. **Region 2 Area Agency on Aging**'s CAP included, but was not limited to, tracking the process of sending the corrected version of the provider list to all participants; staff training; and a review of one chart per month per supports coordinator. However, the CAP also indicated internal monitoring is required by **Region 2 Area Agency on Aging** until compliance in excess of 90 percent is achieved. Therefore, HSAG recommends that **Region 2 Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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 SFY 2021, after CQAR 2020 was complete, **Region 2 Area Agency on Aging** completed extensive education regarding PCSPs (member goals and preferences, MI Choice Waiver guidelines for PCSPs with supports coordinators regarding citations received). **Region 2 Area Agency on Aging** provider list is printed and available to all members. A copy of the list is in each new assessment packet, and any member who requests or needs an updated list is given one. Supports coordinators and support staff have been educated on where to find the current list and how to document that list was sent. Staff are available to mail provider list to members whenever requested. **Region 2 Area Agency on Aging**'s Quality Assistants review one chart per supports coordinator per month on an ongoing basis. **Region 2 Area Agency on Aging** currently has 17 supports coordinators. Therefore, approximately 17 Chart Audits are completed monthly except for two months per year based on CQAR Scheduling.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): HSAG recommendations for CQAR 2020 CAP was received at the beginning of SFY 2022, therefore improvements have not been noted.
c. Identify any barriers to implementing initiatives: HSAG recommendations were not known until SFY 2022.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG's Assessment: HSAG determined that **Region 2 Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • Although no substantial weaknesses were identified within any of the program areas under review, **Region 2 Area Agency on Aging** had noted deficiencies in the Follow-Up and Monitoring standard; this indicated there are opportunities for improvement related to timely follow-up with the member, including ensuring the member is receiving services in accordance with MDHHS requirements. Although MDHHS required a CAP for the noted area of deficiency, HSAG also recommends **Region 2 Area Agency on Aging** implement an ongoing and robust internal auditing process to ensure all follow-up and monitoring program requirements are being met by **Region 2 Area Agency on Aging**.
MCE's Response
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)***: CQAR 2020 findings are reviewed and education provided to supports coordinators regarding the Follow-Up and Monitoring Citation. **Region 2 Area Agency on Aging** Quality Assistants monitor one chart per supports coordinator per month for approximately 10 months of the year. The other 2 months are focused on CQAR preparation and follow-up. Supports coordinators whose charts have a 70% or below work with Quality Assistants, and Clinical Supervisors in the areas that they are deficient in. In addition, the quality and clinical staff created a Supports Coordinator Procedure manual for supports coordinators to use as a guide.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): HSAG recommendations for the CQAR 2020 CAP came in SFY 2022. In SFY 2022, between CQAR 2021 completing in March 2022 and the initiation of CQAR 2022 in June 2022, supports coordinators completed a Peer/Self Audit of charts to look for any follow up and monitoring that may have been missed between October 2021 and June 2022.
c. Identify any barriers to implementing initiatives: HSAG recommendations received in SFY 2022. In addition, CQAR 2021 ended in March 2022 and CQAR 2022 begins in June 2022, leaving little time to see performance improvements after Supports Coordinator Training.
HSAG's Assessment: HSAG determined that **Region 2 Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Region 3B Area Agency on Aging

Table 4-10—Prior Year Recommendations and Responses for Region 3B

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Region 3B Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. • HSAG recommends **Region 3B Area Agency on Aging** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective. • HSAG recommends that **Region 3B Area Agency on Aging** monitor the percentage results for each quality indicator on an ongoing basis to determine if interventions are successful throughout the time period of the QIP. • HSAG recommends that **Region 3B Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Region 3B Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Region 3B Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 3B Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Region 3B Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 3B Area Agency on Aging** in a methodologically sound manner.
MCE's Response
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)***: **Region 3B Area Agency on Aging** chose five goals to focus on in SFY 2021 which are prevalence of falls, prevalence of any injuries, prevalence of dehydration, prevalence of neglect/abuse, and prevalence of pain with inadequate pain control. For each goal **Region 3B Area Agency on Aging** provided education, a target percentage goal was added to quality management work plan, and measuring tools were developed. These goals are being monitored monthly by the Quality Manager and then reported quarterly at our quality meeting.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Prevalence of falls had a continuous decrease each quarter with it starting at 7.9% and ending at 3.4%. Prevalence of neglect/abuse had a continuous decrease each quarter with it starting at 7.5% and ending at 3.1%. Prevalence of pain with inadequate pain control 3 out of 4 quarters with a decreased percentage, the highest being 19.7% and the lowest being 16.1%.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
c. Identify any barriers to implementing initiatives: The barriers that **Region 3B Area Agency on Aging** has run into with implementation of the plan are getting staff to be compliant and staying up to date and maintaining adequate tools to accommodate changes to policy that have come down from the State.
HSAG's Assessment: HSAG determined that **Region 3B Area Agency on Aging** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Region 3B Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Region 3B Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Region 3B Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 3B Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Region 3B Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 3B Area Agency on Aging** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Region 3B Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 19. **Region 3B Area Agency on Aging**'s CAP included, but was not limited to, staff education and training and ongoing auditing of records. HSAG recommends that **Region 3B Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly) as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: As recommended by HSAG, **Region 3B Area Agency on Aging** has continued to audit a minimum of two records per supports coordinator to ensure performance will continue to improve to meet goals.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Region 3B Area Agency on Aging** did not identify any measurable improvements, but it has allowed **Region 3B Area Agency on Aging** to target specific staff that is not performing up to standards.
c. Identify any barriers to implementing initiatives: **Region 3B Area Agency on Aging** did not have any barriers with this implementation.
HSAG's Assessment: HSAG determined that **Region 3B Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • Although no substantial weaknesses were identified within any of the program areas under review, **Region 3B Area Agency on Aging** had a noted deficiency in the Critical Incidents standard, indicating there are opportunities for improvement related to entering, reporting, and providing updates to the critical incident portal in accordance with MDHHS requirements. Although MDHHS required a CAP for the noted area of deficiency, HSAG also recommends **Region 3B Area Agency on Aging** implement an ongoing and robust internal auditing process to ensure all critical incident program requirements are being met by **Region 3B Area Agency on Aging**.
MCE's Response
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)***: **Region 3B Area Agency on Aging** created a process that includes reviewing all open Critical Incidents (CIs) on a weekly basis and working with support coordination to provide education on any missing documentation. The Clinical Manager of Social Work consults with supports coordinators regarding open CI to help find solutions to resolve it and find ways to help prevent future CI. Education was also created and shared with staff on the different areas of the assessment that trigger neglect and abuse.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Region 3B Area Agency on Aging** had a continuous decrease in prevalence of neglect and abuse showing that the processes and education seem to be working.
c. Identify any barriers to implementing initiatives: **Region 3B Area Agency on Aging** did not have any barriers with this implementation.
HSAG's Assessment: HSAG determined that **Region 3B Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Region IV Area Agency on Aging

Table 4-11—Prior Year Recommendations and Responses for Region IV Area Agency on Aging

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Region IV Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be documented within its QMP, and an evaluation of these specific goals should be included in the annual report. • HSAG recommends **Region IV Area Agency on Aging** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective. • HSAG recommends that **Region IV Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Region IV Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region IV Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Region IV Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region IV Area Agency on Aging** in a methodologically sound manner.
MCE's Response
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)***: • **Region IV Area Agency on Aging** utilized the "Instructions for completing the MI Choice Summary of Quality Management Plan" when implementing the SFY 2022-SFY 2023 QMP ensuring that all each clinical and non-clinical Performance Improvement Projects met the defined reporting and structure requirements to include: objectives, measurable quality indicators, and established goals. It is the intention of **Region IV Area Agency on Aging** to evaluate and measure the goals that will be reflected annually in the Activities and Outcomes report submitted to MDHHS as required. The Instructional Guide and feedback submitted to **Region IV Area Agency on Aging** from MDHHS provided improved and new guidance of the expectations of MDHHS. • **Region IV Area Agency on Aging** utilized the "Instructions for completing the MI Choice Summary of Quality Management Plan" when implementing the SFY 2022-SFY 2023 QMP ensuring that all quality indicators identified the baseline period and rate for each quality indicator. It is the intention of **Region IV Area Agency on Aging** to evaluate and measure the goals that will be reflected annually in the Activities and Outcomes report submitted to MDHHS to reflect whether the interventions implemented were effective, as required. The Instructional Guide and feedback submitted to **Region IV Area Agency on Aging** from MDHHS provided improved and new guidance of the expectations of MDHHS. • **Region IV Area Agency on Aging** implemented the SFY 2022- SFY 2023 QMP in April of 2022 following the requested revisions made by MDHHS. **Region IV Area Agency on Aging** will be utilizing evidenced based interventions that will be evaluated for effectiveness ongoing. HSAG recommended that **Region IV Area Agency on Aging** document and implement evidence-based interventions despite

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
receiving documentation that showed implementation of STEADI (Stopping Elderly Accidents, Deaths, and Injuries) an evidence-based intervention tested and designed by the CDC. **Region IV Area Agency on Aging** had full confidence that this intervention would lead to positive movement towards the statewide goal. In SFY 2022-2023 **Region IV Area Agency on Aging** will ensure any evidenced based intervention implemented is analyzed and interpreted at multiple points in time as recommended, and revision of interventions will occur as warranted. • **Region IV Area Agency on Aging** is incorporating the *CMS EQR Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019 and contractual instructions provided by MDHHS for ensuring technical structure.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Region IV Area Agency on Aging** have notable performance improvements regarding initiating Performance Improvement Projects and Quality Improvement Projects, but the hypothesis of those improvements may be related to process review and changes versus any evidenced based interventions. Due to the current evaluation period being less than 90 days based on changes made to the QMP following feedback and requested changes by MDHHS. Improvements include: 40% in maintaining useful and accurate medication list following an emergency department visit, discharge from and long-term care facility or hospitalization and an improvement of 10% of obtaining Residential Care Agreements, Health Appraisals, and Assessment Plans for participants in a Residential Care Setting.
c. Identify any barriers to implementing initiatives: • **Region IV Area Agency on Aging** has not experienced any barriers to implementing initiative to the clinical and non-clinical Performance Improvement Plans outlined in the SFY 2022- SFY 2023 QMP. **Region IV Area Agency on Aging** continues to implement initiatives for MDHHS required Quality Improvement Projects of reducing falls and preventing injuries, however **Region IV Area Agency on Aging** notes that the data collection utilized by MDHHS and Waiver agents is flawed, and therefore the accuracy of data collected is questionable. **Region IV Area Agency on Aging** and all waiver agencies have advocated to evaluate the data collection utilized to see if improvements in accuracy can be made.
HSAG's Assessment: HSAG determined that **Region IV Area Agency on Aging** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Region IV Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Region IV Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region IV Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Region IV Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region IV Area Agency on Aging** in a methodologically sound manner.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Region IV Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 18 and 19. **Region IV Area Agency on Aging**'s CAP included, but was not limited to, staff training and implementation of a secondary review process. However, the CAP also indicated internal monitoring is required by **Region IV Area Agency on Aging** until compliance in excess of 85 or 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Region IV Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: • **Region IV Area Agency on Aging** submitted a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 18 and 19 as required for SFY 2020 by MDHHS and CQAR and achieved compliancy. Specific ongoing monitoring of those CAPs as outlined in the HSAG report issued to **Region IV Area Agency on Aging** on 12/01/2021 was outside of the contractual requirement to the CQAR CAPs cited and not completed. **Region IV Area Agency on Aging** completes ongoing monitoring of performance measures as required by the QMP and MDHHS MI Choice Contract.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Region IV Area Agency on Aging** has expanded performance measurement monitoring and review with the implementation of focused secondary care manager reviews, monitoring and evaluating performance improvement projects and the use of a Quality Indicator Care Management dashboard.
c. Identify any barriers to implementing initiatives: • **Region IV Area Agency on Aging** did not receive the EQR technical report until 12/01/2021 from MDHHS which is SFY 2022 and therefore ongoing monitoring in SFY 2021 was not possible. **Region IV Area Agency on Aging** will continue to monitor findings from the SFY 2021 CQAR audit as recommended by MDHHS.
HSAG's Assessment: HSAG determined that **Region IV Area Agency on Aging** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Region IV Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless of whether the designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • This section is not applicable as there were no substantial areas of weakness for **Region IV Area Agency on Aging**; therefore, HSAG has no recommendations for improvement.
MCE's Response
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)***: N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
c. Identify any barriers to implementing initiatives: N/A
HSAG's Assessment: HSAG did not identify any weaknesses; therefore, no recommendations were made to **Region IV Area Agency on Aging** for the compliance review activity.

Region VII Area Agency on Aging

Table 4-12—Prior Year Recommendations and Responses for Region VII Area Agency on Aging

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Region VII Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. Additionally, **Region VII Area Agency on Aging** should ensure that the evaluation of the measured rates against the goals are reported accurately. • HSAG recommends that **Region VII Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Region VII Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Region VII Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region VII Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Region VII Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region VII Area Agency on Aging** in a methodologically sound manner.
MCE's Response
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)***: • **Region VII Area Agency on Aging** completed its Quality Management Plan for FY2022-FY2023 and submitted it to MDHHS on 01/15/2022. **Region VII Area Agency on Aging** did review the report from HSAG prior to completing the QMP and utilized the HSAG recommendations in completing the plan. • **Region VII Area Agency on Aging** selected two performance improvement projects that included one clinical (Skilled Care Collaboration) and one non-clinical (Accurate and Complete Service Summaries) as the main focus for SFY 2022-SFY 2023. Clear goals, metrics, and measurement periods were determined for each project. The Quality Department is monitoring performance on a quarterly basis to evaluate effectiveness of measures put in place to improve performance. • **Region VII Area Agency on Aging** submitted its QMP to MDHHS on 01/15/2022, received feedback from MDHHS, and completed minor adjustments to the QMP that was then resubmitted and accepted on 03/22/2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Region VII Area Agency on Aging** has been monitoring its Performance Improvement Projects through the first and second quarters of SFY 2022, results are still being compiled in order to determine effectiveness and compliance of the goals.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
c. Identify any barriers to implementing initiatives: It has been determined that the method of auditing by the Quality Department may be too broad, and changes to the internal audit plan are being implemented to focus more closely on the specific goals for 3rd and 4th Quarters of FY2022. Results will be upcoming as those quarters are completed.
HSAG's Assessment: HSAG determined that **Region VII Area Agency on Aging** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Region VII Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes) and innovative (e.g., not an activity already included as part of the expected care management processes). **Region VII Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Region VII Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Region VII Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Region VII Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region VII Area Agency on Aging** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Region VII Area Agency on Aging** to submit a CAP to remediate the deficiencies identified through the CQAR that are used to calculate the performance rates for Performance Measures 15 and 20. **Region VII Area Agency on Aging**'s CAP included, but was not limited to, staff training and a review of at least two chart audits per supports coordinator each quarter. However, the CAP also indicated internal monitoring is required by **Region VII Area Agency on Aging** until compliance in excess of 85 or 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Region VII Area Agency on Aging** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: • **Region VII Area Agency on Aging** did submit a CAP related to CQAR for SFY2020, that CAP was approved and compliance was demonstrated through internal chart audits to the satisfaction of the CQAR auditors.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• **Region VII Area Agency on Aging** staff received their annual Person Centered Service Planning Training during SFY 2021 that included Performance Measure 15 and 20. • **Region VII Area Agency on Aging** Quality Staff continue to audit in excess of the recommended number of charts per quarter and provide valuable feedback to all **Region VII Area Agency on Aging** supports coordinators to educate and improve their quality performance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Region VII Area Agency on Aging** attained 100% compliance with both Performance Measures 15 and 20 on the SFY 2021 CQAR Record Review.
c. Identify any barriers to implementing initiatives: • No barriers identified to reaching the initiatives for Performance Measures 15 and 20. • **Region VII Area Agency on Aging** continues to complete chart audits of these measures as recommended by CQAR as well as through the Quality Department's own internal auditing plans.
HSAG's Assessment: HSAG determined that **Region VII Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • This section is not applicable (N/A) as there were no substantial areas of weakness for **Region VII Area Agency on Aging**; therefore, HSAG has no recommendations for improvement.
MCE's Response
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)***: N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
c. Identify any barriers to implementing initiatives: N/A
HSAG's Assessment: HSAG did not identify any weaknesses; therefore, no recommendations were made to **Region VII Area Agency on Aging** for the compliance review activity.

Region 9 Area Agency on Aging

Table 4-13—Prior Year Recommendations and Responses for Region 9 Area Agency on Aging

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Region 9 Area Agency on Aging** ensure its QMP and annual report include baseline data and the year-over-year comparative analysis. • HSAG recommends that **Region 9 Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Region 9 Area Agency on Aging** in a methodologically sound manner.
MCE's Response
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)***: • **Region 9 Area Agency on Aging** compiles data for year over year analysis for internal use. It will be begin including the year over year and baseline data in the QMP/Activities & Outcomes reports for SFY 2022. • **Region 9 Area Agency on Aging** followed the PIP methodology outlined in the EQR protocols when designing PIP projects for use in SFY 2022-2023 QMP report.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • This is a change in reporting and formatting that cannot be adequately captured at this time.
HSAG's Assessment: HSAG determined that **Region 9 Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • This section is not applicable (N/A) as no weaknesses were identified; therefore, HSAG has no recommendations for improvement.
MCE's Response
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)***: N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
c. Identify any barriers to implementing initiatives: N/A
HSAG's Assessment: HSAG did not identify any weaknesses; therefore, no recommendations were made to **Region 9 Area Agency on Aging** for the PMV activity.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • Although no substantial weaknesses were identified within any of the program areas under review, **Region 9 Area Agency on Aging** had noted deficiencies in the Critical Incidents and Adverse Benefit Determination standards; this indicated there are opportunities for improvement related to the waiver agency entering, reporting, and providing updates to the critical incident portal as required by MDHHS, and having complete and accurate information in the adverse action and/or ABD notice. MDHHS required a CAP for the noted areas of deficiency. **Region 9 Area Agency on Aging**'s CAP included, but was not limited to, providing staff education and training; conducting quarterly chart reviews; and re-evaluation of monitoring activities if measures fail to meet compliance within two quarters. HSAG recommends **Region 9 Area Agency on Aging** implement an ongoing and robust internal auditing process to ensure **Region 9 Area Agency on Aging** remains compliant with all requirements.
MCE's Response
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 internal auditing process is better captured in **Region 9 Area Agency on Aging** 's SFY 2022-2023 QMP. This process includes quarterly and random chart reviews that ensure compliance with these measures on an ongoing basis. As part of HSAGs recommendations **Region 9 Area Agency on Aging** is participating in the New Quality Focus Group. As part of that group we will be working to re-frame its auditing process withing the new Quality Assessment and Performance Process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • SFY 2021 activities were completed by the time this report was received.
HSAG's Assessment: HSAG determined that **Region 9 Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Reliance Community Care Partners

Table 4-14—Prior Year Recommendations and Responses for Reliance Community Care Partners

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Reliance Community Care Partners** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Reliance Community Care Partners** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Reliance Community Care Partners** should analyze and interpret results at multiple points in time and test for statistical significance. **Reliance Community Care Partners** should also evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Reliance Community Care Partners** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Reliance Community Care Partners** in a methodologically sound manner.
MCE's Response
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)***: **Reliance Community Care Partners** Quality Improvement Projects are focused on improving compliance with CQAR standards released by MDHHS. Six agencies are working on the CQAR score improvement together and sharing best practices for coordination of care and follow-up of identified gaps and unmet needs. We are in the process of moving our work plan and QIP to the recommended format currently and will adapt as the MDHHS releases new QAPI structure.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Reliance Community Care Partners** and the other 5 agencies are generating quarterly reports and analyzing data along with identifying interventions based on best practices and available evidence-based practices/research. These reports are shared with the Leadership Committee of our Association and we are using the continuous quality improvement framework to introduce changes/interventions to improve outcomes. We have completed training and are evaluating monthly and unfortunately have seen the results increase across the board versus lower results as anticipated.
c. Identify any barriers to implementing initiatives: **Reliance Community Care Partners** has made all of the fields required and blank when completing assessments to help with the data being accurate and trained staff on the way to ask/respond to the questions. Unfortunately, this has increased the score when we were expecting a lower score. A focus group from the staff state that they have been asking the question as written and not trying to define the question in simplifier terms as they would have prior to training.
HSAG's Assessment: HSAG determined that **Reliance Community Care Partners** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Reliance Community Care Partners** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Reliance Community Care Partners** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Reliance Community Care Partners** should analyze and interpret results at multiple points in time and test for statistical significance. **Reliance Community Care Partners** should also evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Reliance Community Care Partners** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Reliance Community Care Partners** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Reliance Community Care Partners** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Reliance Community Care Partners** reviews 12 charts per month and conducts retraining of staff as needed. HSAG recommends **Reliance Community Care Partners** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **Reliance Community Care Partners** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required. • MDHHS required **Reliance Community Care Partners** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Reliance Community Care Partners** reviews 12 charts per month and retrains staff as necessary. HSAG recommends **Reliance Community Care Partners** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans are completed within the required 10 days of enrollment. Additionally, HSAG recommends that **Reliance Community Care Partners** ensure mechanisms are in place that verify timely completion of the person-centered service plan as required.
MCE's Response
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)***: **Reliance Community Care Partners** monthly conducts two chart audits for each staff providing long-term case management and we conduct 100% audit of all newly enrolled members to ensure criteria are met, all required documents are attached to the record and the assessment and care plans meet required standards. The CAP charts submitted is a random evaluation for the audit citations.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Chart audits are a staple within our Continuous Quality Improvement program. Chart audits are conducted daily and all new hires received 100% audit for the first 30-45 days after being released to their case assignment. Conducting 100% audit of all newly enrolled client records has substantially increase our CQAR

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
scores the past nine years and this is a best practice that we will continue. Chart audits are also utilized to refresh training and onboarding along with determining the need for one-on-one training with specific staff.
c. Identify any barriers to implementing initiatives: **Reliance Community Care Partners** continues to experience bottlenecks with timely chart audits and training days are packed and there never seems to be enough time to complete the necessary training.
HSAG's Assessment: HSAG determined that **Reliance Community Care Partners** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Reliance Community Care Partners** ensure mechanisms are in place that verify timely completion of the PCSP as required.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, reviewing the FY 2020 CQAR Records as part of a root cause analysis; retraining of staff members regarding communication with guardian or authorized representative, including client and documentation requirements, annually and with staff members that score *Non-Evident* on audits conducted internally and externally; and a review of 12 records per month. However, the CAP also indicated internal monitoring is required until compliance in excess of 90 percent is achieved. Therefore, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. • MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners'** CAP included, but was not limited to, reviewing the FY 2020 CQAR Records as part of a root cause analysis; retraining of staff members regarding education on health, welfare, and safety requirements annually and with staff members that score *Non-Evident* on audits conducted internally and externally; annual training with providers on the need to report health, welfare, and safety issues to the case manager; as well as reviewing 12 charts per month until 90 percent compliance is attained. However, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor vendors to ensure performance stays consistent and contract requirements are met. • **Reliance Community Care Partners** was required to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, a root cause analysis; retraining staff members; annual training with providers; monthly maintenance of critical incident system; and a review of 12 records per month by the management team. However, **Reliance Community Care Partners** also indicated records will be reviewed until 90 percent compliance is attained. Therefore, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
• MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. **Reliance Community Care Partners**' CAP included, but was not limited to, retraining of staff members regarding Adverse Beneficiary Determination requirements annually and with staff members that score *Non-Evident* on audits conducted internally and externally; a root cause analysis; and a review of 12 records per month by the management team. However, **Reliance Community Care Partners** also indicated records will be reviewed until 90 percent compliance is attained. Therefore, HSAG recommends that **Reliance Community Care Partners** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: **Reliance Community Care Partners** continues to conduct monthly chart audits, 100% audit of all newly enrolled member records and placing staff on Quality Performance Improvement Plans as indicated (less than 85% score for more than one month). Chart audits is our best defense and our best practice to identify training needs.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Reliance Community Care Partners** high performing staff take the audits very serious and try to do a great job as they don't want the CQI Department to identify any patterns or trends. About 40% of the staff use the CQI Department to help them get everything done versus taking accountability for doing a great job before the chart is audited. Root cause identified that we need to work on accountability and holding staff to the requirements.
c. Identify any barriers to implementing initiatives: Root cause identified that we need to work on accountability and holding staff to the requirements. We also discovered this same issue at our Quality Committee (the 6 agencies of our association) and have been working with the leadership committee to work toward continuous quality improvement for accountability. The biggest barrier is staff shortage especially Social Workers and the need to retain staff while balancing morale.
HSAG's Assessment: HSAG determined that **Reliance Community Care Partners** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Senior Resources

Table 4-15—Prior Year Recommendations and Responses for Senior Resources

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Senior Resources** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Senior Resources** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. • HSAG recommends that **Senior Resources** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Senior Resources** in a methodologically sound manner.
MCE's Response
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)***: • **Senior Resources**' QMP SFY 2022-2023 contains clear and measurable quality indicators (Advance Care Planning, Reduce the Prevalence of Falls and Reduce Injuries). Baseline data has been compiled for each indicator along with established goals. Measures will be calculated bi-annually to determine progress. Any indicators that do not show an improvement towards the goal will have new actions/protocols/procedures added to impact the results. The goals are monitored bi-annually by the Quality Improvement Coordinator and the Quality Improvement Committee. • **Senior Resources** will add an analysis of the above indicators to the SFY 2022 Annual Report.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The quality indicator: Reduce the Prevalence of Injuries has made progress toward achieving the established goal. Percentage decreased from 5.6% to 5.0%. Intervention of staff asking more detailed questions has been incorporated.
c. Identify any barriers to implementing initiatives: • There is difficulty in obtaining clear data related to Advance Care Planning due to limitations on the reports **Senior Resources** has access to. The data department is working on writing a script to obtain more detailed data. Staff are being instructed to use questions within the assessment so that this data can be collected. • Prevalence of Falls is difficult to impact due to circumstances beyond the staff's control. A Fall Protocol has been initiated that has specific steps for staff to follow when a fall is reported.
HSAG's Assessment: HSAG determined that **Senior Resources** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG continues to recommend that **Senior Resources** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Senior Resources** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Senior Resources** to submit a CAP to remediate the deficiencies identified through the CQAR that were used to calculate the performance rate for Performance Measure 1. **Senior Resources**' CAP included, but was not limited to, staff training and review of 12 charts per month. However, the CAP also indicated internal monitoring is required by **Senior Resources** until compliance in excess of 80 to 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Senior Resources** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. • MDHHS required **Senior Resources** to submit a CAP to remediate the deficiencies identified through the CQAR that were used to calculate the performance rate for Performance Measure 18. **Senior Resources**' CAP included, but was not limited to, staff training and review of 12 charts per month. However, the CAP also indicated internal monitoring is required by **Senior Resources** until compliance in excess of 80 to 90 percent (depending on the requirement) is achieved. Therefore, HSAG recommends that **Senior Resources** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: • Minimally 15 chart reviews are being conducted monthly on a going basis. When non-compliance is detected through these reviews, staff members are required to make corrections. The correction procedures have been communicated to staff verbally through staff training and in documented staff guidelines. Any incidences of staff not following procedures are addressed and the new procedure followed. As staff communicate difficulty in understanding procedures a FAQ [frequently asked questions] document is drafted for the use of all staff.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Non-compliance has decreased. Remediation procedures are in place to support staff who have continued difficulty following the documented procedures.
c. Identify any barriers to implementing initiatives: • New staff have a significant number of procedures and guidelines to follow. This impacts the overall compliance.
HSAG's Assessment: HSAG determined that **Senior Resources** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • This section is not applicable (N/A) as there were no substantial areas of weakness for **Senior Resources**; therefore, HSAG has no recommendations for improvement.
MCE's Response
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)***: N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
c. Identify any barriers to implementing initiatives: N/A
HSAG's Assessment: HSAG did not identify any weaknesses; therefore, no recommendations were made to **Senior Resources** for the compliance review activity.

The Information Center

Table 4-16—Prior Year Recommendations and Responses for The Information Center

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **The Information Center** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report. • HSAG recommends that **The Information Center** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently identified within all QMP reports (i.e., QMP, annual report). • HSAG recommends **The Information Center** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective. • HSAG recommends that **The Information Center** calculate QIP performance rates at the end of the specified measurement period (i.e., conclusion of the state fiscal year) using the numerators and denominators applicable for the entire state fiscal year. These performance rates should then be assessed against a specified baseline rate to determine whether performance in each QIP improved or declined over time. **The Information Center** should use the results of this assessment to determine whether its implemented interventions should continue or be discontinued, be revised, or whether new interventions need to be developed. • HSAG recommends that **The Information Center** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **The Information Center** should analyze and interpret results at multiple points in time and test for statistical significance. **The Information Center** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **The Information Center** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **The Information Center** in a methodologically sound manner.
MCE's Response
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)***: • Coordination of quality indicators with the MHCSN and establishing baseline period for data collection and review • Synthesize current raw data from internal quality indicators to be included in the next QMP report to be submitted to MDHHS SFY 2023 to include: Community Transition Services (CTS) re-institutionalized, Waiver members without services within 30 days, and services implemented within five days of enrollment. • Establish evidence-based interventions based on HSAG recommendations.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance improvement has not been evaluated. The initiatives have not been implemented to date due to lag time between the HSAG technical report and the development and implementation of recommendations.
c. Identify any barriers to implementing initiatives: Implementation barrier is a result of the turnaround time from the receipt of the HSAG report to the development and application of the initiatives and recommendations. A revised internal agency Quality Committee is in process of developing and executing initiatives based on HSAG recommendations.
HSAG's Assessment: HSAG determined that **The Information Center** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **The Information Center** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **The Information Center** should analyze and interpret results at multiple points in time and test for statistical significance. **The Information Center** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **The Information Center** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **The Information Center** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **The Information Center** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **The Information Center** would conduct education and training for staff members and the quality department would use reports to audit compliance to determine if individual CAPs need to be developed. HSAG recommends **The Information Center** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans contain all required components, and that the person-centered service plans include documentation to support waiver members are receiving all approved services and supports. • MDHHS required **The Information Center** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **The Information Center** would conduct education and training for staff members and the quality department would use reports to audit compliance to determine if individual CAPs need to be developed. HSAG recommends **The Information Center** continue to conduct audits of individual supports coordinators/care managers on an ongoing basis to ensure person-centered service plans contain all required components, and that the person-centered service plans include documentation to support waiver members are receiving all approved services and supports. HSAG also recommends that **The Information Center** determine whether the results of the record review were related to staff documentation errors, or whether there was a lack of service providers available to provide the services approved in the person-centered service plan. If the latter, **The Information Center** should analyze its

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
available provider network to determine if additional providers are needed to ensure timely and accessible care.
MCE's Response
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)***: • Training based on identified deficiencies were conducted in SFY 2020 and SFY 2021 as part of the CAP. This activity has been an ongoing part of the annual audit process. • The Quality and Training Coordinator and Care Management Department Clinical Supervisor provide monthly reports for the supports coordinators to review and address identified deficiencies. • Supports coordinators that do not meet the standards have monthly supervision with the Care Management Department Clinical Supervisor that includes additional individualized training on deficiencies identified. • **The Information Center** identified a need for additional service providers and is recruiting on an ongoing basis. • The Quality and Training Coordinator audits a minimum of 10 charts monthly per the agency CAP to ensure compliance with audit standards.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): There is cursory performance improvement, as supports coordinators fully understand to date how to read and understand the reports of deficiencies. Further improvement is to be determined with additional time to review the initiatives implemented.
c. Identify any barriers to implementing initiatives: The turnaround time between receiving the HSAG EQR Technical report and the review of the performance improvement as a result of the initiatives is the barrier to date. The goal is to have a plan in place to review and analyze implemented initiatives July 1, 2022.
HSAG's Assessment: HSAG determined that **The Information Center** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • Although no substantial weaknesses were identified within any of the program areas under review, **The Information Center** had noted deficiencies in the Follow-Up and Monitoring, Critical Incidents, and Adverse Benefit Determination standards. This indicated there are opportunities for improvement related to the supports coordinators' adherence to processes to follow-up with the member/guardian timely to ensure services are being accessed in accordance with the person-centered service plan; ensure all reported critical incidents are being entered into the critical incident portal for appropriate and timely follow up and resolution; and to ensure members/guardians receive an ABD when being disenrolled from the waiver program for not meeting the NFLOC criteria and/or for any service denial, reduction, suspension, and/or termination. MDHHS required a CAP for the noted areas of deficiency; however, HSAG recommends **The Information Center** implement an ongoing and robust internal auditing process of individual supports coordinators to ensure all program requirements are being met, assuring **The Information Center**'s waiver members are afforded all rights under Medicaid and waiver requirements, and are able to access timely and quality services as indicated in their person-centered service plans.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
MCE's Response
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)***: • Training based on CAP was completed SFY 2020 and SFY 2021 (Critical Incident Training is completed annually outside of CAP requirements). Agenda included Follow–up and monitoring, Critical Incidents, and Adverse Benefit Determination standards. • Supports coordinators that do not meet the standards have monthly supervision with the Care Management Department Clinical Supervisor, that includes additional individualized training as needed. • The Quality and Training Coordinator audits a minimum of 10 charts monthly auditing the based on the CAP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): No extensive performance improvement is noted to date; further analysis with more time from development to implementation will provide more accurate and detailed results.
c. Identify any barriers to implementing initiatives: The turnaround time from the receipt of the HSAG technical report and the review of the initiatives implemented is the barrier to date. The goal is to develop a comprehensive plan and implement July 1, 2022.
HSAG's Assessment: HSAG determined that **The Information Center** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

The Senior Alliance

Table 4-17—Prior Year Recommendations and Responses for The Senior Alliance

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **The Senior Alliance** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report. • HSAG recommends that **The Senior Alliance** consult with MDHHS to confirm it is appropriate to establish its own QIP goals that are both attainable and drive improvement, even if those goals do not align with the statewide goals set by MDHHS. • HSAG recommends that **The Senior Alliance** calculate QIP performance rates at the end of the specified measurement period (i.e., conclusion of the state fiscal year) using the numerators and denominators applicable for the entire state fiscal year. These performance rates should then be assessed against a specified baseline rate to determine whether performance in each QIP improved or declined over time. **The Senior Alliance** should use the results of this assessment to determine whether its implemented interventions should continue or be discontinued, be revised, or whether new interventions need to be developed. • HSAG recommends that **The Senior Alliance** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **The Senior Alliance** should analyze and interpret results at multiple points in time and test for statistical significance. **The Senior Alliance** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **The Senior Alliance** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **The Senior Alliance** in a methodologically sound manner.
MCE's Response
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 Senior Alliance** had discussions with MDHHS regarding the requirements for the QMP vs the Activities and Outcomes report. **The Senior Alliance** had believed that the report submitted for SFY 2020-2021 met the requirements for the QMP and Activities and Outcomes in one document. Based on discussions, **The Senior Alliance** submitted a QMP for SFY 2022-2023 for the two-year plan that met requirements and a separate Activities and Outcomes for SFY 2021. • **The Senior Alliance** realized that the QIP goals listed on the SFY 2020-2021 QMP were incorrect. Those goals were corrected and re-submitted. All future QMPs will have the QIP goals set by MDHHS listed. • **The Senior Alliance** does calculate/review the QIP rates quarterly. The results are reviewed, and changes made to interventions if needed. If changes are made, those will be reported in the Activities & Outcomes report.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
• For future QMPs, **The Senior Alliance** plans to put further effort into researching and implementing evidence-based interventions for QIPs. Outcomes of those interventions will be evaluated on a more frequent basis and changes made based on the outcomes. • **The Senior Alliance** is currently in the process of reviewing the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* document and plan to utilize techniques learned when designing and conducting future QIPs.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **The Senior Alliance** submitted a separate QMP for SFY 2022-2023 and an Activities & Outcomes report for SFY 2021 that met guidelines set by MDHHS. • **The Senior Alliance** submitted correct QIP goals on the current QMP.
c. Identify any barriers to implementing initiatives: Due to not receiving the HSAG report until after SFY 2022 began, **The Senior Alliance** was not able to implement recommendations for evidence-based interventions and following CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* in FY2021. **The Senior Alliance** is currently reviewing this document and plans to use techniques outlined in future QMPs and QIPs.
HSAG's Assessment: HSAG determined that **The Senior Alliance** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **The Senior Alliance** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **The Senior Alliance** should analyze and interpret results at multiple points in time and test for statistical significance. **The Senior Alliance** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **The Senior Alliance** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **The Senior Alliance** in a methodologically sound manner.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **The Senior Alliance** to develop a CAP to remediate the deficiencies associated with Performance Measures 1, 18, and 19. The completed CAP indicated that **The Senior Alliance** would conduct education and training for staff members, and the quality and training manager would continue to monitor compliance. HSAG recommends **The Senior Alliance** continue its monitoring efforts and conduct an audit of a designated number of cases (e.g., 10 per month) for each supports coordinator on an ongoing basis that includes a review of all required components of the person-centered service plan, as well as the processes required to develop the person-centered service plan.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
MCE's Response
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 Senior Alliance** continues to monitor all standards including Performance Measures 1, 18 and 19 on an ongoing basis. At minimum 10 records per month are reviewed by Quality and Training Managers and feedback is given to supports coordinators after the review is complete. • **The Senior Alliance** is in the process of creating a more comprehensive in-person annual training for supports coordinators on the requirements of the PCSP and that will be presented to staff in July 2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Improvements to the completeness of the PCSP have been seen but also vary from month to month.
c. Identify any barriers to implementing initiatives: • Supports coordinators do not have a high enough caseload to be able to review 10 cases per month per supports coordinator. Quality and Training Managers review at least 10 cases total per month. • **The Senior Alliance** has had a recent turnover of staff in the waiver department which contributes to initial lower quality in PCSPs.
HSAG's Assessment: HSAG determined that **The Senior Alliance** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • MDHHS required **The Senior Alliance** to submit a CAP to remediate the deficiencies. **The Senior Alliance**'s CAP indicated staff members would provide education to service providers through the annual vendor meeting, and ongoing monitoring through monthly chart reviews would occur until a rate of 75 percent compliance is met. However, HSAG recommends that **The Senior Alliance** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor vendors to ensure performance stays consistent and contract requirements are met.
MCE's Response
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 Senior Alliance** continues to monitor all standards set by MDHHS and CQAR on an ongoing basis, regardless of when the designated percentage of compliance is achieved. **The Senior Alliance** continues to report to CQAR until compliance is achieved and then monitors internally after. At minimum 10 records per month are reviewed by Quality and Training Managers and feedback is given to supports coordinators after the review is complete.

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): • This fiscal year, no issues have been identified related to service providers not reporting to **The Senior Alliance**.
c. Identify any barriers to implementing initiatives: • None noted.
HSAG's Assessment: HSAG determined that **The Senior Alliance** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Tri-County Office on Aging

Table 4-18—Prior Year Recommendations and Responses for Tri-County Office on Aging

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Tri-County Office on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Tri-County Office on Aging** should ensure that its annual report includes a more comprehensive analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. Further, HSAG recommends that **Tri-County Office on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Tri-County Office on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Tri-County Office on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Tri-County Office on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Tri-County Office on Aging** in a methodologically sound manner.
MCE's Response
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)***: After thorough discussion and consideration of agency and program priorities, the Quality Management Team (QMT) agreed to the following two goals, one clinical and one non-clinical, as the performance improvement programs for SFY 2022-2023. Goal one is increasing the number of Person-Centered Planning (PCP) Meetings that are completed timely, within the range specified by members' Communication Plans within the PCSP, to 98%. This goal is defined as clinical because the main and established priority of PCP Meetings is to assess how the PCSP is progressing, and if any additions or changes could be beneficial to members' plans. Updates made to PCSPs as a result of

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
PCP Meetings directly impact the health and wellbeing of members, so ensuring these meetings occur timely is a vital-clinical programmatic goal. **Goal 1 (Clinical):** Increase the number of PCP Meetings Completed Timely to 98%. **Objective 1:** PCP Meetings will be completed timely, within the range specified by members' Communication Plans within the PCSP, 98% of the time. Goal two is increasing the number of members who are contacted by supports coordinators within seven days of a hospital discharge back to the community to 95%. This goal is defined as non-clinical because, while the impact of contact with supports coordinators following a planned or un-planned transition can affect clinical outcomes, the main purpose of this goal is to ensure administrative compliance with internal policies and procedures. **Goal 2 (Non-Clinical):** Increase the number of members who are contacted by supports coordinators within 7-days of a hospitalization discharge to 95% **Objective 2:** 95% of members who experience a hospitalization will be contacted by supports coordinators within 7-days of discharge to the community. **Tri-County Office on Aging** has implemented several activity projects including training and education, monitoring, and supports coordinator involvement in potential update of policy or procedures. **Tri-County Office on Aging** utilizes the e-learning platform, Relias, to provide education related to best-practices of multiple clinical and non-clinical topics, including person-centered planning and reducing rehospitalizations.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Following the implementation of the performance activity projects, **Tri-County Office on Aging** has seen a small, but consistent increase in PCSP Meetings that occurred on a timely basis. Internal quality auditing showed that compliance rates for this goal averaged 86% for the first half of SFY 2022, but increased to 93% during Q3 of SFY 2022. Performance improvement for the goal of contacting members within 7-days is being collected, but no significant increases in compliance have been demonstrated yet. **Tri-County Office on Aging** anticipates increased compliance following the release of additional ADT reports, which will allow **Tri-County Office on Aging** to monitor this goal more effectively.
c. Identify any barriers to implementing initiatives: The largest barrier to implementing initiatives thus far has been the lack of reports available to measure outcomes and improvement. The current reporting capacity for the above goals is limited and requires much drilldown auditing to ensure accuracy. **Tri-County Office on Aging** anticipates access to a more wide array of accurate reports as the C2C (Connected 2 Care) brain trust group progresses with their goals to develop reports for Waiver Agents that capture individual and population health data.
HSAG's Assessment: HSAG determined that **Tri-County Office on Aging** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Tri-County Office on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should be consistently documented within its QMP reports. Additionally, **Tri-County Office on Aging** should ensure that its annual report includes a more comprehensive analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. Further, HSAG recommends that **Tri-County Office on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Tri-County Office on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Tri-County Office on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Tri-County Office on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Tri-County Office on Aging** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • This section is not applicable (N/A) as no substantial weaknesses were identified; therefore, HSAG has no recommendations for improvement.
MCE's Response
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)***: N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A
c. Identify any barriers to implementing initiatives: N/A
HSAG's Assessment: HSAG did not identify any weaknesses; therefore, no recommendations were made to **Tri-County Office on Aging** for the PMV activity.
3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • Although no substantial weaknesses were identified within any of the program areas under review, **Tri-County Office on Aging** had noted deficiencies in the Follow-Up and Monitoring and Critical Incidents standards. This indicated there are opportunities for improvement related to contacting the member timely for follow-up and monitoring; taking appropriate action to address critical incidents, including discussing strategies to prevent future critical incidents; and ensuring that all critical incidents are appropriately reported through the critical incident database. MDHHS required a CAP for the noted areas of deficiency; however, HSAG recommends **Tri-County Office on Aging** implement an ongoing and robust internal auditing process to ensure **Tri-County Office on Aging** remains compliant with all requirements.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
MCE's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: To ensure thorough and timely reporting supports coordinators investigate and evaluate all incidents within one business day of identification, unless immediate action is needed, in which case supports coordinators develop a plan immediately to ensure member safety. Supports coordinators enter all critical incidents into the Compass Critical Incident Portal within two business days of notification of the incident. Supports coordinators include the actions taken to investigate and resolve the incident, the steps taken to prevent further incidents, including but not limited to removing threats from the environment and ensuring back-up providers are in place if necessary, and the status/resolution of incident within the email template. Supervisors review all information supports coordinators enter into the Compass Critical Incident Portal prior to submitting the final Critical Incident resolution. All staff complete trainings related to the Critical Incident Management System upon orientation and at least annually thereafter. Select Critical Incidents are shared at the RN [registered nurse] and Social Work meetings as a reminder of the type of incident to be reported and what follow-up is expected. In addition, the RN and Social Work Supervisors continue to educate new and established staff of the importance of reporting anything that was described as a critical incident by the state to ensure accurate data. In-services continue to be provided as needed at the monthly services meetings to review the process with supports coordinators. Supervisors track data related to critical incidents for the purposes of analyzation, identification of trends and mitigation of future risk for members using reports available within the Center for Information Management (CIM), Critical Incident portal, including Critical Incident Summary Report, Critical Incident Quality Report, Critical Incident Counts Report and the Critical Incidents Listing Report.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): After implementing the updated process for Critical Incidents, **Tri-County Office on Aging** saw an increase in compliance with reporting and follow-up related to critical incidents. Peer Review audit results from SFY 2022 Q3 indicate a 100% compliance rate for the 12 records reviewed. Peer Review data will be submitted to the CQAR portal on 5/20/2022.
c. Identify any barriers to implementing initiatives: Barriers to implementation of initiatives have been largely related to staffing changes and training needs. During SFY 2021 and the beginning of SFY 2022, **Tri-County Office on Aging** onboarded several new Supports coordinators who require training for processing CIs, including training related to use of the CI portal. **Tri-County Office on Aging** anticipates continued compliance with this standard as the Supports Coordination team becomes more tenured.
HSAG's Assessment: HSAG determined that **Tri-County Office on Aging** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend **Tri-County Office on Aging** implement an ongoing and robust internal auditing process to ensure **Tri-County Office on Aging** remains compliant with all requirements.

UPCAP Care Management, Inc.

Table 4-19—Prior Year Recommendations and Responses for UPCAP Care Management, Inc.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends **UPCAP Care Management, Inc.** ensure that it completes and submits to MDHHS an updated QMP every two years that includes an appropriate title and date. • HSAG recommends that **UPCAP Care Management, Inc.**'s annual report includes an evaluation of the entire state fiscal year's performance results for each QIP quality indicator. • HSAG recommends that **UPCAP Care Management, Inc.** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **UPCAP Care Management, Inc.** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. • HSAG recommends that **UPCAP Care Management, Inc.** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **UPCAP Care Management, Inc.** should analyze and interpret results at multiple points in time and test for statistical significance. **UPCAP Care Management, Inc.** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **UPCAP Care Management, Inc.** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **UPCAP Care Management, Inc.** in a methodologically sound manner.
MCE's Response
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)***: With a change in leadership, **UPCAP Care Management, Inc.** has completed and submitted updated QMPs with the proper title and date as required as well as include the entire state fiscal year's performance results for each QIP quality indicator.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **UPCAP Care Management, Inc.** has seen significant improvement as a result of initiatives implemented since the change of leadership and focus on performance improvements. **UPCAP Care Management, Inc.**'s new QIP since SFY 2020 has been submitted to include clearly defined, objective and measurable quality indicators and established goals. **UPCAP Care Management, Inc.** now has staff in place to monitor ongoing performance and objectives.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
c. Identify any barriers to implementing initiatives: At this time **UPCAP Care Management, Inc.** does not have any barriers to implementing initiatives. In the past it was difficult due to staffing changes. Since SFY 2020, **UPCAP Care Management, Inc.** has identified key staff to monitor ongoing performance and objectives.
HSAG's Assessment: HSAG determined that **UPCAP Care Management, Inc.** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **UPCAP Care Management, Inc.** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **UPCAP Care Management, Inc.** should analyze and interpret results at multiple points in time and test for statistical significance. **UPCAP Care Management, Inc.** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **UPCAP Care Management, Inc.** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **UPCAP Care Management, Inc.** in a methodologically sound manner.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **UPCAP Care Management, Inc.** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **UPCAP Care Management, Inc.** would conduct education sessions with the supports coordinators, and departmental leadership would monitor performance monthly and conduct random chart audits to ensure supports coordinators meet compliance. The CAP indicated leadership would conduct monitoring efforts and audits until an assigned percentage of performance is achieved (i.e., 85 and 90 percent depending on the deficient standard); however, HSAG recommends **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the supports coordinator(s) achieves the designated percent of compliance, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met.
MCE's Response
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)***: **UPCAP Care Management, Inc.** currently conducts record reviews on all new members and no less than 20 record reviews on a monthly basis for existing members. **UPCAP Care Management, Inc.** utilizes a peer review tool that identifies areas of deficiencies. Based on results of monthly peer reviews staff are provided ongoing education on the areas identified as deficient.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): **UPCAP Care Management, Inc.** has found since the use of the peer review tool, ongoing education and individual peer support, overall improvements on areas of deficiencies.
c. Identify any barriers to implementing initiatives: None
HSAG's Assessment: HSAG determined that **UPCAP Care Management, Inc.** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • MDHHS required **UPCAP Care Management, Inc.** to submit a CAP to remediate the deficiencies. **UPCAP Care Management, Inc.**'s CAP indicated that further education would be provided to all supports coordinators, and supports coordinators would be provided with an example of what is required to be included as part of the ABD notices. Additionally, **UPCAP Care Management, Inc.** leadership would randomly audit charts to ensure supports coordinators' compliance with requirements. **UPCAP Care Management, Inc.** also indicated that monitoring would continue until 80 percent compliance is met. HSAG recommends that **UPCAP Care Management, Inc.** continue conducting a specific number of record reviews (e.g., 10 records) on an ongoing basis (e.g., monthly), regardless if the designated percent of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. HSAG further recommends that **UPCAP Care Management, Inc.** consider implementing a peer-to-peer ABD review process or have leadership review all ABD notices before notices are sent to members to ensure the notices contain all required federal and state-specific content and comply with the language and format requirements under 42 CFR §438.10(d).
MCE's Response
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)***: **UPCAP Care Management, Inc.** currently conducts record reviews on all new members and no less than 20 record reviews on a monthly basis for existing members. **UPCAP Care Management, Inc.** utilizes a peer review tool that identifies areas of deficiencies. Based on results of monthly peer reviews staff are provided ongoing education on the areas identified as deficient. **UPCAP Care Management, Inc.** has met and continues to meet all criteria as it relates to ABD notices to ensure they contain all required federal and state-specific contact and comply with the language and format requirements. **UPCAP Care Management, Inc.**'s Compliance Officer also runs monthly reports to ensure ABD notices were sent to members as required.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Results of the SFY 2021 CQAR audit clearly shows performance improvement in regards to ABDs as specified above.
c. Identify any barriers to implementing initiatives: None
HSAG's Assessment: HSAG determined that **UPCAP Care Management, Inc.** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives.

Valley Area Agency on Aging

Table 4-20—Prior Year Recommendations and Responses for Valley Area Agency on Aging

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • HSAG recommends that **Valley Area Agency on Aging** follow the MDHHS requirement to complete and submit an updated QMP every two years. This QMP should be separate from the annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report. • HSAG recommends that **Valley Area Agency on Aging** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. These goals should align with the goals established by MDHHS. Additionally, **Valley Area Agency on Aging** should ensure that its annual report includes an analysis on whether it met its established goals, the successes or barriers in achieving its goals, and the strategies for eliminating identified barriers. • HSAG recommends that **Valley Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Valley Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Valley Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. • HSAG recommends that **Valley Area Agency on Aging** follow CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Valley Area Agency on Aging** in a methodologically sound manner.
MCE's Response
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)***: • **Valley Area Agency on Aging** received the HSAG recommendations on November 10, 2021. This was one month into SFY 2022, thus many of the recommendations from HSAG were not able to be completed in SFY 2021. Below are the recommendations that were implemented during the first quarter of SFY 2022. The final bullet in this section will address the recommendations not implemented. • **Valley Area Agency on Aging** completed and submitted the SFY 2022-2023 QMP to the MDHHS on January 13, 2022. A separate annual MI Choice Medicaid Waiver Quality Management Plan Activities & Outcomes Report was also submitted on January 13, 2022. • **Valley Area Agency on Aging** completed and submitted a revised QMP to MDHHS on March 25, 2022, that included the addition of a non-clinical goal, clearly defined objectives, baseline information, and measurable quality indicators. • The remaining HSAG recommendations below were not implemented in SFY 2021 but will be implemented and added to the required QMP Report and Activities and Outcomes Report due January 15, 2023, to MDHHS.   ○ **Valley Area Agency on Aging** ensures our annual Activities and Outcome report includes an analysis of whether it met its established goals, the successes, or barriers in achieving its goals, and the strategies for eliminating identified barriers.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
○ **Valley Area Agency on Aging** to document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Valley Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Valley Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. ○ **Valley Area Agency on Aging** follow *CMS EQR Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019, when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Valley Area Agency on Aging** in a methodologically sound manner.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Valley Area Agency on Aging** is currently implementing the HSAG recommendations in its entirety and expects to have performance data available after September 30, 2022.
c. Identify any barriers to implementing initiatives: • **Valley Area Agency on Aging** received the HSAG recommendations on November 10, 2021. This was one month into SFY 2022. This created a barrier to **Valley Area Agency on Aging** successfully implementing the recommended strategies within the required timeframe of SFY 2021. This issue was shared with MDHHS on May 18, 2022.
HSAG's Assessment: HSAG determined that **Valley Area Agency on Aging** was unable to fully address the prior year's recommendations. Waiver agency QMPs cover a two-year period; in this instance they covered SFY 2020–2021. Consequently, QMPs remained unchanged from the SFY 2020 MI Choice EQR Technical Report to the SFY 2021 MI Choice EQR Technical Report. Therefore, HSAG's recommendations related to the QMP enhancements could not be implemented and remain the same for SFY 2021. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that **Valley Area Agency on Aging** document and implement interventions that are evidence-based (i.e., there should be existing evidence suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes). **Valley Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **Valley Area Agency on Aging** should evaluate the effectiveness of the intervention(s) by measuring change in performance and continue, revise, or discontinue the intervention(s) based on the results. Additionally, HSAG recommends that **Valley Area Agency on Aging** follow the CMS EQR Protocols when initiating QIPs to ensure the technical structure of each QIP is designed, conducted, and reported by **Valley Area Agency on Aging** in a methodologically sound manner.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • MDHHS required **Valley Area on Aging** to develop a CAP to remediate the deficiencies. The completed CAP indicated that **Valley Area on Aging** quality staff members would conduct 12 monthly audits on all supports coordinators. HSAG recommends that supports coordinators continue to be audited on an ongoing basis against the requirements of the waiver, including requirements related to the LOCD, assessment process, and person-centered planning process.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
MCE's Response
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)***: • **Valley Area Agency on Aging** conducted 12 internal monthly audits from October 2020 through March 2021 and 11 internal monthly audits from April 2021 through September 2021 on all waiver staff during SFY 2021. These audits included all the program requirement standards using the CQAR protocol tool. The protocol includes standards for the LOCD, assessment process, and person-centered planning process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • FY 2021 staff performance for LOCD compliance was 99%, assessment process 94% and person-centered planning process was 91%.
c. Identify any barriers to implementing initiatives: • There were no barriers identified at this time, as the HSAG recommendation to continue ongoing auditing on program staff against program requirements has been and remains an internal requirement for **Valley Area Agency on Aging** quality staff.
HSAG's Assessment: HSAG determined that **Valley Area Agency on Aging** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that supports coordinators continue to be audited on an ongoing basis against the requirements of the waiver, including requirements related to the LOCD, assessment process, and person-centered planning process.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • MDHHS required **Valley Area on Aging** to submit a CAP to remediate the deficiencies. **Valley Area on Aging**'s CAP indicated the supervisor provided education on the CQAR findings and quality staff members would conduct 12 monthly audits of all supports coordinators. HSAG recommends that **Valley Area on Aging** continue to audit staff members on an ongoing basis to ensure requirements continue to be met and performance continues to demonstrate improvement. HSAG also recommends **Valley Area on Aging** implement tracking mechanisms to ensure that all incident reports are being appropriately reported through the critical incident reporting database when supports coordinators are notified, and that timely follow-up occurs for all members when a critical incident is reported. **Valley Area on Aging** should use the data available through the Critical Incident Reporting System and its own internal tracking systems to monitor for systemic trends and subsequently implement interventions to mitigate future incidents from occurring. • MDHHS required **Valley Area on Aging** to submit a CAP to remediate the deficiencies. **Valley Area on Aging**'s CAP indicated the supervisor provided education on the CQAR findings and quality staff members would conduct 12 monthly audits of all supports coordinators. HSAG recommends that **Valley Area on Aging** continue to audit staff members on an ongoing basis to ensure requirements continue to be met and performance continues to demonstrate improvement. HSAG also recommends **Valley Area on Aging** implement tracking mechanisms to ensure that all grievances are being resolved and notice is provided to

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
members in accordance with resolution timeliness requirements. HSAG further recommends that **Valley Area on Aging** ensure all issues that are brought forth by members and members' legal guardians are treated as grievances and tracked and responded to in accordance with federal and State grievance tracking and resolution requirements.
MCE's Response
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)***: • **Valley Area Agency on Aging** conducted 12 internal monthly audits from October 2020 through March 2021 and 11 internal monthly audits from April 2021 through September 2021 on all waiver staff during SFY 2021. These audits included all the program requirement standards using the CQAR protocol tool. The protocol includes standards for timely reporting and follow-up of critical incidents, and timely response and follow-up of complaints and grievances according to the program contract. • **Valley Area Agency on Aging** tracked critical incidents for the MI Choice Waiver program using an internal spreadsheet. All critical incidents entered in the MDHHS approved portal are reviewed by the quality department quarterly for timeliness and staff follow-up. • **Valley Area Agency on Aging** tracked complaints and grievances for the MI Choice Waiver program using an internal spreadsheet. All complaints and grievances received by **Valley Area Agency on Aging** staff are added to this tracker. The tracker details the person making the complaint or grievance, the member information (if applicable), the date of the complaint, the complaint, and the action taken by **Valley Area Agency on Aging**.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In SFY 2021, there were 362 critical incidents reported in the MDHHS portal compared to 68 reported in SFY 2019. Staff identified and reported 137% more incidents in SFY 2021 compared to SFY 2019. • In SFY 2021, four complaints were recorded on the internal tracker. There were 522 members enrolled in the Waiver program in SFY 2021. The complaints reported represent 0.7% of the program enrollment for these programs.
c. Identify any barriers to implementing initiatives: • While there were no barriers to implementing **Valley Area Agency on Aging**'s critical incident tracker as this is and has been an ongoing internal process, SFY 2021 results demonstrated an 11% noncompliance rate. This was due to 23 of the 39 critical incidents occurring in AFC facilities. **Valley Area Agency on Aging** staff was waiting to enter critical incidents into the MDHHS portal until after the incident report was received from the AFC. Staff was re-educated to document and enter critical incidents upon knowledge on January 20, 2022. Improved performance has yet to be demonstrated as monthly audit results for February 2022, March 2022, and April 2022 only identified one applicable record. Quality will continue to monitor performance over the next quarter for compliance. • There were no barriers identified in conducting ongoing staff monitoring against program requirements to track critical incidents and complaints and grievances as this has and is currently an internal requirement for **Valley Area Agency on Aging** quality staff.
HSAG's Assessment: HSAG determined that **Valley Area Agency on Aging** was unable to fully address the prior year's recommendations. Please note that due to the timing of the SFY 2020 MI Choice EQR Technical

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
Report, waiver agencies did not have time to make changes to their programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. HSAG continues to recommend that supports coordinators continue to be audited on an ongoing basis against the requirements of the waiver, including requirements related to the LOCD, assessment process, and person-centered planning process.

5. Waiver Agency Comparative Information

In addition to performing a comprehensive assessment of the performance of each waiver agency, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each waiver agency to assess the MI Choice Waiver Program. Specifically, HSAG identifies any patterns and commonalities that exist across the 20 waiver agencies and the MI Choice Waiver 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.

Waiver Agency EQR Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the waiver agencies.

Validation of Performance Improvement Projects

Table 5-1 provides a comparison of the prevalence rates for SFY 2021 for the five state-required QIPs, either as reported to MDHHS or as calculated by HSAG using the numerators and denominators provided by the waiver agencies, which were included in their QMP reports. Lower prevalence rates are indicative of higher performance for all QIPs. Table 5-1 also provides the baseline performance measure rate using SFY 2019 performance measure data, the SFY 2021 statewide goal, and the SFY 2021 statewide rate as provided by MDHHS. Bold font indicates the statewide goal was met for SFY 2021.

The data provided to HSAG for the QIP activity included QMPs (as available) and annual reports for each waiver agency. The methodology for developing the QIPs was not described within the waiver agencies' QMPs or the annual reports provided to HSAG for this EQR; therefore, there may be variances in the data collection and rate calculation process. Due to these potential variances in the methodologies, the reader should use caution when interpreting the comparative results of the QIP outcomes. Additionally, HSAG did not validate any of the data provided in the MDHHS-provided QIP documents (i.e., QMPs and annual reports), as HSAG did not conduct the QIP validation activity.

Table 5-1—Comparison of QIP Outcomes*

Waiver Agency	1. Prevalence of Neglect/Abuse	2. Prevalence of Pain With Inadequate Pain Control	3. Prevalence of Falls	4. Prevalence of Any Injuries	5. Prevalence of Dehydration
A&D Home Health Care	**0.44%**	20.40%	**20.89%**	**1.65%**	**0.61%**
Agency on Aging of Northwest Michigan[1]	4.3%	21.9%	28.0%	6.7%	2.0%
Area Agency on Aging 1B	30.16%	30.35%	**16.90%**	**2.92%**	2.60%
Area Agency on Aging of Western Michigan[2]	**0.03%**	22%	29%	6.0%	3%
Detroit Area Agency on Aging[3,5]	3.68%	30.94%	**17.92%**	3.70%	6.84%
Milestone Senior Services	**1%**	**18%**	48%	6%	2%
MORC Home Care[4]	—	—	—	—	—
Northern Healthcare Management[5]	**2.44%**	31.98%	35.58%	7.93%	1.63%
Region 2 Area Agency on Aging[5]	**1.60%**	**15.76%**	33.52%	6.28%	1.60%
Region 3B Area Agency on Aging[5]	**2.29%**	20.38%	25.17%	4.46%	3.69%
Region IV Area Agency on Aging[5]	**1.95%**	27.67%	30.00%	4.69%	2.93%
Region VII Area Agency on Aging	5.1%	22.2%	29.7%	4.8%	2.9%
Region 9 Area Agency on Aging[5]	**1.94%**	**15.22%**	28.91%	5.10%	1.78%
Reliance Community Care Partners[6]	**2.95%**	20.75%	29.95%	4.91%	2.95%
Senior Resources	3.2%	**16.5%**	27.05%	5.4%	1.6%
The Information Center[2]	**0.033%**	37.23%	25.31%	5%	7.6%
The Senior Alliance[5]	5.06%	**19.82%**	28.77%	3.46%	**1.04%**
Tri-County Office on Aging	3.8%	30.8%	30%	6.7%	**1.4%**
UPCAP Care Management, Inc.[1]	5.8%	30.8%	39.0%	10.5%	3.8%
Valley Area Agency on Aging	3.1%	**14.4%**	**22.4%**	4.9%	**0.9%**
SFY 2019 Statewide Baseline Rate	**5.1%**	**24.24%**	**27.3%**	**5.6%**	**2.6%**
SFY 2021 Statewide Goal	**3%**	**20%**	**23%**	**3%**	**1.5%**
SFY 2021 Statewide Rate	**5.3%**	**23%**	**19.8%**	**4.2%**	**2.7%**
Count of Waiver Agencies That Met SFY 2021 Statewide Goal	**10**	**6**	**4**	**2**	**4**

Prevalence rates displayed in **bold** font met the SFY 2021 statewide goal.

*Waiver agency results are displayed as reported by the waiver agency and not validated by HSAG. The SFY 2020 and SFY 2021 statewide rates and SFY 2021 statewide goal were provided to HSAG by MDHHS.

[1]Prevalence rates provided by the waiver agency were not for the entire SFY 2021 and only included data from April 2021 to September 2021; therefore, the rates are not comparable or displayed.

[2]Waiver agency prevalence rates should be interpreted with caution as all rates provided by the waiver agency did not align with HSAG's calculation of the rate using the numerators and denominators reported by the waiver agency.

[3]Data provided for the *Prevalence of Any Injuries* QIP were unreliable, as the numerators and denominators did not appear to match the stated goal.

[4]Prevalence rates provided by the waiver agency were for each SFY 2021 quarter only; therefore, the rates are not comparable or displayed.

[5]HSAG calculated the SFY 2020 and 2021 performance rates using the numerators and denominators provided by the waiver agency in the annual report.

[6]Waiver agency prevalence rates should be interpreted with caution as they were the same numerators and denominators provided by the waiver agency in the SFY 2020 annual report. Therefore, HSAG assumed the rates were incorrect for SFY 2021.

—	Rates were not displayed due to incomparability.
	Waiver agency with the lowest reported prevalence rate per QIP.
	Waiver agency with the highest reported prevalence rate per QIP.

Performance Measure Validation

Table 5-2 displays the MI Choice Waiver Program statewide performance measure rates for the SFY 2021 PMV activity as presented through the MI Choice Performance Measure Report FY 2021, which included the data used for the CMS-372 report. MDHHS calculates all performance measures at the statewide rate; therefore, individual waiver agency performance measure data were not provided to HSAG for review as part of the assessment, except as described in the introduction paragraph for Table 5-3. Additionally, as confirmed by MDHHS, no benchmarks have been established specific to performance measure rates.

Table 5-2—Statewide Performance Measure Rates

Performance Measures		Statewide (%)
Administrative Authority		
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.*	**88.45**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.*	**96.06**
3	*Number and percent of waiver agencies who submit annual Quality Management Plan (QMP) activity and outcome reports that illustrate they are adhering to their QMP.*	**100**
4	*Number and percent of appropriate LOCDs found after MDHHS review.*	**99.21**

	Performance Measures	Statewide (%)
5	*Number and percent of corrective action plans that were provided by waiver agencies according to requirements set by the Michigan Department of Health and Human Services (MDHHS) or the External Quality Review Organization (EQRO).*	**100**
	Evaluation/Reevaluation of Level of Care	
6	*Number and percent of new MI Choice waiver participants who meet the NFLOC criteria prior to waiver enrollment.*	**99.97**
7	*Number and percent of LOCDs made by a qualified evaluator.*	**100**
8	*Number and percent of participants who had initial LOCDs where the NFLOC criteria were accurately applied.*	**99.14**
9	*Number and percent of MI Choice disenrollments based upon no longer meeting NFLOC criteria that were determined correctly.*	**Not reviewed**
10	*Number and percent of providers continuing to meet applicable licensure & certification standards in accordance with state law following initial enrollment.*	**99.56**
11	*Number and percent of new waiver service provider applications that meet initial licensure/certification standards in accordance with state law prior to the provision of waiver services.*	**100**
12	*Number and percent of non-licensed or non-certified waiver providers that initially met provider qualifications.*	**100**
13	*Number and percent of non-licensed or non-certified waiver providers that continue to meet provider qualifications.*	**97.95**
14	*Number and percent of providers who meet provider training requirements.*	**98.66**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.*	**97.11**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.*	**98.69**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.*	**91.34**
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.*	**94.75**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.*	**88.45**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.*	**93.18**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.*	**95.01**

	Performance Measures	Statewide (%)
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.*	**99.74**
	Participant Safeguards	
23	*Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.*	**82.98%**
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.*	**99.74**
25	*Number and percent of critical incidents due to unexplained death reported within two business days of notification that the incident occurred.*	**85.00**
26	*Number and percent of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred.*	**96.38**
27	*Number and percent of waiver agencies that utilize the critical incident database to track incidents through effective resolution.*	**100**
28	*Number and percent of waiver agencies with staff who have completed required training to prevent incidents.*	**100**
29	*Number and percent of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident.*	**100**
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of caregiver).*	**90.29**
31	*Number and percent of participant suicide attempts that resulted in follow up by the waiver agency.*	**100**
32	*Number and percent of participants requiring emergency medical treatment or hospitalization due to medication error.*	**53.16**
33	*Number and percent of critical incidents reporting hospitalization or emergency room visit within 30 days of the previous hospitalization due to neglect or abuse.*	**100**
34	*Number and percent of properly reported suicide attempts in the critical incident database.*	**100**
	Financial Accountability	
35	*Number and percent of encounters submitted to MDHHS with all required data elements.*	**96.78**
36	*Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility.*	**100**
37	*Number and percent of encounters submitted to MDHHS within required timeframes.*	**99.98**
38	*Number and percent of service plans that supported paid services.*	**99.48**

	Performance Measures	Statewide (%)
39	*Number and percent of capitation payments that have been paid at rates approved by the Actuary.*	**100**

For 15 of the 39 performance measures calculated by MDHHS that used CQAR as the data source, individual waiver agency performance impacted the overall statewide percentage rates as those percentage rates were less than 100 percent. Performance Measure 7, *number and percent of LOCDs made by a qualified evaluator*, received a statewide percentage rate of 100 percent as reported through the CMS-372 report and is, therefore, not included in Table 5-3. Table 5-3 displays the 15 performance measures and CQAR standards that determine the statewide percentage rate, the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and each waiver agency's percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average as well as demonstrate a comparison of all waiver agencies. Performance rates shaded in red indicate that performance is worse than the statewide rate.

Table 5-3—Waiver Agency Impact on Statewide Performance Measure Rates and Comparison of Performance

Waiver Agency	Performance Measures (%)														
	1	2	4	8	15	16	17	18	19	20	21	22	24	30	38
A&D Home Health Care	93.16	96.18	100	100	97.64	98.39	95.16	92.41	93.75	85.00	96.77	100	100	80.00	93.55
Agency on Aging of Northwest Michigan	80.95	97.50	100	100	97.73	100	72.73	91.55	72.22	86.67	100	100	100	96.00	100
Area Agency on Aging 1B	92.63	97.19	100	100	98.23	100	96.43	97.39	77.55	94.87	89.29	100	100	93.06	100
Area Agency on Aging of Western Michigan	95.09	98.48	100	100	98.31	100	91.38	97.07	96.00	93.02	86.21	100	100	100	100
Detroit Area Agency on Aging	84.71	92.66	100	100	92.26	98.78	89.02	91.36	78.57	92.86	95.12	97.56	100	83.15	100
Milestone Senior Services	88.31	90.10	90.00	100	95.00	95.00	95.00	88.80	88.24	100	90.00	100	100	85.71	100
MORC Home Care	97.47	99.07	100	100	100	100	95.00	98.85	94.74	100	100	100	100	91.67	100
Northern Healthcare Management	87.01	92.08	100	100	97.62	100	75.00	93.89	82.35	100	90.00	100	100	86.36	100
Region 2 Area Agency on Aging	91.61	94.20	100	100	94.44	100	91.67	95.44	94.29	95.83	100	100	100	94.74	100
Region 3B Area Agency on Aging	97.39	99.38	100	100	100	90.00	100	97.68	92.00	89.47	100	100	100	97.37	100
Region IV Area Agency on Aging	92.42	97.77	100	100	95.65	97.06	91.18	96.54	87.10	94.74	100	100	100	89.19	100
Region VII Area Agency on Aging	95.83	97.38	100	100	97.41	100	94.64	97.66	95.83	100	100	100	100	95.59	100
Region 9 Area Agency on Aging	96.94	97.76	100	100	100	100	96.15	94.94	100	100	100	100	100	93.55	100
Reliance Community Care Partners	87.43	94.68	100	100	97.94	100	93.75	95.49	83.87	86.84	95.83	100	100	80.00	100
Senior Resources	95.06	93.48	100	100	98.81	95.24	95.24	96.51	97.22	96.00	95.24	100	100	96.23	100

Waiver Agency	Performance Measures (%)														
	1	2	4	8	15	16	17	18	19	20	21	22	24	30	38
The Information Center	81.82	100	100	100	100	100	90.00	93.00	82.35	92.31	80.00	100	100	95.45	100
The Senior Alliance	91.74	96.61	93.75	100	96.97	100	84.38	95.18	92.00	94.74	93.75	100	100	97.30	100
Tri-County Office on Aging	90.67	97.18	100	92.31	97.12	100	90.00	93.21	86.05	94.59	92.00	100	100	88.89	100
UPCAP Care Management, Inc.	84.47	94.29	92.31	100	94.34	100	84.62	88.25	80.00	100	100	100	94.87	66.67	100
Valley Area Agency on Aging	93.75	97.27	100	100	100	100	90.91	96.82	100	75.00	100	100	100	100	100
CMS-372 Report Statewide % Rate*	**88.45**	**96.06**	**99.21**	**99.14**	**97.11**	**98.69**	**91.34**	**94.75**	**88.45**	**93.18**	**95.01**	**99.74**	**99.74**	**90.29**	**99.48**

*Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate is lower than the statewide rate as calculated by HSAG.

Compliance Review

Table 5-4 provides the overall percentage of compliance for each waiver agency's SFY 2021 CQAR record review and home visit interview results. Table 5-4 also provides the overall CQAR compliance level as provided by MPHI for MDHHS in each waiver agency's MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination report.

Table 5-4—Summary of SFY 2020 Compliance Review Results—CQARs

Waiver Agency	Medical Record Review Percent Evident	Home Visit Review Percent Evident	MDHHS Rating for Compliance
A&D Home Health Care	93.29%	100%	**3.91**
Agency on Aging of Northwest Michigan	89.49%	98.75%	**3.62**
Area Agency on Aging 1B	95.06%	100%	**3.91**
Area Agency on Aging of Western Michigan	95.31%	99.87%	**3.86**
Detroit Area Agency on Aging	89.01%	99.12%	**3.73**
Milestone Senior Services	88.07%	100%	**3.59**
MORC Home Care	97.90%	99.60%	**4.00**
Northern Healthcare Management	93.03%	99.61%	**3.89**
Region 2 Area Agency on Aging	94.95%	100%	**3.95**
Region 3B Area Agency on Aging	95.76%	99.05%	**3.91**
Region IV Area Agency on Aging	94.83%	100%	**3.90**
Region VII Area Agency on Aging	96.62%	100%	**3.91**
Region 9 Area Agency on Aging	95.54%	100%	**3.98**
Reliance Community Care Partners	92.70%	100%	**3.84**
Senior Resources	95.35%	100%	**3.96**
The Information Center	93.13%	99.22%	**3.92**
The Senior Alliance	94.28%	100%	**3.88**
Tri-County Office on Aging	91.92%	99.85%	**3.82**
UPCAP Care Management, Inc.	89.99%	99.71%	**3.84**
Valley Area Agency on Aging	95.33%	100%	**3.89**

Indicates substantial compliance: 3.26 or higher.

Indicates some compliance, needs improvement: 2.51 to 3.25.

Indicates not full or substantial compliance: 1.76 to 2.50.

Indicates compliance not demonstrated: 1.00 to 1.75.

Consumer Assessment of Healthcare Providers and Systems: Home and Community-Based Services Analysis

Table 5-5 displays each waiver agency's scores and the statewide satisfaction rates for each domain. Scores in green denote that the waiver agency had the highest score in that domain, and scores in red denote that the waiver agency had the lowest score in that domain.

Table 5-5—Statewide Comparisons: CAHPS Domains

Waiver Agency	Global Ratings Measures	Recommendation Measures	Staff are Reliable and Helpful	Staff Listen and Communicate Well	Case Manager is Helpful	Choosing the Services that Matter to You	Transportation to Medical Appointments	Personal Safety and Respect	Planning Your Time and Activities	Met Need	Physical Safety Measure
A&D Home Health Care	86.0%	90.6%	89.8%	88.3%	91.7%	91.8%	89.2%	95.0%	75.6%	91.7%	100%
Agency on Aging of Northwest Michigan	95.9%	96.4%	95.3%	96.6%	91.0%	93.0%	95.0%	99.1%	74.4%	95.7%	100%
Area Agency on Aging 1B	86.6%	93.9%	92.1%	98.0%	99.0%	93.8%	92.0%	98.3%	78.6%	95.2%	100%
Area Agency on Aging of Western Michigan	89.2%	85.8%	92.4%	94.0%	96.0%	94.5%	93.3%	96.1%	77.3%	95.0%	100%
Detroit Area Agency on Aging	94.6%	96.7%	91.5%	97.4%	99.1%	94.0%	87.2%	100%	71.5%	99.1%	100%
Milestone Senior Services	90.8%	91.9%	91.4%	95.4%	93.8%	91.6%	93.0%	97.5%	75.2%	92.0%	100%
MORC Home Care	89.1%	89.2%	88.4%	90.5%	98.9%	93.8%	90.0%	99.2%	78.7%	100%	97.5%
Northern Healthcare Management	90.1%	94.0%	91.8%	96.7%	89.1%	92.6%	92.6%	95.7%	75.8%	99.2%	97.5%
Region 2 Area Agency on Aging	92.3%	94.3%	92.9%	94.6%	99.1%	95.1%	93.7%	98.4%	79.3%	96.6%	100%
Region 3B Area Agency on Aging	97.1%	96.2%	95.4%	97.9%	94.6%	92.0%	93.0%	99.1%	70.6%	94.7%	100%
Region IV Area Agency on Aging	94.9%	94.1%	93.0%	94.1%	97.5%	95.4%	92.2%	96.7%	74.7%	95.3%	100%
Region VII Area Agency on Aging	92.1%	96.5%	94.7%	97.5%	91.1%	91.1%	95.3%	96.7%	79.9%	95.3%	100%
Region 9 Area Agency on Aging	90.4%	87.4%	93.4%	97.0%	81.4%	90.6%	96.1%	97.5%	76.1%	95.0%	100%
Reliance Community Care Partners	93.2%	92.3%	91.5%	95.5%	100%	88.8%	92.5%	92.1%	74.7%	97.2%	97.5%
Senior Resources	91.3%	92.4%	86.9%	93.9%	98.1%	94.0%	94.7%	98.3%	74.3%	94.5%	100%

Waiver Agency	Global Ratings Measures	Recommendation Measures	Staff are Reliable and Helpful	Staff Listen and Communicate Well	Case Manager is Helpful	Choosing the Services that Matter to You	Transportation to Medical Appointments	Personal Safety and Respect	Planning Your Time and Activities	Met Need	Physical Safety Measure
The Information Center	92.3%	91.7%	90.2%	96.3%	90.7%	89.0%	92.9%	99.1%	74.9%	94.9%	100%
The Senior Alliance	90.4%	89.8%	87.2%	94.5%	95.8%	90.2%	94.9%	98.3%	72.0%	91.1%	100%
Tri-County Office on Aging	96.7%	97.7%	96.1%	95.8%	100%	93.1%	92.7%	94.1%	73.3%	92.4%	100%
UPCAP Care Management, Inc.	95.8%	98.6%	92.6%	97.6%	96.4%	97.4%	91.8%	97.4%	80.0%	98.3%	100%
Valley Area Agency on Aging	90.9%	92.3%	91.7%	95.2%	88.4%	92.0%	94.8%	95.8%	72.9%	94.4%	100%
Statewide	**91.5%**	**92.6%**	**91.9%**	**95.0%**	**95.2%**	**92.7%**	**92.5%**	**97.2%**	**75.4%**	**95.3%**	**99.6%**

Indicates the waiver agency scored the highest of all waiver agencies

Indicates the waiver agency scored the lowest of all waiver agencies

Program-Wide Conclusions and Recommendations

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

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified areas of strength in the program related to the quality, timeliness, and accessibility of care and services.

- The overarching aggregated findings from the PIP, PMV, compliance review, and CAHPS analysis activities demonstrate that MDHHS focused its quality improvement efforts on care management processes and person-centered planning to support waiver members' access to services in accordance with their individualized health needs. Additionally, through CAHPS, the waiver agencies are assessing members' satisfaction with their healthcare and, specifically, with the quality of services being provided to them by waiver agency staff members and providers.
- MDHHS and its contracted waiver agencies are focusing strategies on quality of care by implementing quality improvement initiatives that are intended to ensure the health, safety, and well-being of members by mitigating risks that could lead to poor health outcomes.
- Through the CQAR process, MDHHS mandates immediate corrective action when issues are identified that may impact a member's ability to maintain optimal function, make informed choices, preserve independence and community integration, and/or create barriers to quality care or access to timely and necessary services.

Weaknesses

HSAG's comprehensive assessment of the waiver agencies and the MI Choice Waiver Program also identified areas of focus that represent significant opportunities for improvement within the program related to the quality, timeliness, and accessibility of care and services.

- Although the MI Choice Waiver Program focuses on person-centered planning and members' individual needs, waiver members may not be engaging with family and friends or participating in activities within their communities as often as they would like, as the CAHPS domain, *Planning Your Time and Activities*, received the lowest score statewide. Spending time with family and friends and interacting within the communities in which they live can help promote enhanced quality of life for waiver members, including both their physical and mental health. The CAHPS survey was

conducted during a time when individuals may have avoided physical contact with family and friends due to the COVID-19 pandemic, which may have negatively impacted this domain. However, the waiver program should identify mechanisms to mitigate the barriers that exist during the COVID-19 pandemic.

- Based on HSAG's assessment of the waiver agencies' QMPs and annual activities and outcomes reports, the MI Choice performance measure report, and the CQAR results and succeeding CAPs, the MI Choice Waiver Program has opportunities to enhance its EQR-related processes for overseeing and managing its contracted waiver agencies and subsequently assisting them to improve their performance with respect to quality, timeliness, and access to care, which should support an improvement in the MI Choice Waiver Program's overall performance in these performance domains. Additionally, although the quality and accessibility of waiver services were being evaluated through the MI Choice Waiver Program activities, there appeared to be minimal mechanisms used to evaluate for the timeliness of waiver services.
- HSAG's assessment identified that the weaknesses within the MI Choice Waiver Program were primarily related to the gaps in MDHHS' processes for conducting EQR-related activities, as there were noted discrepancies within the data reviewed or the data were not available as expected. The discrepant and incomplete data created challenges in evaluating each waiver agency's performance in the domains of quality, timeliness, and access to care as it relates to member outcomes.
  - As it related to the PIP activity, the following deficiencies were noted for some waiver agencies:
    - QMPs were not submitted to MDHHS or did not include PIP data for SFY 2021, and/or there was no evidence that PIP documentation was maintained by the waiver agencies in separate documents other than the QMPs or the annual reports to MDHHS. Additionally, documentation did not support that the waiver agencies' PIPs aligned with CMS' guidance within the CMS EQR Protocols for implementing PIPs to assess and improve processes and outcomes of care.
    - PIP designs and the methodologies used for evaluating outcomes and the success of the PIPs were not comprehensive or were unclear.
    - Documentation within the waiver agencies' QMPs and/or annual reports related to the PIPs did not include goals or objectives or did not align with the goals required by MDHHS.
    - The numerators and/or denominators documented by the waiver agencies to calculate performance were not valid or were unavailable within the QMPs and/or annual reports. Therefore, the performance rates of the PIPs were unreliable, and the data could not be used to accurately measure PIP outcomes.
    - The scope (e.g., measurement time frames) of the PIPs were not consistent amongst the waiver agencies and, therefore, were not appropriate for waiver agency to waiver agency comparison of performance.
    - The PIPs required by MDHHS did not consistently support areas of opportunities for all waiver agencies, and the waiver agencies did not appear to have waiver agency-specific PIPs to support areas identified as having significant opportunities for improvement.
    - Documentation within the waiver agencies' QMPs and/or annual reports did not support that the PIPs focused on both clinical and nonclinical areas.

  - MDHHS, MDHHS' agent who is not a waiver agency, or an EQRO did not appear to be validating each waiver agency's PIP in accordance with the CMS EQR Protocols, as determined through the documentation issues noted during the EQR.
- As it related to the PMV activity, the following trends and process gaps were noted:
  - No standard performance measures were identified by MDHHS to evaluate individual waiver agency performance. Although MDHHS calculates and reports statewide data to CMS using the CMS-372 report, the performance measures were not used to calculate individual waiver agency performance. Additionally, some performance measures identified by MDHHS are MDHHS-driven and performance is not impacted by individual waiver agencies (e.g., performance related to capitation payments to the waiver agencies). Further, although the CQAR process assesses waiver agency compliance with waiver-specific standards and contract requirements through a sample of record reviews and home visits, the CQAR did not assess aggregated waiver agency performance in any specified performance areas.
  - The waiver agencies were not annually measuring and reporting to MDHHS on any required performance measure standards, and MDHHS was not requiring the waiver agencies to provide data for MDHHS to calculate waiver agency performance in specified areas.
- As it related to the compliance review activity, the following trends and process gaps were noted:
  - While MPHI conducts an annual CQAR on behalf of MDHHS, the CQAR focused on waiver-specific requirements and whether PCSPs and service delivery comply with State and federal regulations. The documentation provided to HSAG for this EQR did not support that MDHHS, its agent who is not a waiver agency, or an EQRO were evaluating waiver agencies' compliance with all standards outlined under 42 CFR §438.358(b)(1)(iii) and their associated requirements.
  - While MDHHS confirmed that emergency and post-stabilization services do not apply to waiver agencies due to the scope of services of the MI Choice Waiver Program, most federal Medicaid managed care requirements related to the compliance review activity were not addressed through the CQAR. Additionally, the CMS-approved waiver application for the MI Choice Waiver Program required MDHHS to complete a biennial on-site AQAR to evaluate waiver agency policies and procedure manuals, peer review reports, provider monitoring reports, provider contract templates, financial systems, encounter data accuracy, QMPs, and verification of provider licensure. The scope of the AQAR would appear to address at least some of the federal requirements required to be included in a comprehensive compliance review; however, MDHHS informed HSAG that the AQAR has not been completed in SFY 2020 or SFY 2021 due to staffing issues and the COVID-19 pandemic.

Quality Strategy Recommendations for the MI Choice Waiver Program

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

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

Recommendation 1—Implementation of EQR Activities in Accordance With CMS EQR Protocols

In consideration of the goals of the CQS and the comparative review of findings for all activities related to quality, timely, and accessible care and services, HSAG recommends the following quality improvement initiatives, which focus on the EQR-related processes designed to provide a sound understanding of the strengths and weaknesses of waiver agencies' performance related to the quality, timeliness, and accessibility of care, and primarily target goals 1 and 3 and the associated objectives within MDHHS' CQS.[6-1]

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

- **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.

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

- **Objective 3.1**: Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.

Implementation of EQR-related activities in accordance with 42 CFR §438.358 and in alignment with the CMS EQR Protocols will improve MDHHS' ability to oversee and manage the waiver agencies, and should lead to more comprehensive, accurate, and reliable data to assess the MI Choice Waiver Program's performance related to the quality, timeliness, and accessibility of care. As such, HSAG

[6-1] 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: Sept 13, 2022.

recommends MDHHS conduct its EQR-related activities following the Medicaid and CHIP Managed Care Final Rule and the CMS EQR Protocols.

- **Validating PIPs**—In accordance with 42 CFR §438.330(d), MDHHS must require that waiver agencies conduct PIPs, including any PIPs required by CMS, that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements:
  - Measurement of performance using objective quality indicators.
  - Implementation of interventions to achieve improvement in the access to and quality of care.
  - Evaluation of the effectiveness of the interventions based on the performance measures.
  - Planning and initiation of activities for increasing or sustaining improvement.

  While MDHHS currently requires the waiver agencies to conduct PIPs, referred to by MDHHS and the waiver agencies as QIPs, for five selected quality indicators, HSAG recommends that MDHHS select two of the quality indicators, or other quality indicators (e.g., one clinical and one nonclinical), of particular interest to MDHHS and the MI Choice Waiver Program and require the waiver agencies to implement these PIPs using a formalized and evidence-based process that aligns with CMS EQR *Protocol 8. Implementation of Additional Performance Improvement Projects: An Optional EQR-Related Activity*, October 2019. MDHHS, its agent that is not a waiver agency, or an EQRO must conduct the validation of the PIPs in adherence with 42 CFR §438.358(b)(1)(i) and CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, and use the documentation provided by the waiver agencies to verify that each waiver agency used sound methodology in its design, implementation, analysis, and reporting of the PIPs.
- **Validating Performance Measures**—In accordance with 42 CFR §438.330(c), MDHHS must specify standard performance measures for waiver agencies to include in their comprehensive QAPI programs. Each year, the waiver agencies must measure and report to MDHHS the standard performance measures specified by MDHHS; submit specified data to MDHHS, which enable MDHHS to calculate the standard performance measures; or a combination of these approaches.

  HSAG recommends that MDHHS identify a specific number of performance measures that will provide meaningful information on individual waiver agency performance and require the waiver agencies to calculate and report these measures to MDHHS annually.
  - Since the MI Choice Waiver Program and its waiver agencies provide LTSS, MDHHS should specifically identify standard performance measures relating to quality of life, rebalancing, and community integration activities for members receiving LTSS. MDHHS should also ensure that the performance measures selected support a comprehensive assessment of waiver agency performance with respect to the quality, timeliness, and accessibility of care and services provided to waiver members.
  - Once the performance measures are identified, MDHHS should provide the waiver agencies with the performance measures' specifications for calculating numerators and denominators and the subsequent percentage rates and develop a timeline in which the waiver agencies must submit to MDHHS the calculated rates for each performance measure identified.

  - MDHHS, its agent that is not a waiver agency, or an EQRO must then conduct the validation of these performance measures in accordance with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019, and 42 CFR §438.358(b)(1)(ii). The validation activity should assess whether the performance measures calculated by each waiver agency are accurate based on the measure specifications and State reporting requirements.
  - Once MDHHS has selected a set of performance measures and has collected baseline data, MDHHS should also consider establishing minimum performance standards for each measure to drive continuous improvement.

- **Conducting Compliance Reviews**—In accordance with 42 CFR §438.358(b)(1)(iii), MDHHS, its agent that is not a waiver agency, or an EQRO must perform the mandatory compliance review, conducted within the previous three-year period to determine each waiver agency's compliance with the standards set forth in 42 CFR §438 Subpart D, the disenrollment requirements and limitations described in 42 CFR §438.56, the enrollee rights requirements described in 42 CFR §438.100, the emergency and post-stabilization services requirements described in 42 CFR §438.114, and the quality assessment and performance improvement requirements described in 42 CFR §438.330. HSAG recommends that MDHHS conduct a comprehensive compliance review during each three-year cycle.
  - The review must include all federally mandated standards for managed care plans. The compliance review activity should align with CMS EQR *Protocol 3. Review of Compliance With Medicaid and Chip Managed Care Regulations*: *A Mandatory EQR-Related Activity*, October 2019.
  - MDHHS should begin with developing a crosswalk of the standards currently reviewed as part of the CQAR against the standards required to be part of a compliance review according to 42 CFR §438.358(b)(1)(iii). Any federally required standards that do not apply to the scope of the MI Choice Waiver Program (e.g., the disenrollment requirements and limitations) should also be identified within this crosswalk. Based on the findings of the crosswalk, MDHHS should immediately begin preparations to address all gaps identified in its current compliance review process.

Recommendation 2—Quality Assessment and Performance Improvement Program

In consideration of the goals of the CQS and based on the review of findings from the PIP activity, which used QAPI program documentation, HSAG recommends the following initiatives, which focus on waiver agencies' quality improvement efforts and provide the foundation for assessing and improving performance related to the quality, timeliness, and accessibility of care, and primarily target goals 1 and 3 and the associated objectives within MDHHS' CQS.[6-2]

[6-2] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy: 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Sept 9, 2022.

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

- **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.

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

- **Objective 3.1**: Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.

In accordance with 42 CFR §438.330(d), MDHHS must require through its contracts that each waiver agency establish and implement an ongoing comprehensive QAPI program for the services it furnishes to its members. A comprehensive QAPI program must include at least the following elements:

- PIPs.
- Collection and submission of performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness furnished to members with special health care needs.
- For waiver agencies providing LTSS:
  - Mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable.
  - Participate in efforts by MDHHS to prevent, detect, and remediate critical incidents for home- and community-based waiver programs.

To address the gaps noted in the waiver agencies' QAPI documentation that was reviewed as part of the SFY 2020 PIP activity, HSAG recommended in SFY 2020 that MDHHS host a work group with representation of each waiver agency's quality improvement team to enhance the QMPs and the annual QMP evaluations to ensure each waiver agency's QAPI program description, work plan, and annual evaluation addressed all components of a QAPI program required under 42 CFR §438.330. Due to the timing of the SFY 2020 MI Choice EQR Technical Report, waiver agencies did not have time to make significant changes to their QAPI programs prior to the commencement of the SFY 2021 MI Choice EQR Technical Report. However, per discussion with MDHHS, MDHHS and the waiver agencies initiated a work group to enhance their QAPI program descriptions, work plans, and annual evaluations. HSAG continues to recommend, as applicable to the scope of the MI Choice Waiver Program, the program description should include the following components:

- Vision and mission of the program.
- Organizational/committee structure.

- Key quality staff member roles and responsibilities.
- Resources supporting the quality program.
- Data collection and validation processes.
- Performance measures.
- PIPs.
- Mechanisms to detect under- and overutilization.
- Mechanisms to assess the quality and appropriateness of care for members with special health care needs.
- Adoption and dissemination of clinical practice guidelines; specifically, those adopted from nationally recognized sources.
- Provider network monitoring, such as access standards.
- Grievances and appeals and identified trends.
- Member outreach and education needs and activities.
- Cultural competency.
- Social determinants of health.
- Credentialing activities.
- Quality of care concerns and peer review.

Specifically, as applicable to the scope of the MI Choice Waiver Program, the work plan should include the following components:

- Measurable goals and objectives. Goals should be related to the activities identified in its QAPI program description and priority areas of MDHHS and the waiver agency. The waiver agency should consider using data from the previous year to identify focus areas and subsequent measurable goals.
- Targeted completion dates for each goal.
- Assigned person(s) or department responsible for each goal.
- Interventions and activities to be implemented in an effort to meet each goal.
- Quarterly reviews and documentation of progress or barriers in meeting each goal.

Specifically, as applicable to the scope of the MI Choice Waiver Program, the program evaluation should include an assessment of whether established measurable goals have been met, and the waiver agencies should:

- Identify successes, barriers, and recommendations for improvement, as applicable, for each activity and goal.
- Solicit input from the assigned persons(s) or department responsible for each goal.
- Establish new goals when they have been maintained and sustained or when new focus or priority areas have been identified.
- When goals are not met, complete a barrier analysis and action steps for the upcoming year.

Recommendation 3—Implementation of PIP to Address Member Dissatisfaction

In consideration of the goals of the CQS and the review of findings across the CAHPS activity, HSAG also recommends the following quality improvement initiative, which focuses on improving waiver members' quality of life and integration into the community and primarily targets goals 2 and 4 and the associated objectives within MDHHS' CQS.

Goal 2: Strengthen person and family-centered approaches.

- **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.

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

- **Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.

To promote optimal health and well-being for waiver members, HSAG recommends MDHHS focus efforts on improving members' satisfaction with their ability to get together with family and friends, participate in community and social events, and having the autonomy to make decisions about their day-to-day activities. To support these efforts, MDHHS should implement a statewide PIP that focuses on improving member satisfaction rates for the *Planning Your Time and Activities* component of the CAHPS activity, and to improve waiver members' overall quality of life and integration into the community. When developing the PIP, MDHHS should consider the following:

- Require the waiver agencies to use the demographics data from the CAHPS HCBS survey to identify whether there are disparities that exist amongst the respondents as they pertain to the focus areas identified through the *Planning Your Time and Activities* CAHPS domain.
- Require the waiver agencies to conduct a root cause analysis for their lowest performing question(s) within the *Planning Your Time and Activities* CAHPS domain to determine potential reasons for member dissatisfaction and to identify priority areas of focus for the PIP. Because many waiver members are vulnerable to COVID-19 and should limit physical contact with friends and family when appropriate, the waiver agencies should identify other mechanisms to help members interact with friends and family, such as through video chat features, social media, and other technology platforms that allow for contact-free communication.
- Require the waiver agencies to design a PIP in accordance with the guidance provided under the CMS EQR Protocols.
- Validate each PIP in accordance with the CMS EQR Protocols, or contract with an agent other than a waiver agency, or an EQRO, to validate the PIPs in accordance with the CMS EQR Protocols.
- Require the waiver agencies to submit to MDHHS annually the status and results of the implemented PIP.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

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

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

The goal of each PIP is to assess and improve processes and outcomes of care provided by the waiver agencies in the State of Michigan for the MI Choice Waiver Program.

Technical Methods of Data Collection and Analysis

Each waiver agency develops a QMP every other year that addresses CMS and MDHHS quality requirements. MDHHS also requires each waiver agency to compile an annual report, called the MI Choice Summary of Quality Management Plan Activities & Outcomes Report, which provides a description of the waiver agency's quality management activities and outcomes. Every two years, the QMC members vote on five quality indicators to initiate QIPs, and goals and strategies. Progress of these quality indicators are reported annually to MDHHS through the MI Choice Summary of Quality Management Plan Activities & Outcomes Report. MDHHS reviews and analyzes waiver agency QMPs and the associated annual reports. MDHHS also compiles and compares individual waiver agency quality indicators and statewide averages. Table A-1 outlines the selected five QIP quality indicators for the waiver agencies for the SFY 2020 and SFY 2021 review years.

Table A-1—QIP Indicators

QIP Indicators
1. *Prevalence of Neglect/Abuse*
2. *Prevalence of Pain With Inadequate Pain Control*
3. *Prevalence of Falls*

QIP Indicators
4. *Prevalence of Any Injuries*
5. *Prevalence of Dehydration*

Description of Data Obtained and Related Time Period

In SFY 2021, each waiver agency submitted detailed information about each of the five QIP indicators to MDHHS through the QMP and MI Choice Summary of Quality Management Plan Activities & Outcomes Report. The waiver agencies were required to submit their completed reports to MDHHS by January 15, 2021, along with detailed data regarding each QIP indicator's goals, strategies, and results during the time period of October 1, 2019, through September 30, 2020. Each waiver agency's QIPs is reported to MDHHS through a yearly activities and outcomes report. These reports provide data about each of the QIPs and the activities completed. The MI Choice Summary of Quality Management Plan Activities & Outcomes Report and each waiver agency's QMP were provided to HSAG by MDHHS for this EQR.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each waiver agency provided to members, HSAG reviewed the QIP information included through the QMP and MI Choice Summary of Quality Management Plan Activities & Outcomes Reports to ensure the waiver agencies used a sound methodology in their design, implementation, analysis, and reporting of the QIP indicator findings and outcomes. HSAG analyzed the quantitative results (e.g., study indicator results compared to baseline, prior remeasurement period results, and study goal) and qualitative results (e.g., technical design of the PIP, data analysis, and implementation of improvement strategies) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the waiver agency's members.

Performance Measure Validation

Activity Objectives

42 CFR §438.350(a) requires states that contract with waiver agencies 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 waiver agency.
- Determine the extent to which the specific performance measures reported by the waiver agency followed the State and federal specifications and reporting requirements.
- Identify overall strengths and areas for improvement in the PMV.

Annually, MDHHS calculates 39 performance measure rates and subsequently reports the statewide percentage rates for each measure to CMS using the CMS-372 report. MDHHS adheres to the performance measure specifications and methodology described in its CMS-approved Section 1915(c) HCBS waiver for the MI Choice Waiver Program.

Technical Methods of Data Collection and Analysis

MDHHS has systems in place to measure the overall performance of the MI Choice Waiver Program in the following waiver assurance domains: Administrative Authority, Evaluation/Reevaluation of Level of Care, Participant Services, Participant-Centered Planning and Service Delivery, Participant Safeguards, and Financial Accountability. In SFY 2021, MDHHS or its contracted EQRO, MPHI, obtained data through the annual CQAR reviews and MDHHS' online reporting databases, including the Critical Incident Reporting System, NFLOC system, CHAMPS, and the MMIS. The data from these sources were used by MDHHS to calculate and subsequently report statewide performance measure percentage rates to CMS through the CMS-372 report. Table A-2 lists the performance measures calculated by MDHHS and whether the source of the data was from the CQAR, the waiver agency and validated by MDHHS, or a database.

Table A-2—Performance Measures and Source Data

Performance Measures		Source Data	Sampling Approach
Administrative Authority			
1	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.*	CQAR	Representative sample
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.*	CQAR	Representative sample
3	*Number and percent of waiver agencies who submit annual Quality Management Plan (QMP) activity and outcome reports that illustrate they are adhering to their QMP.*	Reports	100% review
4	*Number and percent of appropriate LOCDs found after MDHHS review.*	CQAR	Representative sample
5	*Number and percent of corrective action plans that were provided by waiver agencies according to requirements set by the Michigan Department of Health and Human Services (MDHHS) or the External Quality Review Organization (EQRO).*	Reports	100% review
Evaluation/Reevaluation of Level of Care			
6	*Number and percent of new MI Choice waiver participants who meet the NFLOC criteria prior to waiver enrollment.*	Online database	100% review

	Performance Measures	Source Data	Sampling Approach
7	*Number and percent of LOCDs made by a qualified evaluator.*	CQAR	Representative sample
8	*Number and percent of participants who had initial LOCDs where the NFLOC criteria were accurately applied.*	CQAR	Representative sample
9	*Number and percent of MI Choice disenrollments based upon no longer meeting NFLOC criteria that were determined correctly.*	Online database	Not reviewed*
10	*Number and percent of providers continuing to meet applicable licensure & certification standards in accordance with state law following initial enrollment.*	Record reviews	100% review
11	*Number and percent of new waiver service provider applications that meet initial licensure/certification standards in accordance with state law prior to the provision of waiver services.*	Record reviews	100% review
12	*Number and percent of non-licensed or non-certified waiver providers that initially met provider qualifications.*	Record reviews	100% review
13	*Number and percent of non-licensed or non-certified waiver providers that continue to meet provider qualifications.*	Record reviews	100% review
14	*Number and percent of providers who meet provider training requirements.*	Record reviews	100% review
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.*	CQAR	Representative sample
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.*	CQAR	Representative sample
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.*	CQAR	Representative sample
18	*Number and percent of participants whose service plans are developed in accordance with policies and procedures established by MDHHS for the person-centered planning process.*	CQAR	Representative sample
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.*	CQAR	Representative sample
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.*	CQAR	Representative sample

	Performance Measures	Source Data	Sampling Approach
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.*	CQAR	Representative sample
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.*	CQAR	Representative sample
	Participant Safeguards		
23	*Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.*	Critical events and incident reports	100% review
24	*Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.*	CQAR	Representative sample
25	*Number and percent of critical incidents due to unexplained death reported within two business days of notification that the incident occurred.*	Critical incident reporting database	100% review
26	*Number and percent of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred.*	Critical incident reporting database	100% review
27	*Number and percent of waiver agencies that utilize the critical incident database to track incidents through effective resolution.*	Critical incident reporting database	100% review
28	*Number and percent of waiver agencies with staff who have completed required training to prevent incidents.*	Record reviews	100% review
29	*Number and percent of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident.*	Critical incident reporting database	100% review
30	*Number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of caregiver).*	CQAR	Representative sample
31	*Number and percent of participant suicide attempts that resulted in follow up by the waiver agency.*	Critical incident reporting database	100% review
32	*Number and percent of participants requiring emergency medical treatment or hospitalization due to medication error.*	Critical incident reporting database	100% review
33	*Number and percent of critical incidents reporting hospitalization or emergency room visit within 30 days of the previous hospitalization due to neglect or abuse.*	Critical incident reporting database	100% review
34	*Number and percent of properly reported suicide attempts in the critical incident database.*	Critical events and incident reports	100% review

	Performance Measures	Source Data	Sampling Approach
Financial Accountability Performance Measures			
35	*Number and percent of encounters submitted to MDHHS with all required data elements.*	Online database	100% review
36	*Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility.*	Online database	100% review
37	*Number and percent of encounters submitted to MDHHS within required timeframes.*	Online database	100% review
38	*Number and percent of service plans that supported paid services.*	CQAR	Representative sample
39	*Number and percent of capitation payments that have been paid at rates approved by the Actuary.*	Online database	100% review

*MDHHS was unable to calculate the rate for this performance measure due to data limitations. MDHHS indicated it will need to revise the performance measure specifications to appropriately calculate this performance measure's rate.

Indicates the performance measures that rely on the CQAR as the data source for reporting and used by HSAG to assess individual waiver agency performance as part of this EQR.

For data derived through CQAR results, MDHHS calculated the performance measure rates in accordance with the following steps:

1. On a Microsoft (MS) Excel spreadsheet, MDHHS entered:
   a. The applicable standard from the CQAR
   b. The percent of compliance
   c. The reason for the citations
2. Auto summed the "Percent Compliance" column
3. Divided the Auto Sum calculation by the number of standards included in the applicable Performance Measure to obtain the Percentage of Compliance for the Performance Measure
   a. Example: Performance Measure
      i. 1-12 standards
      ii. 2-22 standards
4. Determined the number of participants that would be applicable for the Performance Measure Percentage of Compliance
   a. The denominator was the number of participants reviewed by CQAR in SFY 2021
   b. The numerator was determined by completing the following:
      i. Performance Measure 6 Example:
         1. SFY 2021 116 participants were reviewed
         2. Overall percentage of compliance of 99.14 percent

3. After manually changing the numerator, MDHHS determined that 115/116 participants had an overall percentage of compliance of 99.14 percent

For the performance measures that did not use data from the CQAR, MDHHS manually calculated statewide rates using data obtained through reports generated in internal databases or from information collected from the waiver agencies and subsequently validated by MDHHS.

Description of Data Obtained and Related Time Period

MDHHS provided HSAG with each of the 20 waiver agencies' CQAR results and a copy of the MI Choice performance measure report, which included each of the 39 performance measures, the numerator and denominator for each performance measure, and the statewide percentage rate for each performance measure.

The performance measures were calculated by MDHHS using data collected between October 1, 2020, and September 30, 2021 (SFY 2021).

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each waiver agency provided to members, HSAG evaluated the results for each statewide performance measure reported by MDHHS through the CMS-372 report and calculated the individual waiver agency result for each performance measure that relied on the CQAR as the source for the data. HSAG further analyzed the results of the waiver agency's 2021 performance measure rates based on comparisons to the statewide rates 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 the waiver agency's 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 MI Choice waiver agencies' compliance with the applicable standards for waiver agencies set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the member 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 42 CFR §438.330. To meet this requirement, MDHHS performed annual compliance monitoring activities of its 20 contracted PAHP waiver agencies.

The objectives of conducting compliance reviews are to ensure performance and adherence to contractual provisions as well as compliance with federal Medicaid managed care regulations. The

reviews also aid in identifying areas of noncompliance and assist waiver agencies in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection and Analysis

MDHHS contracts with its EQRO, MPHI, to complete a CQAR for every waiver agency each state fiscal year that consists of a record review and home visit interview. During the CQAR, reviewers examine case records and other information to gauge the level of compliance with program standards and to assess the quality of waiver agency service to each participant. The CQAR includes a review of whether person-centered service plans and service delivery are in compliance with State and federal requirements. The purpose of the home visits is to verify that what is contained in the record is consistent with what the reviewer observes in the home.

MDHHS selects a random sample of each waiver agency's MI Choice member records. MDHHS determines a statistically significant number of records to review based upon the total number of MI Choice slots used in a given fiscal year. The sampling methodology is less than 100 percent review with a sample confidence interval = +/-5%. MPHI used the Raosoft tool to determine the sample size needed for a 95 percent confidence level with MI Choice population size and allowing for a 5 percent margin of error. The total sample size was portioned over the 20 waiver agencies, depending on their enrollment percentage of the total enrollment to determine the sample needed from each waiver agency. If the waiver agency sample size was less than 10, the sample size was rounded up to 10.

The SFY 2021 CQAR consisted of 17 focus areas identified in Table A-3. Table A-3 also identifies the focus areas included as part of the record review and/or the home visit interview.

Table A-3—CQAR Standards

Standards		Record Review	Home Visit Interview
Focus 1	Level of Care Determination	✓	✓
Focus 2	Freedom of Choice	✓	
Focus 3	Release of Information	✓	
Focus 4	Status	✓	
Focus 5	Pre-Planning	✓	✓
Focus 6	Assessment	✓	✓
Focus 7	Medication Record	✓	✓
Focus 8	Person-Centered Service Planning	✓	✓
Focus 9	MI Choice Services	✓	✓
Focus 10	Linking and Coordinating	✓	✓
Focus 11	Follow-Up and Monitoring	✓	✓
Focus 12	Service Provider	✓	
Focus 13	Contingency Plan	✓	✓

Standards		Record Review	Home Visit Interview
Focus 14	Critical Incidents	✓	✓
Focus 15	Adverse Benefit Determination	✓	
Focus 16	Complaints and Grievances	✓	
Focus 17	Home and Community Based		✓

Each review element was assigned a value of *Evident*, *Non-Evident*, or *NA*. A percentage of *Evident* values for each focus area was derived from the total number of elements assigned a value of *Evident* divided by the number of total applicable elements. MDHHS required a CAP for all cited focus areas/standards.

MDHHS assigned an importance and harm score for each standard reviewed based on the criteria in the table below:

Table A-4—Importance and Harm Score

Score	Importance	Harm
1	**Extremely Important**—standard is a basic CMS assurance	**Definite Risk** to participant's health and welfare and FFP if not present.
2	**Highly Important**—CMS and/or State requirement	**Likely Risk** to participant's health and welfare and/or FFP if not present
3	**Important**—CMS recommendation and/or State contract requirement	**Slight Risk** to participant's health and welfare or FFP if not present.

Following the completion of the CQAR, each standard received a score based on a compliance level (A-B-C-D) and the percentage of compliance shown in Table A-5.

Table A-5—Compliance Level

Total Score	Compliance Level	Citation Threshold	Recommendation Threshold
2	**A**	10.01% or more "Non-Evident" scores	5.01–10% "Non-Evident" scores

Total Score	Compliance Level	Citation Threshold	Recommendation Threshold
3	B	15.01% or more "Non-Evident" scores	10.01–15% "Non-Evident" scores
4	C	20.01% or more "Non-Evident" scores	15.01–20% "Non-Evident" scores
5 or 6	D	25.01% or more "Non-Evident" scores	20.01.–25% "Non-Evident" scores

Table A-6 identifies the four compliance determination categories and the accompanying compliance levels, which MDHHS incorporates into each waiver agency's MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination report.

Table A-6—Compliance Level Determination Matrix

Compliance Level Determination Matrix							
Overall Compliance Level:			A	B	C	D	Compliance Determination Report
Compliance Determination	Substantial	Waiver Agent substantially meets assurances.	90% Compliant or better	85% Compliant or better	80% Compliant or better	75% Compliant or better	3.26 or higher
	Some, Needs Improvement	Waiver Agent demonstrates assurances, but MDHHS recommends improvements or requires additional information.	85-89% Compliant	80-84% Compliant	75-79% Compliant	70-74% Compliant	2.51 - 3.25
	Not Full or Substantial	Waiver Agent does not fully or substantially demonstrate assurance, though there is evidence that it may be clarified or readily addressed.	80-84% Compliant	75-79% Compliant	70-74% Compliant	65-69% Compliant	1.76 - 2.50
	Not Demonstrated	Waiver Agent does not demonstrate the assurance.	79% Compliant or worse	74% Compliant or worse	69% Compliant or worse	64% Compliant or worse	1 - 1.75

Description of Data Obtained and Related Time Period

Table A-7 lists the major data sources MDHHS used in determining the waiver agencies' performance in complying with requirements and the time period to which the data applied. For this EQR, MDHHS provided HSAG with the completed SFY 2021 CQAR tools and CAPs.

Table A-7—Description of Waiver Agency Data Sources

Data Obtained	Time Period to Which the Data Applied
Record reviews of MDHHS selected members	October 1, 2020–September 30, 2021
Information obtained through member home visit interviews	October 1, 2020–September 30, 2021

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each waiver agency individually, HSAG used the results of the CQAR and the overall compliance determination rating calculated by MDHHS for each standard. HSAG determined each waiver agency's substantial strengths and weaknesses as follows:

- Strength—Any standard that achieved a 100 percent compliance score.
- Weakness—Any standard that scored 5 percentage points or more below the statewide compliance score.

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, timeliness, and accessibility of care and services that each waiver agency 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 each waiver agency's members.

Of note, HSAG did not receive a crosswalk that compared federal standards required under 42 CFR §438.358(b)(1)(iii) to the standards included as part of the CQAR. However, HSAG determined the CQAR tools did not include all requirements that align to federal Medicaid managed care standards.

Consumer Assessment of Healthcare Providers and Systems Survey

Activity Objectives

The CAHPS HCBS surveys ask adult members to report on and evaluate their experiences with healthcare. The IHP, a unit within the CHM of Michigan State University, administered the CAHPS surveys on behalf of the waiver agencies. Survey results were standardized to a 100-point scale with mean scores calculated. HSAG presents the percentage of members or parents/caretakers who responded to the survey with positive experiences in a particular aspect of their healthcare.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the CAHPS Home- and Community-Based Services Survey Version 1.0. Telephone interviews were used for data collection.

The survey questions were categorized into various measures of member experience. These measures included three global ratings measures, three recommendation measures, and nine composite measures. The global ratings measures reflected respondents' overall experience with their personal assistance and behavioral health staff, homemakers, and case managers. The recommendation ratings reflected respondents' willingness to recommend their personal assistance and behavioral health staff, homemakers, and case managers to others. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Choosing the Services that Matter to You* and *Personal Safety and Respect*).

Official reporting of CAHPS HCBS survey results requires a minimum of 100 responses on each item to report the measure as a valid CAHPS HCBS survey result. Measure results that did not meet the minimum number of 100 responses are denoted in the tables with an "s." Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. Considering the Technical Assistance Guide for Analyzing Data from the CAHPS HCBS survey, survey results were standardized to a 100-point scale with mean scores calculated. A very small proportion of the respondents opted to use the alternative responses where options are presented as "mostly yes" or "mostly no" instead of a more cognitively challenging Likert-type scale. The alternative responses were also converted to the standardized scale.

Description of Data Obtained and Related Time Period

IHP administered the CAHPS HCBS survey to the waiver agency population. There were 11,483 enrollees who met the following criteria for the sampling frame: (1) enrolled in the MI Choice Waiver Program for at least three months between December 2020 and February 2021; (2) had at least one claim during that time period; and (3) were 18 years of age or older. A random number methodology per agency was then applied, resulting in 5,816 enrollees being included in the sample frame statewide.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of services provided by the waiver agencies, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-8.

Table A-8—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
CAHPS HCBS Survey Domain			
Global Ratings Measures	✓		
Recommendation Measures	✓		
Staff are Reliable and Helpful	✓		
Staff Listen and Communicate Well	✓		
Case Manager is Helpful	✓		
Choosing the Services that Matter to You	✓		✓
Transportation to Medical Appointments	✓		
Personal Safety and Respect	✓		
Planning Your Time and Activities	✓		
Met Need	✓		
Physical Safety Measure	✓		