2022–2023 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 Behavioral and Physical Health and Aging Services Administration (BPHASA) 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 2022–2023 are displayed in Table 1-1.

Table 1-1—PAHP Waiver Agencies in Michigan

Waiver Agency Name*
A&D Home Health Care
Area Agency on Aging 1-B
Area Agency on Aging of Northwest Michigan
Area Agency on Aging of Western Michigan
Detroit Area Agency on Aging
Easterseals/MORC
Milestone Senior Services
Northern Health Care Management
Region 3B Area Agency on Aging/Carewell Services
Region IV Area Agency on Aging
Region VII Area Agency on Aging
Region 9 Northeast MI Community Service Agency

Waiver Agency Name*
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
WellWise Services Area Agency on Aging

* Please note that HSAG included waiver agency names within this report as provided by MDHHS upon the development of the external quality review (EQR) technical report. Any revisions received to the waiver agency names after the development of this EQR technical report will be updated in future reports. Of note, MDHHS notified HSAG on January 10, 2024, that UPCAP Care Management, Inc. is now UPCAP Services, Inc.

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. Most of the EQR activities included as part of this assessment were conducted by MDHHS or its contracted vendor, and MDHHS submitted the data from these activities to HSAG. HSAG compared the methodologies for the activities conducted by MDHHS to the EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the CMS EQR Protocols).[1-1] The one activity performed by HSAG (Encounter Data Validation [EDV]) was also conducted consistent with the CMS EQR Protocols.[1-2] The purpose of the EQR 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 2022–2023 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 5, 2024.

[1-2] HSAG updated the EQR methodology for the EDV activity to align with the 2023 CMS EQR Protocols published in February 2023. However, for the SFY 2023 EDV initiated with the waiver agencies prior to the release of the 2023 CMS EQR Protocols, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols (https://www.medicaid.gov/sites/default/files/2023-03/2019-eqr-protocols-updated.pdf) and updated the methodologies for future EDV activities to the 2023 CMS EQR Protocols. HSAG also advised MDHHS to adhere to the 2023 CMS EQR Protocols for future EQR activities.

the quality, timeliness, and accessibility of care and services provided by each waiver agency. Detailed information about each activity methodology is provided in Appendix A of this report.

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 (CMS EQR Protocol 1)
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 (CMS EQR Protocol 2)
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 (CMS EQR Protocol 3)
EDV	This activity validates the accuracy and completeness of encounter data submitted by a waiver agency.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (CMS EQR Protocol 5)
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 members receive.	Protocol 6. Administration or Validation of Quality of Care Surveys (CMS EQR Protocol 6)

* 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 Conclusions and Recommendations

HSAG used MDHHS' and its contracted vendor's analyses and evaluations of EQR activity findings from the 2022–2023 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] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

1-3 highlights substantive findings and actionable state-specific recommendations for MDHHS to further promote the goals and objectives of Michigan's Comprehensive Quality Strategy (CQS)[1-4] and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to MI Choice Waiver Program members.

Table 1-3—MI Choice Waiver Program Conclusions and Recommendations

EQR Activity	Overall Performance Impact	Performance Domain
Validation of PIPs	**Conclusions:** PIPs are used to design projects for improvement using targeted initiatives to positively change behavior at a member, provider, or system level. Effective PIPs must have a baseline, a goal, and at least two remeasurement periods. In state fiscal year (SFY) 2022, MDHHS required all waiver agencies to conduct PIPs for the *Prevalence of Falls* and *Prevalence of Any Injuries* in an effort to decrease the two rates. As several waiver agencies already met the statewide goals, those waiver agencies' goals were reduced to the prior year's rate; therefore, these waiver agencies could meet the goal without any performance improvement. However, since the purpose of a PIP is continuous sustainable improvement, the goals for those waiver agencies did not encourage improvement in the rates and a reduction in falls and injuries. Additionally, MDHHS required the PIP related to *Falls with Injury* for SFY 2023, and while several waiver agencies have room to improve this rate, based upon baselines reported by some waiver agencies, their rate is already between 0 percent and 1 percent, leaving very little room to improve the prevalence of falls resulting in injuries. As the purpose of a PIP is to improve upon rates that are not meeting performance thresholds, the PIP is not conducive for performance improvement for those waiver agencies. Additionally, for PIPs for which data are collected less than annually (i.e., six months) the waiver agencies and MDHHS should also report results using data for the entire state fiscal year. Although waiver agencies and MDHHS were able to obtain data for the entire year or at any point during the year, MDHHS and the waiver agencies compared the baseline data for only the first six months of the state fiscal year, then the results of only the first six months of the following state fiscal year. An entire six months of data were not used by MDHHS for the entire annual remeasurement period to identify and analyze all falls and injuries that had occurred during that time and to learn if there are differences in the types of	☒ Quality ☐ Timeliness ☐ Access

[1-4] 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: Jan 5, 2024.

EQR Activity	Overall Performance Impact	Performance Domain
	falls and injuries that may occur during the time period for which data were not compared. Omitting these data from the study does not provide a complete assessment of falls and injuries for the entire year and may limit the waiver agencies from identifying initiatives that could support the reduction of all falls and injuries that may occur over the state fiscal year (i.e., falls occurring due to seasonal changes, such as icy conditions). Further, several waiver agencies' PIP documentation demonstrated the following findings: • PIP designs and the methodologies used for evaluating outcomes and the success of the PIPs were not comprehensive or were unclear. • Documentation of 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 PIP documentation. 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. Lastly, while MDHHS provided limited feedback to the waiver agencies regarding their PIPs through an annual review of the Quality Assessment and Performance Improvement (QAPI) program description, MDHHS, MDHHS' agent who is not a waiver agency, or an EQRO did not validate each waiver agency's PIP in accordance with the CMS EQR Protocols, as determined through the documentation issues noted during the EQR. **Recommendations:** 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.	

EQR Activity	Overall Performance Impact	Performance Domain
	• 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 a clinical and nonclinical PIP and has emphasized the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1), requirements for a PIP that must be included in the waiver agencies' QAPI program descriptions, HSAG recommends that MDHHS require the waiver agencies to set goals that encourage improvement from the baseline rate. HSAG also recommends that MDHHS select PIP topics that support opportunities for improvement (i.e., address lower performing program areas) for 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*, February 2023 (CMS EQR Protocol 8). MDHHS may want to consider whether it would be appropriate to require a general area of focus and request that each waiver agency identify specific PIP topics within the general area of focus that would support improvement for their particular waiver agency through internal data analyses (e.g., a baseline rate of 90 percent may not signify an appropriate area requiring improvement). Additionally, MDHHS should require the waiver agencies to continue the PIP for at least two remeasurement periods after the baseline (i.e., at least three full years of data collection and analysis) to monitor improvement over time and give the waiver agencies sufficient time to implement interventions and improve member outcomes. Further, 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, using the documentation provided by the waiver agencies to verify that each waiver agency used sound methodology in its design, implementation, and outcomes of the PIPs. HSAG strongly recommends that MDHHS reference the PIP worksheets within CMS EQR Protocol 1 to ensure all validation requirements are met. MDHHS must also assign two validation ratings based on the assessment of whether the PIP adhered to an acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and	

EQR Activity	Overall Performance Impact	Performance Domain
	produced evidence of significant improvement in accordance with the CMS EQR Protocol 1.	
PMV	**Conclusions:** MDHHS must use performance measures to monitor the performance of individual waiver agencies at a point in time, to track performance over time, to compare performance among waiver agencies, and to inform the selection and evaluation of quality improvement activities. MDHHS must specify standard performance measures which the waiver agencies must include in their QAPI programs. Based on the documentation provided for the PMV activity, HSAG determined that 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 measure data 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 Clinical Quality Assurance Review (CQAR) process assessed waiver agency compliance with waiver-specific standards and contract requirements through a sample of record reviews and home visits, the CQAR process did not assess aggregated waiver agency performance in alignment with the performance measures reported by MDHHS in the CMS-372 report. The contract with the waiver agencies also does not outline specific performance measure reporting as required by 42 CFR §438.330(c), and subsequently, the waiver agencies were not annually measuring and reporting to MDHHS on any required performance measure standards. **Recommendations:** 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 for validation. MDHHS should specifically require the waiver agencies to report the numerators, denominators, and performance measure rates that align with the MI Choice Waiver	☒ Quality ☐ Timeliness ☐ Access

EQR Activity	Overall Performance Impact	Performance Domain
	Program performance measures identified within Appendix D: 2023–2026 Comprehensive Quality Strategy (CQS) Goals & Objectives Metrics Table of the 2023–2026 MDHHS CQS. Currently, MDHHS collects a limited sample of data per waiver agency through the CQAR process (e.g., 10 records per waiver agency, and some selected records may not be applicable for all standards being reviewed). Performance measure rates should include all applicable data (i.e., denominators should include the entire population, as applicable) or, in lieu of the entire population when it is not appropriate for a particular performance measure, a statistically significant representative sample per waiver agency in accordance with the performance measure specification. In addition to the performance measures identified within the 2023–2026 MDHHS CQS, MDHHS should also consider identifying standard performance measures that relate specifically to quality of life, rebalancing, and community integration activities. 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. CMS offers nationally standardized long-term services and supports (LTSS) quality measures, which are available at www.Medicaid.gov. For the performance measures identified for waiver agency reporting, MDHHS should update its contract to specifically include each required performance measure. MDHHS should also notify the waiver agencies of the reporting requirements and the performance measures' specifications for calculating numerators and denominators and the percentage rates. MDHHS should also provide a timeline in which the waiver agencies must submit to MDHHS the calculated rates and supporting data for each performance measure identified so that MDHHS can conduct the validation activities (i.e., pre-site visit, site visit, and post-site visit) in accordance with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 2). For future EQR technical reports, MDHHS must provide the EQRO (i.e., HSAG) the individual waiver agency performance measure rates for all required performance measures. HSAG can use the MDHHS-established performance measure benchmarks to gauge waiver agency performance against MDHHS' set expectations.	

EQR Activity	Overall Performance Impact	Performance Domain
Compliance Review	**Conclusions:** Federal regulations require waiver agencies to have undergone a review within the three-year period preceding each annual EQR to determine waiver agency compliance with federal standards. The standards that are the subject of the compliance review activity are stipulated within 42 CFR §438.358(b)(1)(iii). While MDHHS has contracted with a vendor to conduct an annual waiver agency record and home visit review (i.e., CQAR), which focus on waiver-specific requirements and whether care management and service delivery processes 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 poststabilization 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 Annual Quality Assurance Review (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 within the previous three-year period. Further, HSAG provided MDHHS with a crosswalk to compare MDHHS' compliance review standards with the federally required standards. Although the crosswalk identified specific standards within focus areas that MDHHS associated with a federal standard, most of MDHHS' cited standards did not align with most requirements under each of the federal standards. For example, MDHHS cited *15.3 Did the Waiver Agent (WA) adhere to MDHHS policy when the participant/guardian filed an appeal?* but the file review tool used by the vendor did not include all federal appeals requirements that apply to timeliness, extensions, content of notices, etc. Therefore, HSAG is unable to confirm that all rules associated with federal standards are included in MDHHS' compliance review process.	☒ Quality ☐ Timeliness ☐ Access

EQR Activity	Overall Performance Impact	Performance Domain
	Recommendations: 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 member rights requirements described in 42 CFR §438.100, the emergency and poststabilization services requirements described in 42 CFR §438.114, and the quality assessment and performance improvement requirements described in 42 CFR §438.330. MDHHS must ensure that it conducts a comprehensive compliance review during each three-year cycle. The review must include all federally mandated standards for MCEs, which include PAHPs (i.e., the waiver agencies). The compliance review activity must align with CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations*: *A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3), using documents from and interviews with the waiver agencies to verify compliance with federal regulations and State requirements. HSAG strongly recommends that MDHHS reference the compliance review worksheets within CMS EQR Protocol 3 to ensure a comprehensive review. MDHHS should also use the crosswalk (included in Section 3 of this EQR technical report) of the standards currently reviewed as part of the CQAR and compare to the standards required to be part of a compliance review according to 42 CFR §438.358(b)(1)(iii). As part of this review, MDHHS should identify all federal requirements under a standard including all subelements (e.g., 42 CFR §438.210[a]-[e] referenced under the Coverage and Authorization of Services standard) and compare to the current standards being reviewed to identify gaps in the scope of MDHHS' compliance review activity and requirements being assessed. Based on the comparison findings, MDHHS should immediately begin preparations to address all gaps identified.	

Table 1-4—Programwide Conclusions and Recommendations by CQS Goal

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1—Ensure high quality and high levels of access to care	**Conclusions:** The results of the PMV activity confirmed that MDHHS and the MI Choice Waiver Program are making improvements in achieving Goal #1 of the CQS in the following performance measures: • Performance Measure 15—*number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* Although the statewide rate decreased by 2.35 percentage points from the prior year, the rate continued to demonstrate high performance at 94.76 percent. • Performance Measure 16—*number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* Although the statewide rate decreased by 5.5 percentage points from the prior year, the rate continued to demonstrate high performance at 93.19 percent. • Performance Measure 20—*number and percent of participants who received all of the services and supports identified in their person-centered service plan.* Although the statewide rate decreased by 2.87 percentage points from the prior year, the rate continued to demonstrate high performance at 90.31 percent. • Performance Measure 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.* The statewide rate for this measure improved to 100 percent. Additionally, the results of the CQAR activity demonstrated high performance in the following focus areas: • MI Choice Services—All 20 waiver agencies received a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. • Service Provider—19 waiver agencies received a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. Further, the results of the CAHPS HCBS activity demonstrated high performance across all measures that affect access to quality services, including *Choosing the Services that Matter to You, Transportation to Medical Appointments, Personal Safety and Respect, Met Need,* and *Physical Safety Measure*.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	However, the results of the PMV activity also demonstrated continued opportunities to enhance access to quality care as several performance measure rates declined from the previous year. Additionally, two performance measure rates indicated a negative impact to quality and timely access to care, including Performance Measure 1 (*number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*) and Performance Measure 30 (*number and percent of participants with an individualized contingency plan for emergencies [e.g., severe weather or unscheduled absence of a caregiver]*) as the statewide rate for Performance Measure 1 was 86.65 percent and for Performance Measure 30 was 42.67 percent, demonstrating opportunities to improve timely completion of service plans and the prevalence of contingency plans available in the event of emergencies. Further, the results of the CQAR activity showed continued opportunities to enhance access to quality care as several focus areas demonstrated low performance: • Follow-Up and Monitoring—Seven waiver agencies received a *Not Full or Substantial* compliance level, indicating more than a third of the waiver agencies did not fully or substantially adhere to MI Choice waiver requirements. • Contingency Plan—Seven waiver agencies received a *Not Full or Substantial* compliance level, indicating more than a third of the waiver agencies did not fully or substantially adhere to MI Choice waiver requirements. • Critical Incidents—Eleven waiver agencies received a *Not Full or Substantial* compliance level, indicating more than half of the waiver agencies did not fully or substantially adhere to MI Choice waiver requirements. • Adverse Benefit Determination—Ten waiver agencies received a *Not Full or Substantial* or *Not Demonstrated* compliance level, indicating half of the waiver agencies did not fully or substantially adhere to or did not adhere to MI Choice waiver requirements. Lastly, within the PIP activity, the statewide rate for the *Prevalence of Falls* PIP scored 23.5 percent, which is 0.5 percentage points above the goal, and the statewide rate for the *Prevalence of Any Injuries* PIP scored 3.3 percent, which is 0.3 percentage points above the goal. For both PIPs, a lower percentage is a better rate. Therefore, performance has slightly worsened from the prior year's statewide	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	rates, indicating that more members experienced falls or injuries during the assessment period. These results indicate that while most members received all the services and supports they needed according to their assessed needs, were assisted with identifying and mitigating any risks to their health and safety, and were generally happy with the services, MDHHS and the MI Choice Waiver Program continue to have opportunities to improve access to waiver services for all members and ensure members' health and safety when risks are identified, particularly when supports coordinators are not directly providing services (i.e., during times when the member is not with the supports coordinator). **Recommendations:** MDHHS could continue to request that the waiver agencies consider system enhancements and/or use existing system capabilities to remind supports coordinators when assessments are due (Performance Measure 1) and require a contingency plan to be completed before moving forward in the system (Performance Measure 30). System reminders can also be used for other time bound requirements to ensure supports coordinators complete those requirements timely, which could support improvement in the Follow-Up and Monitoring and Critical Incidents CQAR focus areas. Additionally, MDHHS could collaborate with the waiver agencies and determine fields within the system that should be required to prevent supports coordinators from moving forward until those fields are complete. System enhancements could also improve performance in several performance measures and CQAR focus areas and assist supports coordinators with identifying any new health and safety concerns members may have or any new health conditions to better coordinate the care members need. Additionally, identifying critical incidents and the root causes of those incidents helps supports coordinators address and mitigate causes of incidents, which can improve member safety and health outcomes. MDHHS has retired the *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs; however, waiver agencies are still required to monitor performance in these measures, and interventions implemented could support improvement in the SFY 2023 required PIP, *Falls with Injury*. Therefore, HSAG recommends that MDHHS and its contracted waiver agencies collaborate to identify evidence-based interventions that improve performance in preventing falls and implement those interventions statewide.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** The results of the PMV activity confirmed that MDHHS and the MI Choice Waiver Program are making improvement in achieving Goal #2 of the CQS in the following performance measures: • Performance Measure 4—*number and percent of appropriate level of care determinations (LOCDs) found after MDHHS review*. Although the rate for this measure decreased slightly from the SFY 2021 rate, the rate continued to demonstrate high performance at 98.95 percent. • Performance Measure 8—*number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied*. The rate improved to 100 percent for this measure. • 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.* Although this performance measure decreased by 3.65 percentage points, the rate continued to demonstrate high performance at 91.1 percent. • Performance Measure 22—*number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* The rate improved to 100 percent for this measure. • Performance Measure 38—*number and percent of service plans that supported paid services.* The rate for this measure demonstrated high performance at 99.48 percent. Additionally, through the CQAR activity, the MI Choice Waiver Program demonstrated strong performance in the following focus areas related to person-centered care coordination: • Pre-Planning—All 20 waiver agencies scored a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. • Assessment—All 20 waiver agencies scored a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. • Person-Centered Service Planning—All 20 waiver agencies scored a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. Further, the results of the CAHPS HCBS activity demonstrated high performance across several measures that affect person-centered	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	care, including *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, and *Case Manager is Helpful*. However, the results of the PMV activity also demonstrated continued opportunities to enhance person-centered care as several performance measure rates declined from the previous year or were below 90 percent. These performance measure results that indicated a negative impact on quality and access to care included Performance Measure 17 (*number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*), Performance Measure 19 (*number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*), and Performance Measure 21 (*number and percent of waiver participants whose records indicate choice was offered among waiver services*). Additionally, through the CAHPS HCBS activity, although the rate increased 3.1 percentage points from SFY 2021, the MI Choice Waiver Program demonstrated low performance in the *Planning Your Time and Activities* domain, with a statewide rate of 78.5 percent. These results indicate that members were generally being assessed appropriately and were satisfied with their supports coordinators, care team, and the waiver agency. However, many members were not always offered choices among the services they received and felt that they were not able to participate in their communities or enjoy time with family and friends as much as they would have liked. Patients who have a say in their care are more likely to follow the recommendations of their healthcare team and comply with treatment plans. Additionally, to have a good quality of life, it is important that members can participate in their communities and be with family and friends. Person-centered care coordination helps members to achieve these goals. **Recommendations:** Person-centered care is paramount to overall good health outcomes. To improve performance in person-centered care coordination, MDHHS could continue to request that the waiver agencies consider system enhancements and/or use existing system capabilities to remind supports coordinators when tasks are due and to require certain fields to be completed before moving forward in the system. Additionally, MDHHS could conduct periodic statewide trainings that focus on the CQAR requirements	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	frequently missed by a large percentage of the waiver agencies. To help improve the *Planning Your Time and Activities* CAHPS domain, MDHHS could require the waiver agencies to deep dive into the questions on the CAHPS survey that directly impact this domain and conduct a root cause analysis determining why the domain has a low score and implement interventions to eliminate barriers. Further, MDHHS should require the waiver agencies to report and evaluate their CAHPS HCBS results through their QAPI programs and include activities to address lower performing areas.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)	**Conclusions:** Because the MI Choice Waiver Program provides only the HCBS benefits for Medicaid members and medical care and behavioral healthcare are provided through other Michigan Medicaid programs, it is important that the MI Choice Waiver Program coordinate benefits and care between all programs to ensure the best possible outcomes for members. The results of the CQAR activity demonstrated high performance in the Linking and Coordinating focus area as 19 waiver agencies received a *Substantial* or *Some Compliance, Needs Improvement* compliance level. This result indicates that supports coordinators help link members with the waiver and non-waiver services they may need. However, MDHHS does not currently have other performance metrics to measure meaningful collaboration across program areas and delivery systems; support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations; or promote the use and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize member outcomes. **Recommendations:** Although most waiver agencies scored high in the Linking and Coordinating CQAR focus area, MDHHS should develop additional metrics to measure the waiver agencies' collaboration across programs and other payers of services (e.g., fee-for-service [FFS] and prepaid inpatient health plans [PIHPs]), transitions across the continuum of care, and adoption of health information technology to optimize member outcomes.	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** According to the Centers for Disease Control and Prevention (CDC), "racial and ethnic minority groups, throughout the United States, experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts."[1-5] In order to improve outcomes for racial and ethnic minority groups, MDHHS and its waiver agencies should develop initiatives directed toward these individuals, taking into account any cultural needs and preferences. Through the review of the existing EQR activities, HSAG did not identify activities or performance metrics that focused on and addressed racial and ethnic disparities that align with MDHHS' objectives under Goal #4. However, the MDHHS CQS 2023–2026 indicates that MDHHS received a grant from the Michigan Health Endowment Fund (MHEF), which provided funding for various programs under MDHHS, including the MI Choice Waiver Program, to develop a health equity project to assist the MI Choice Waiver Program with identifying barriers to and increasing the use of HCBS. Through this project, the MI Choice Waiver Program goals are to provide opportunities, services, and programs to ensure equitable access to Michigan's HCBS programs. Project activities include working with local communities to learn what keeps someone from using HCBS services and analysis of Medicaid data to determine if HCBS services offered to individuals differ based on race or ethnicity. **Recommendations:** HSAG recommends that MDHHS and the MI Choice Waiver Program continue work on the health equity project, and through this project, identify specific performance metrics to monitor the reduction of racial and ethnic disparities across the MI Choice Waiver Program. MDHHS should also update the CQS to add new objectives under Goal #4 that align to the newly created performance metrics specific to the MI Choice Waiver Program. Additionally, MDHHS could require each waiver agency to conduct a PIP that focuses on health disparities identified within its low-performing program areas.	☒ Quality ☐ Timeliness ☒ Access

[1-5] Centers for Disease Control and Prevention. Racism and Health, September 18, 2023. Available at: https://www.cdc.gov/minorityhealth/racism-disparities/index.html. Accessed on: Jan 8, 2024.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** The aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had on improving quality outcomes and disparity reduction through value-based initiatives and payment reform. **Recommendations:** If appropriate, MDHHS could implement requirements for waiver agencies to use value-based payment models to improve quality of care. This could include incentives for specific HCBS that may be lacking in their service area in order to incentivize providers to employ additional staff. Additionally, MDHHS could collaborate with other programs' leaders to identify potential value-based payment models that have supported improvement in quality outcomes and disparity reduction.	☒ Quality ☐ Timeliness ☒ Access

2. Overview of the MI Choice Waiver Program

Managed Care in Michigan

BPHASA within MDHHS administers and oversees the Michigan Medicaid managed care programs. Table 2-1 displays the Michigan Medicaid managed care programs, including the MI Choice Waiver Program, and the MCE(s) responsible for providing services to members.

Table 2-1—2022–2023 Michigan Medicaid Managed Care Programs

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
Comprehensive Health Care Program (CHCP)				
Medicaid Health Plans (MHPs)	Managed Care Organization (MCO)	1915(b)	July 1997	MHPs provide comprehensive healthcare services to low-income adults and children.
• MIChild (CHIP)		1915(b)	January 2016	MIChild is a Medicaid program for low-income uninsured children under the age of 19.
• Children's Special Health Care Services (CSHCS)		Michigan Medicaid State Plan	October 2012	CSHCS is a program within MDHHS for children and some adults with special health care needs and their families.
Healthy Michigan Plan (HMP) (Medicaid Expansion)	MCO	1115 Demonstration	April 2014	HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment.
Flint Medicaid Expansion (FME) Waiver	MCO	1115 Demonstration	March 2016	The waiver provides Medicaid coverage and benefits to individuals affected by the Flint Water Crisis.
MI Health Link Demonstration (Integrated Care Organizations [ICOs])	ICO	1915(b) & 1915(c)	March 2015	Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age of 21 and reside in one of the four regions where the program is available.
MI Choice Waiver Program (PAHPs)	PAHP	1915(c) since 1992 1915(b) since 2012	1992	The elderly or disabled adults (aged 18+) who meet the NFLOC.

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
Dental Health Programs				
Healthy Kids Dental (HKD) (PAHP)	PAHP	1915(b)	October 2016	The HKD program provides dental services to beneficiaries under age 21.
Adult Dental (MHPs)	MCO	1915(b)	April 2023	Medicaid beneficiaries aged 21 years and older, including HMP beneficiaries and pregnant individuals who are enrolled in an MHP, ICO, or Program of All-Inclusive Care for the Elderly (PACE) receive dental benefits through their MHP.
Behavioral Health Managed Care **Children's Behavioral Health—Bureau of Children's Coordinated Health Policy & Supports (BCCHPS)** **Adult Behavioral Health—Bureau of Specialty Behavioral Health Services (SBHS)**				
Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs)	PIHP	Behavioral Health 1115 Demonstration Waiver	October 2019	Individuals with intellectual and developmental disability (I/DD), serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD).
		1915(i) SPA [State Plan Amendment]	October 2022	
		1115 HMP	April 2014	
		Flint 1115 Waiver or Community Block Grant	May 2016	
		1915(c) Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP), and Children's Serious Emotional Disturbance Waiver (SEDW)	October 2019	

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 2022–2023 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) during the time period under review.

Table 2-2—Waiver Agency Profiles

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 • Community living supports (CLS) • Community transportation • Counseling • Environmental accessibility adaptations • Fiscal intermediary • Goods and services • Home delivered meals • Nursing services	Region 7	Accredited—NCQA (Case Management)
Area Agency on Aging 1-B		Region 1B	Accredited—NCQA (Case Management; expired 08/22/23)
Area Agency on Aging of Northwest Michigan		Region 10	Accredited—NCQA (Case Management)
Area Agency on Aging of Western Michigan		Region 8	Accredited—NCQA (Case Management)
Detroit Area Agency on Aging		Region 1A	Accredited—NCQA (Case Management)
Easterseals/MORC		Region 1B	Accredited—NCQA (Case Management; expired 07/11/23)
Milestone Senior Services		Region 3	Not Accredited

Agency	Covered Services	Service Area/ Regions Served	Accreditation Status/Accrediting Body
Northern Health Care Management	• Personal emergency response system (PERS) • Private duty nursing/respiratory care • Respite services • Specialized medical equipment and supplies • Training in a variety of independent living skills	Region 10	Accredited—NCQA (Case Management; expired 07/05/23)
Region 3B Area Agency on Aging/Carewell Services		Regions 3 and 4	Not Accredited
Region 9 Northeast MI Community Service Agency		Region 9	Accredited—NCQA (Case Management; expired 07/11/23)
Region IV Area Agency on Aging		Region 4	Accredited—NCQA (Case Management)
Region VII Area Agency on Aging		Region 7	Accredited—NCQA (Case Management; expired 09/26/23)
Reliance Community Care Partners		Regions 8 and 14	Accredited—NCQA (Case Management)
Senior Resources		Region 14	Accredited—NCQA (Case Management)
The Information Center		Region 1C	Accredited—NCQA (Case Management; expired 07/11/23)
The Senior Alliance		Region 1C	Accredited—NCQA (Case Management; expired 08/08/23)
Tri-County Office on Aging		Region 6	Accredited—NCQA (Case Management)
UPCAP Care Management, Inc.		Region 11	Not Accredited
Valley Area Agency on Aging		Region 5	Accredited—NCQA (Case Management; expired 09/12/23)
WellWise Services Area Agency on Aging		Region 2	Accredited—NCQA (Case Management)

Quality Strategy

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

Table 2-3—2020–2023 MDHHS CQS Goals and Ojectives

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

[2-1] The 2020–2023 MDHHS CQS was submitted to CMS and published on the MDHHS website in January 2021. Due to the timing of the EQR activities, and at the direction of MDHHS, HSAG used the 2020–2023 MDHHS CQS for the 2022–2023 EQR assessment. However, the 2023–2026 MDHHS CQS was submitted to CMS in October 2023 and has replaced the 2020–2023 version on MDHHS' website. The 2023–2026 MDHHS CQS is now available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=c062404614184b219a8e4b1d6ddd520a.

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

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

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

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

These domains address the required state-defined network adequacy and availability of services standards and take into consideration the health status of all populations served by the MCEs in

Michigan. Each program also has identified performance measures that are specific to the populations it serves.

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

3. Assessment of Waiver Agency Performance

HSAG used findings across mandatory and optional EQR activities conducted during the preceding 12 months 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 weaknesses 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 during the preceding 12 months to provide context for the resulting findings of each EQR activity. As HSAG did not conduct most 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 related time period, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

The waiver agencies implemented two PIPs, previously referred to as "quality indicators" by the MI Choice Waiver Program, that were initiated in SFY 2022 with a baseline of SFY 2021 data. Each waiver agency develops a QAPI program description, previously referred to as the Quality Management Plan (QMP), biennially that addresses CMS and MDHHS quality requirements, including the MDHHS-required PIPs. MDHHS also requires each waiver agency to compile an annual report, called the MI Choice Summary of Quality Management Plan Activities & Outcomes Report,[3-1] which provides a description of each waiver agency's quality management activities and outcomes. Throughout this report, the QAPI program description and the annual report are collectively referred to as "QAPI reports." At MDHHS' discretion, the MI Choice Quality Management Collaboration (QMC) members vote on two PIPs and the associated quality indicators, goals, and strategies. Waiver agency progress of each PIP and the associated measure indicators are reported annually to MDHHS through the MI Choice Summary of Quality Management Plan Activities & Outcomes Report. Table 3-1 outlines the two PIP measure indicators for the waiver agencies for the SFY 2022 and SFY 2023 review years, and the MDHHS-defined statewide goals, when available, for each PIP measure indicator. As this is the first year of the SFY 2023 PIPs, only the PIP design was included in this annual EQR technical report.

Table 3-1—PIP Indicators and Goals

PIP Indicators	MDHHS Statewide Goals
2022 PIPs	
1. *Prevalence of Falls*	23%
2. *Prevalence of Any Injuries*	3%
2023 PIPs	
1. *Prevalence of Falls with Injury*	No established statewide goal; goal determined by each waiver agency.
2. *[Determined by Waiver Agency]*	Goal determined by each waiver agency.

[3-1] The actual name of each waiver agency's report varies across waiver agencies.

Performance Measure Validation

The PMV activity comprised information derived from the CQAR, in which reviewers from the Michigan Public Health Institute (MPHI) selected and evaluated a sample of records from each waiver agency and provided the resulting data to MDHHS to calculate applicable performance measures in the Form CMS-372(S) Annual Report on Home- and Community-Based Services (HCBS) Waivers and Supporting Regulations (CMS-372 report) that is submitted to CMS and used to determine program wide performance 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 included as part of the CMS-372 report. 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 rates were 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. However, 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 database (i.e., critical incident database for Participant Safeguards measures). However, waiver agency-specific data were not available for HSAG to calculate waiver agency-specific rates. 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(i) waiver application for the MI Choice Waiver Program.

Table 3-2—Performance Measures and Source Data

Performance Measure		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 QMP activity and outcome reports that illustrate they are adhering to their QMP.*	Reports	100% review

	Performance Measure	Source Data	Sampling Approach
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
7	*Number and percent of LOCDs made by a qualified evaluator.*	CQAR	Representative sample
8	*Number and percent of participants who had initial LOCDs or redeterminations 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	Unable to gather data*
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 of 20% of providers in the network
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

	Performance Measure	Source Data	Sampling Approach
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
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

	Performance Measure	Source Data	Sampling Approach
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
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

* The CMS-372 report included a statement that MDHHS was unable to gather and calculate the data for this performance measure as it has data limitations.

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* (noncompliant), or *NA* (not applicable). 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 2022 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, and which federal citations align to each of the focus areas.

Table 3-3—CQAR Standards[1]

Standards		Record Review	Home Interview	Associated Federal Citations
Focus 1	Level of Care Determination[2]	✓	✓	
Focus 2	Freedom of Choice	✓		§438.56
Focus 3	Release of Information	✓		§438.224
Focus 4	Status	✓		§438.56
Focus 5	Pre-Planning	✓	✓	§438.10 §438.100 §438.214
Focus 6	Assessment[2]	✓	✓	
Focus 7	Medication Record[2]	✓	✓	
Focus 8	Person-Centered Service Planning	✓	✓	§438.10 §438.100 §438.206 §438.207 §438.208
Focus 9	MI Choice Services	✓	✓	§438.10 §438.100 §438.206 §438.207 §438.210
Focus 10	Linking and Coordinating	✓	✓	§438.208
Focus 11	Follow-Up and Monitoring	✓	✓	§438.206 §438.207 §438.208 §438.214

Standards		Record Review	Home Interview	Associated Federal Citations
				§438.224
Focus 12	Service Provider[2]	✓		
Focus 13	Contingency Plan[2]	✓	✓	
Focus 14	Critical Incidents	✓	✓	§438.10 §438.100
Focus 15	Adverse Benefit Determination	✓		§438.10 §438.56 §438.100 §438.228
Focus 16	Complaints and Grievances	✓		§438.228
Focus 17	Home and Community Based		✓	§438.10 §438.100

[1] The associated federal citations and CQAR standards were provided by MDHHS and not determined by HSAG, nor did HSAG validate this information. Additionally, this crosswalk should not be interpreted to mean the State's standards include all specific federal requirements under 42 CFR §438.358(b)(1)(iii). Further, the Practice Guidelines program area was not reviewed by MDHHS, and while MDHHS indicated HSAG conducts an EDV activity, the HSAG EDV activity is not a substitute for conducting a compliance review of the Health Information Systems program area.

[2] MDHHS did not assign focus areas 1, 6, 7, 12, or 13 to an associated federal standard.

Encounter Data Validation

In SFY 2023, HSAG conducted and completed EDV activities for all 20 waiver agencies. The EDV activities included:

- Information Systems (IS) review—assessment of MDHHS' and the waiver agencies' IS and processes. The goal of this activity was to examine the extent to which MDHHS' and the waiver agencies' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's [Managed Care Plan's] Capability in CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5).
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the waiver agencies in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

Consumer Assessment of Healthcare Providers and Systems Survey

In SFY 2022, MDHHS contracted with the Institute for Health Policy (IHP) College of Human Medicine (CHM) at Michigan State University to conduct the CAHPS HCBS survey. SFY 2023 survey results were not available for the 2022–2023 EQR assessment; therefore, the SFY 2023 results will be published in the SFY 2024 EQR technical report.

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 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 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

External Quality Review Activity Results

A&D Home Health Care

Validation of Performance Improvement Projects

Performance Results

Table 3-5 displays the PIPs in place during SFY 2022. Table 3-5 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **A&D Home Health Care** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **A&D Home Health Care** did not meet the statewide goal or the *New 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 MDHHS and were not validated by HSAG.

Table 3-5—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less. *New Goal*: 19.6% or lower	SFY 2021 = 19.6% SFY 2022 = 18.80% ☑
Interventions: • When trends were discovered, additional education was provided to waiver staff on the prevalence of falls. Education included, but was not limited to, fall prevention, alternative home safety options, and universal best practices to assist in fall reduction. • Implementation of the Stopping Elderly Accidents, Deaths & Injuries (STEADI) program obtained from the Centers for Disease Control and Prevention (CDC). • All supports coordinators have completed the Model of Care certification and utilized resources obtained from the program as individuals with fall risks were identified. • Contracted with an Occupational Therapist to assist with home evaluations and durable medical equipment recommendations and to provide education on safe transfers and fall prevention. • Addition of the fall risk screening and fall risk checklist.		
PIP Validation Feedback: MDHHS did not provide any feedback to **A&D Home Health Care**.		

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less. *New Goal*: 2.7% or lower	SFY 2021 = 2.7% SFY 2022 = 1.30% ☑
Interventions: • Quality Assurance completed audits on the individual participants reporting injuries to identify trends and possible solutions to decrease the prevalence of any injury. Through the completion of the audits, participants who may have experienced a critical incident were reviewed to ensure timely reporting to the State of Michigan via the Critical Incident portal. • When trends were discovered, additional education was provided to waiver staff on the prevalence of injuries. Education included, but was not limited to, education on critical incidents, alternative options to ensure participant safety, and universal best practices to ensure safety.		
PIP Validation Feedback: MDHHS did not provide any feedback to **A&D Home Health Care**.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.
±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.
☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.
☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.
Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-6 displays the two PIPs **A&D Home Health Care** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-6 is displayed as reported by **A&D Home Health Care** and was not validated by HSAG.

Table 3-6—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	The goal of A&D is to reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less. The current statewide average is 27.3%.	Baseline: 20.35%[1] SFY 2023: Not yet reported

PIP Topic	Goal	Measurement and Outcome
	In lowering the prevalence of falls, this in turn, should lower the prevalence of falls with injuries.	
Interventions: • Agency will review each fall screening to discover potential trends which can be altered to decrease falls. • Root cause analysis reviews will be completed on an as needed basis for additional discovery.		
PIP Validation Feedback: MDHHS provided the following feedback to **A&D Home Health Care**: • Clinical Focus PIP #3 covers Prevalence of Falls vs. Falls with Injuries instructed in the outline.		
Timeliness of Monitoring Contacts and Reassessments	Increase Monitoring Contacts & Assessments timeliness by supports coordinators to an acceptable monthly compliance rating (preferred rating of 95% or higher).	Monitoring Contacts: Baseline[2]: 89.2% SFY 2023: Not yet reported Assessment Timeliness: Baseline[2]: 91.9% SFY 2023: Not yet reported
Interventions: • Root cause analysis reviews will be completed on an as needed basis for additional discovery.		
PIP Validation Feedback: MDHHS did not provide any feedback to **A&D Home Health Care** regarding this PIP.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

[1] The waiver agency's reported SFY 2022 baseline rate for the prevalence of falls within the 2023–2024 QAPI is different than the SFY 2022 prevalence of falls rate reported by MDHHS for the SFY 2022 *Prevalence of Falls* PIP, as the data were calculated on a different timing.

[2] While the waiver agency reported SFY 2021 rates as its baseline, the PIP was only implemented in SFY 2023; therefore, SFY 2022 should be used as the baseline. Additionally, the waiver agency only reported SFY 2022 rates per quarter and not an annual aggregate; therefore, HSAG used Quarter 4 as the SFY 2022 baseline as it was the last reported data. Although the waiver agency appeared to initiate this PIP in SFY 2022, HSAG only reported SFY 2023 PIP data as MDHHS mandated the nonclinical PIP in SFY 2023.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 the MDHHS-established goal (i.e., *New Goal*) for the *Prevalence of Falls* PIP. The reduction in the prevalence rate for this PIP was primarily attributed to the implementation of the STEADI program as indicated by the waiver agency. [**Quality**]

Strength #2: A&D Home Health Care met the MDHHS-established goals (i.e., *New Goal*) for the *Prevalence of Any Injuries* PIP. The waiver agency reported that the reduction in prevalence rates for this PIP was primarily attributed to better data collection processes resulting in a more accurate representation of the occurrence injuries within its population. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The 2022 PIP goals identified in **A&D Home Health Care**'s QMP and annual report did not align with MDHHS-required goals. As performance measures 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: MDHHS required all waiver agencies to meet a statewide goal. However, for waiver agencies whose baseline measurement already met the statewide goal, MDHHS assigned the individual waiver agency a *New Goal*. **A&D Home Health Care** only included the statewide goal in its QMP documentation.

Recommendation: HSAG continues to recommend that **A&D Home Health Care** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals that align with MDHHS' expectations. These goals should be consistently documented within its QMP reports and should not change through the measurement period of the PIP unless documentation is provided to support the rationale for the change.

Weakness #2: A&D Home Health Care's PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: A&D Home Health Care calculated its PIP results on a different timing schedule than MDHHS (i.e., **A&D Home Health Care** calculated its results based on the full state fiscal year, and MDHHS calculated the results only on the first half of the state fiscal year for baseline and remeasurement).

Recommendation: HSAG continues to recommend that **A&D Home Health Care** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **A&D Home Health Care** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: A&D Home Health Care's clinical PIP beginning in 2023 was required by MDHHS to focus on *Falls with Injury*; however, the waiver agency's outcome measurement and goal includes the prevalence of all falls. **A&D Home Health Care**'s goal for the *Falls with Injury* PIP also does not drive performance improvement. [**Quality**]

Why the weakness exists: While HSAG understands that a measurement that includes the prevalence of all falls should ultimately lead to a reduced rate of falls resulting in injury, it is important to measure the actual outcomes related to the specific PIP. Additionally, the SFY 2022 baseline rate reported by **A&D Home Health Care** was already meeting its defined goal; therefore, **A&D Home Health Care**'s goal is counterintuitive (i.e., **A&D Home Health Care**'s performance may actually decline, but the goal of the PIP could still be met). Defining an appropriate measurement is key to successful intervention implementation.

Recommendation: HSAG recommends that **A&D Home Health Care** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **A&D Home Health Care** in a methodologically sound manner. HSAG further recommends that **A&D Home Health Care**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **A&D Home Health Care** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **A&D Home Health Care** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **A&D Home Health Care** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-7 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-7 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-7, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-7—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**90.32%**	**93.55%**	**86.65%**
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	**96.18%**	**93.71%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**97.64%**	**94.57%**	**94.76%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**98.39%**	**95.16%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**95.16%**	**70.97% ↓**	**82.72%**
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	**92.41%**	**91.18%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**93.75%**	**94.64%**	**88.74%**
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	**85.00%**	**88.89%**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**96.77%**	**90.32% ↓**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**32.26%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**93.55%**	**100% ↑**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **A&D Home Health Care**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures, not calculated through CQAR record reviews, that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: A&D Home Health Care received a 100 percent performance rating for CQAR-related Performance Measures 4, 7, 8, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied;

choice of waiver providers 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**]

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care 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 11.75 percentage points below the statewide rate and a decrease of 24.19 percentage points from **A&D Home Health Care**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 18 of the 31 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **A&D Home Health Care** reported that in some instances, member issues were documented in progress notes and assessments but were not carried over and addressed in the PCSP. Additionally, **A&D Home Health Care** reported that the concept of "current issue" versus "controlled issue" versus "no issue" was new to the waiver agency, which contributed to missed interventions in PCSPs.

Recommendation: While **A&D Home Health Care**'s corrective action plan (CAP) included staff education, HSAG recommends that this education include clear definitions for "current issue," "controlled issue," and "no issue" if these terms are being used to identify member problems that should be included in the PCSP. **A&D Home Health Care** could also consider system prompts or other workflows that trigger the supports coordinator to validate that all applicable member problems have been incorporated into the PCSP. Additionally, **A&D Home Health Care** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

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 10.41 percentage points below the statewide rate. Although **A&D Home Health Care**'s rate for this performance measure decreased 47.74 percentage points from its SFY 2021 rate, the methodology for this performance measure changed for SFY 2022, and caution should be used when comparing the two rates. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 21 of the 31 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan. **A&D Home Health Care** reported that supports coordinators were drafting an abbreviated contingency plan which did not present all supports and services the member receives. Additionally, **A&D Home Health Care** reported that the concept of "current issue" versus

"controlled issue" versus "no issue" was new to the waiver agency, which contributed to missed interventions in Emergency Backup Plans.

Recommendation: A&D Home Health Care completed a CAP which included training with all supports coordinators on the contingency plan. **A&D Home Health Care** reported that the training assisted supports coordinators in identifying and documenting all supports and services, which, according to preliminary reviews, have indicated promising results. While positive results are not yet reflected in the rates for Performance Measure 30, HSAG recommends that **A&D Home Health Care** provide ongoing training to its supports coordinators and continue its monthly record review process. If positive results are not seen, **A&D Home Health Care** should explore additional interventions to improve performance.

Compliance Review

Performance Results

Table 3-8 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 interviews. Table 3-8 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-8—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	67.74%		**1.00**	4.00
Focus 3	Release of Information	74.19%		**1.00**	4.00
Focus 4	Status	92.41%		**4.00**	4.00
Focus 5	Pre-Planning	98.20%	100%	**4.00**	4.00
Focus 6	Assessment	96.06%	100%	**4.00**	4.00
Focus 7	Medication Record	82.53%	100%	**3.34**	4.00
Focus 8	Person-Centered Service Planning	86.78%	100%	**4.00**	4.00
Focus 9	MI Choice Services	93.89%	99.11%	**4.00**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 10	Linking and Coordinating	91.18%	100%	**4.00**	4.00
Focus 11	Follow-Up and Monitoring	88.06%	100%	**4.00**	3.34
Focus 12	Service Provider	83.33%		**4.00**	4.00
Focus 13	Contingency Plan	73.26%	100%	**2.68**	4.00
Focus 14	Critical Incidents	69.44%	100%	**2.02**	2.68
Focus 15	Adverse Benefit Determination	86.67%		**4.00**	4.00
Focus 16	Complaints and Grievances	83.33%		**3.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**89.52%**	**99.88%**	**3.75**	3.91

Indicates the standard was not reviewed as part of the record review or home visit.
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: A review of 16 home visits was conducted; all reviews achieved full compliance except for one deficiency, and no focus areas received a citation requiring a CAP. 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 nearly full compliance, the record review identified conflicting results in the area of Critical Incidents. [**Quality**]

Strength #2: A&D Home Health Care achieved a substantial compliance rating in 12 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery are being implemented in accordance with several State and federal requirements. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care did not consistently follow all Freedom of Choice requirements; specifically, ensuring a valid Freedom of Choice (FOC) form is on file. **A&D Home Health Care** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 out of 31 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **A&D Home Health Care** reported that prior to the coronavirus disease 2019 (COVID-19) Public Health Emergency (PHE), all FOC forms were filled out and audited with each Nursing Facility Level of Care Determination (NFLOCD) review. Since the implementation of the PHE, the forms have been returned with electronic signatures. Traditionally, the NFLOCD would be completed in person, which would cause the supports coordinator to review the form prior to signature and ensure that the legally responsible person would sign the form during the visit.

Recommendation: As this is a new citation, HSAG recommends that **A&D Home Health Care** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **A&D Home Health Care** should modify its CAP and implement alternative interventions.

Weakness #2: A&D Home Health Care did not consistently follow all Release of Information requirements; specifically, ensuring a valid Release of Information (ROI) form is on file. **A&D Home Health Care** also received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that eight out of 31 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record. **A&D Home Health Care** reported that prior to the COVID-19 PHE, ROI forms were filled out and audited with each NFLOCD review. Since the implementation of the PHE, the forms have been returned with electronic signatures and when signatures were obtained, the lack of a date was overlooked. Traditionally, the ROI form would be completed in person, which would cause the supports coordinator to review the form prior to signature and place it within the member's chart.

Recommendation: As this is a new citation, HSAG recommends that **A&D Home Health Care** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **A&D Home Health Care** should modify its CAP and implement alternative interventions.

Weakness #3: A&D Home Health Care did not consistently follow all Critical Incident 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. **A&D Home Health Care** also received a *Not Full or Substantial* compliance level compared to a *Some, Needs Improvement* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of nine applicable records did not demonstrate evidence that the supports coordinator addressed the incident with the member/guardian; two out of nine 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 seven out of nine 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. **A&D Home Health Care** reported that noncompliance was due to a lack of documentation and a lack of reporting to management. However, the specifics as to why this lack of documentation and reporting occurred remains unclear to HSAG.

Recommendation: MDHHS required **A&D Home Health Care** to submit a CAP to remediate the deficiencies. However, two of the three deficiencies have been noted as noncompliant for the past three and four years; therefore, **A&D Home Health Care**'s interventions have not led to performance improvement. HSAG recommends that **A&D Home Health Care** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **A&D Home Health Care** could develop a critical incident template that must be completed by the supports coordinator for every incident. This template should include all required tasks that must be completed when a critical incident occurs. Management could review the templates as they are completed to immediately address any gaps with the supports coordinator in real time.

Encounter Data Validation

Performance Results

Representatives from **A&D Home Health Care** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **A&D Home Health Care**'s original questionnaire responses, and **A&D Home Health Care** responded to these specific questions. To support its questionnaire responses, **A&D Home Health Care** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **A&D Home Health Care** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-9 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-9—EDV Results for A&D Home Health Care

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **A&D Home Health Care** uses Compass as its primary software for claim adjudication and encounter preparation. It uses Center for Information Management, Inc. (CIM) as its subcontractor for maintaining the database utilized for data input. • **A&D Home Health Care** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **A&D Home Health Care** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **A&D Home Health Care** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.

Analysis	Key Findings
Payment Structures	• **A&D Home Health Care** utilizes line-by-line method for its claim payment strategies. • **A&D Home Health Care**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in Community Health Automated Medicaid Processing System (CHAMPS), and if another insurance covers waiver services, **A&D Home Health Care** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **A&D Home Health Care** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **A&D Home Health Care**'s encounters, **A&D Home Health Care** indicated that it did not store data sent to MDHHS. • **A&D Home Health Care** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **A&D Home Health Care** displayed consistent encounter volume for professional encounters throughout the measurement year. • **A&D Home Health Care** had a low volume of duplicate encounters, with 0.8 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **A&D Home Health Care** demonstrated timely submission for professional encounters. Within 60 days, **A&D Home Health Care** submitted greater than 99.9 percent of professional encounters to MDHHS after the payment date. Within 90 days, **A&D Home Health Care** submitted 100 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• In **A&D Home Health Care**'s submitted professional encounters, the billing provider NPI was populated 9.0 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **A&D Home Health Care**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **A&D Home Health Care**'s submitted data, 99.2 percent were identified in the enrollment data.

Analysis	Key Findings
	• Of all identified provider NPIs in **A&D Home Health Care**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **A&D Home Health Care**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: A&D Home Health Care demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: A&D Home Health Care submitted professional encounters in a timely manner from the payment date, with greater than 99.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **A&D Home Health Care** were populated at high rates, and most data elements were over 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: A&D Home Health Care indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **A&D Home Health Care**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **A&D Home Health Care**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: A&D Home Health Care reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: A&D Home Health Care appears to have a limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: A&D Home Health Care should consider enhancing its data management practices. HSAG recommends that **A&D Home Health Care** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 9 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: A&D Home Health Care should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-10 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 3-10 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-10—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	86.0%	87.9%	91.8%
Recommendation Measures	90.6%	94.6%	92.1%

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Staff are Reliable and Helpful	89.8%	94.4%	92.1%
Staff Listen and Communicate Well	88.3%	96.3% ↑	94.6%
Case Manager is Helpful	91.7%	97.4% ↑	95.8%
Choosing the Services that Matter to You	91.8%	92.7%	90.8%
Transportation to Medical Appointments	89.2%	97.2% ↑	92.4%
Personal Safety and Respect	95.0%	98.3%	97.4%
Planning Your Time and Activities	75.6%	79.2%	78.5%
Met Need	91.7%	97.0% ↑	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 scores higher than the statewide results in the following domains: *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*, and *Met Need*, indicating that **A&D Home Health Care** provides services in a manner that meets or exceeds members' expectations in many domains. **A&D Home Health Care** also demonstrated improvement in rates across all measures, with four measure rates (i.e., *Staff Listen and Communicate Well*, *Case Manager is Helpful*, *Transportation to Medical Appointments*, and *Met Need*) increasing by 5 percentage points or more. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: A&D Home Health 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.

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, **A&D Home Health Care** scored below the statewide average on the *Global Ratings Measures* domain; therefore, HSAG recommends that **A&D Home Health Care** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within the *Global Ratings Measures* domain, develop interventions to improve, and evaluate the results of the interventions on a regular basis, making changes as necessary. Additionally, although **A&D Home Health Care** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **A&D Home Health Care** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **A&D Home Health Care**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **A&D Home Health Care** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **A&D Home Health Care**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-11 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **A&D Home Health Care**'s MI Choice members.

Table 3-11—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **A&D Home Health Care** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members by addressing risks and providing information regarding abuse, neglect, and exploitation. Additionally, through the CAHPS HCBS survey, **A&D Home Health Care** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. Further, through its implementation of PIPs, **A&D Home Health Care** demonstrated improvement in the *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. However, through the CQAR activity, **A&D Home Health Care** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. This finding could imply that while **A&D Home Health Care** ensures the health and safety of members when providing services directly to the member, it lacks the appropriate follow-up and action when critical incidents occur outside of the waiver agency's control. **A&D Home Health Care** should develop new, evidence-based improvement efforts that include more than staff education and chart audits to encourage future performance improvement.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the PMV activity, 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*, and the CQAR Assessment and Person-Centered Service Planning focus areas, **A&D Home Health Care** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the CAHPS HCBS survey, **A&D Home Health Care**'s rates for the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of*

Performance Area	Overall Performance Impact
	Case Manager, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored above the statewide averages. However, **A&D Home Health Care**'s rate for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, decreased from the prior year's rate and fell below the statewide rate. This suggests that while **A&D Home Health Care** conducts care coordination and person-centered service planning according to policies and procedures, it lacks effective methods to ensure members' goals and preferences are included in the PCSP. **A&D Home Health Care** should develop new, evidence-based improvement efforts that include more than staff education and chart audits to encourage future performance improvement.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **A&D Home Health Care** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, Follow-Up and Monitoring, and Adverse Benefit Determination focus areas. Additionally, through the CAHPS HCBS survey, **A&D Home Health Care** scored higher than the statewide averages for the *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, and *Met Need* domains. However, through the PMV activity, three performance measures scored below the statewide averages: Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs;* Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*; and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*. Performance Measure 15 also decreased from the prior year's rate. Additionally, **A&D Home Health Care** demonstrated a *Some Compliance, Needs Improvement* compliance level in the CQAR Contingency Plan focus area. These findings could imply that while **A&D Home Health Care** generally coordinates services, **A&D Home Health Care** should continue to monitor these performance measures and implement interventions as necessary to improve performance. These findings also suggest that while **A&D Home Health Care** supports coordinators generally are able to coordinate care for members, waiver and non-waiver services may not be available to all members, and **A&D Home Health Care** supports coordinators are not consistently ensuring members have a contingency plan when services are not available. As the performance measures related to access to waiver services were below statewide averages, **A&D Home Health Care** should review its network and ensure it has enough contracted providers to provide timely waiver services to its membership.

Area Agency on Aging 1-B

Validation of Performance Improvement Projects

Performance Results

Table 3-12 displays the PIPs in place during SFY 2022. Table 3-12 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Area Agency on Aging 1-B** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Area Agency on Aging 1-B** did not meet the statewide goal or the *New Goal*. Any interventions described within **Area Agency on Aging 1-B**'s QMP reports are also provided in Table 3-12. The results in Table 3-12 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-12—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
1. *Prevalence of Falls*	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less. *New Goal*: 21.1% or lower	SFY 2021 = 21.1% SFY 2022 = 22.60% ☒
Interventions: • **Area Agency on Aging 1-B** implemented interventions on a case-by-case basis to members who had a fall. Interventions may have included ambulation education related to appropriate use of durable medical equipment (DME).		
PIP Validation Feedback: MDHHS did not provide any feedback to **Area Agency on Aging 1-B**.		
2. *Prevalence of Any Injuries*	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 3.4% SFY 2022 = 2.00% ☑
Interventions: • **Area Agency on Aging 1-B** implemented interventions on a case-by-case basis to members who had an injury. Interventions may have included: – Education regarding the use of DME. – Appropriate use of call button. – Addition of standby assistance (e.g., ambulation, transfers, toileting). – Addition of DME.		

PIP Topic	Goal*	Measurement and Outcome±
PIP Validation Feedback: MDHHS did not provide any feedback to **Area Agency on Aging 1-B**.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-13 displays the two PIPs **Area Agency on Aging 1-B** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-13 is displayed as reported by **Area Agency on Aging 1-B** and was not validated by HSAG.

Table 3-13—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the prevalence of falls with injury.	Baseline: Not reported* SFY 2023: Not yet reported
Interventions: • **Area Agency on Aging 1-B** will implement an enhanced iHC [interRAI Home Care] assessment and monitoring contact form by 12/05/22. • Clinical Trainer and/or Sr. Manager of Agency-wide Quality will provide training on STEADI to all supports coordinators by June 2023.		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging 1-B**: • Clinical PIP should be Falls with Injury. Current work plan for Clinical PIP is using prevalence of falls % for goal and baseline and not falls with injuries.		
Completion of Individual Emergency Preparedness Plans (IEPPs)	Improve the percentage of IEPPs completed within 10 days of enrollment to 80.00% by 09/30/23.	Baseline: 65.09% SFY 2023: Not yet reported
Interventions: • **Area Agency on Aging 1-B** will implement a new electronic medical record, MyHealth360, by 12/05/22.		

PIP Topic	Goal	Measurement and Outcome
• The Clinical Trainer and/or Sr. Manager of Agency-wide Quality will provide MI Choice Staff will training in "complete and up-to-date contingency plans" and requirements for completion by June 2023.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Area Agency on Aging 1-B**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.
* While the waiver agency reported baseline data for *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs, the waiver agency did not report baseline data specifically for the *Falls with Injury* PIP.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 1-B met the MDHHS-established goal for the *Prevalence of Any Injuries* PIP. The reduction in the prevalence rate for this PIP was primarily attributed to the implementation of individual interventions following an injury, which included education regarding the use of DME, appropriate use of the call button, addition of standby assistance (e.g., ambulation, transfers, toileting), and/or addition of DME. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Area Agency on Aging 1-B** for the *Prevalence of Falls* PIP did not appear to be effective at improving outcomes as the prevalence rate increased, and **Area Agency on Aging 1-B** did not reach the MDHHS-established goal (i.e., *New Goal*). **Area Agency on Aging 1-B**'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 PIP. [**Quality**]

Why the weakness exists: **Area Agency on Aging 1-B** cited inaccurate coding in the assessment, incomplete documentation, and members not complying with interventions as barriers to improved performance. Additionally, **Area Agency on Aging 1-B** compared its results of the *Prevalence of Falls* PIP against the statewide goal (i.e., at or below 23 percent), not the *New Goal* (i.e., 21.10 percent) established by MDHHS.

Recommendation: HSAG recommends that **Area Agency on Aging 1-B** implement an auditing and monitoring process to ensure all falls are being documented appropriately (i.e., timely, detailed, etc.) to improve the consistency with which falls are documented across all staff members. Additionally, **Area Agency on Aging 1-B** should analyze and interpret results at multiple points in time and test

for statistical significance. **Area Agency on Aging 1-B** 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: Area Agency on Aging 1-B's SFY 2022 PIP results differed from those reported by MDHHS.

Why the weakness exists: Area Agency on Aging 1-B did not document its methodology in its QMP documentation (e.g., the time frames for measurement); as such, it is unclear if **Area Agency on Aging 1-B** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Area Agency on Aging 1-B** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG continues to recommend that both **Area Agency on Aging 1-B** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: Area Agency on Aging 1-B's goal for the *Prevalence of Falls* PIP was indicated as: "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% (2021 agency measurement was 16.90%) by 09/30/2022." However, the statewide PIP for all agencies is the overall prevalence of falls regardless of when the falls occurred. [**Quality**]

Why the weakness exists: Area Agency on Aging 1-B's methodology for calculating the prevalence rate was not in alignment with MDHHS' methodology.

Recommendation: HSAG recommends that **Area Agency on Aging 1-B** consult with MDHHS to ensure its methodology and data sources for the *Prevalence of Falls* PIP are consistent with that of MDHHS and other waiver agencies.

Weakness #4: The documentation pertaining to **Area Agency on Aging 1-B**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Area Agency on Aging 1-B** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Area Agency on Aging 1-B** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The MI Choice Quality Assurance and Performance Improvement Plan Fiscal Years 2023–2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Area Agency on Aging 1-B**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Area Agency on Aging 1-B** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Area Agency on Aging 1-B** in a methodologically sound manner. HSAG further recommends that **Area Agency on Aging 1-B**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Area Agency on Aging 1-B** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Area Agency on Aging 1-B** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Area Agency on Aging 1-B** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-14 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-14 also provides the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Area Agency on Aging 1-B**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-14, as only statewide rates were calculated by MDHHS and made available to HSAG.

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

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**89.29%**	**75.86% ↓**	**86.65%**
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	**97.19%**	**89.83% ↓**	**93.72%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**98.23%**	**92.56% ↓**	**94.76%**
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	**100%**	**100%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**96.43%**	**84.48% ↓**	**82.72%**
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	**97.39%**	**92.94%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**77.55%**	**74.51%**	**88.74%**
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%**	**82.86% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**89.29%**	**93.10%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**100%**	**100%**
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	—	**24.14%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Area Agency on Aging 1-B**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Area Agency on Aging 1-B received a 100 percent performance rating for Performance Measures 4, 7, 8, 16, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; level of care (LOC) criteria were accurately applied; members' PCSPs had strategies to address their assessed 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**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1-B 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 10.79 percentage points below the statewide rate and a decrease of 13.43 percentage points from **Area Agency on Aging 1-B**'s SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that seven of the 29 applicable records did not demonstrate that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements. **Area Agency on Aging 1-B** reported that the root cause of noncompliance with this requirement was due to individual supports coordinator issues such as late 90-day and 180-day PCSP reviews, member being in a different care setting, reviews being scheduled ahead of time according to the member's request, missing signature page, and a delay in completing a significant change assessment timely.

Recommendation: While **Area Agency on Aging 1-B**'s CAP included individual staff education for each supports coordinator whose case files were noncompliant with this requirement and potential disciplinary action if the issue persists, HSAG recommends **Area Agency on Aging 1-B**

explore potential system enhancements or another avenue for automatic reminders to supports coordinators when PCSPs are coming due. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Area Agency on Aging 1-B 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 14.23 percentage points below the statewide rate and a decrease of 3.04 percentage points from **Area Agency on Aging 1-B**'s SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that seven of the 29 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and six of the 22 applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements. **Area Agency on Aging 1-B** reported that the root cause of noncompliance with this requirement was due to individual supports coordinator issues such as late 90-day and 180-day PCSP reviews, member being in a different care setting, reviews being scheduled ahead of time according to the member's request, missing signature page, a delay in completing a significant change assessment timely, lack of referral to alternative services, direct care worker shortage, and a wait for community living services. **Area Agency on Aging 1-B** also reported that staffing changes created additional barriers for supervisors to provide effective coaching to supports coordinators.

Recommendation: While **Area Agency on Aging 1-B**'s CAP included individual staff education for each supports coordinator whose case files were noncompliant with this requirement and potential disciplinary action if the issue persists, HSAG recommends **Area Agency on Aging 1-B** explore potential system enhancements or another avenue for automatic reminders to supports coordinators when PCSPs are coming due. Additionally, **Area Agency on Aging 1-B** noted that most of the noncompliant records were a result of the direct care workforce shortage; therefore, HSAG recommends that the waiver agency consider more aggressive contracting efforts for those particular services if there are additional providers with whom to contract in **Area Agency on Aging 1-B**'s service area. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #3: Area Agency on Aging 1-B 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 7.45 percentage points below the statewide rate and a decrease of 10.32 percentage points from **Area Agency on Aging 1-B**'s SFY 2021 rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, 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,

and four out of the applicable 22 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. **Area Agency on Aging 1-B** reported that the root cause of noncompliance with this requirement was due to individual supports coordinator issues; specifically, the team not completing two-week follow-up calls, lack of timely follow-up to newly implemented services, and documentation discrepancies.

Recommendation: While **Area Agency on Aging 1-B**'s CAP included individual staff education for each supports coordinator whose case files were noncompliant with this requirement and potential disciplinary action if the issue persists, as one of the two deficiencies has been noted as noncompliant for the past two years, HSAG recommends **Area Agency on Aging 1-B** explore potential system enhancements or another avenue for automatic reminders to supports coordinators when follow-up calls are due. Additionally, **Area Agency on Aging 1-B** indicated that some of the noncompliant records were due to documentation errors; therefore, HSAG recommends that **Area Agency on Aging 1-B** focus its quarterly audits on ensuring accurate documentation. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #4: Area Agency on Aging 1-B 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 18.53 percentage points below the statewide rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 22 of the 29 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan. **Area Agency on Aging 1-B** reported that the root causes of noncompliance with this requirement were due to a reporting issue and individual supports coordinators not documenting case and family relations.

Recommendation: While **Area Agency on Aging 1-B**'s CAP included a report update and individual staff education for each supports coordinator whose case files were noncompliant with this requirement and potential disciplinary action if the issue persists, HSAG recommends **Area Agency on Aging 1-B** explore potential system enhancements to require a field for case and family relations to be updated at every contact or assessment. Additionally, **Area Agency on Aging 1-B** indicated that some of the noncompliant records were due to documentation errors; therefore, HSAG recommends that **Area Agency on Aging 1-B** focus its quarterly audits on ensuring accurate documentation. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

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 interviews. Table 3-15 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-15—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100.00%	100.00%	**4.00**	4.00
Focus 2	Freedom of Choice	41.38%		**1.00**	4.00
Focus 3	Release of Information	68.97%		**1.00**	4.00
Focus 4	Status	90.36%		**4.00**	4.00
Focus 5	Pre-Planning	98.06%	100.00%	**4.00**	4.00
Focus 6	Assessment	93.61%	98.89%	**4.00**	4.00
Focus 7	Medication Record	93.29%	100.00%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	91.15%	99.17%	**4.00**	4.00
Focus 9	MI Choice Services	90.42%	98.99%	**4.00**	4.00
Focus 10	Linking and Coordinating	85.94%	100.00%	**3.34**	4.00
Focus 11	Follow-Up and Monitoring	60.94%	98.33%	**2.02**	3.33
Focus 12	Service Provider	94.74%		**4.00**	4.00
Focus 13	Contingency Plan	50.70%	100.00%	**2.02**	4.00
Focus 14	Critical Incidents	88.00%	100.00%	**3.34**	2.67

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	73.81%		**2.00**	4.00
Focus 16	Complaints and Grievances	88.89%		**4.00**	4.00
Focus 17	Home and Community Based		100.00%	**4.00**	4.00
	Totals	**88.44%**	**99.45%**	**3.68**	3.91

Indicates the standard was not reviewed as part of the record review or home visit.
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: A review of 15 home visits was conducted; all reviews achieved full compliance except for four deficiencies, and no focus areas received a citation requiring a CAP. 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 were receiving services in accordance with their service plans and preferences and were satisfied with those services. It should be noted that while the home visit reviews achieved nearly full compliance, the record review identified conflicting results in the areas of Follow-Up and Monitoring and Contingency Plan. [**Quality**]

Strength #2: Area Agency on Aging 1-B achieved a substantial compliance rating in 12 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to 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 1-B 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. **Area Agency on Aging 1-B** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 17 out of 29 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **Area Agency on Aging 1-B** reported that this was a temporary procedure issue related to the PHE.

Recommendation: As this is a new citation, HSAG recommends that **Area Agency on Aging 1-B** continue to implement its CAP of conducting staff education and ongoing chart audits. However, if improvement is not realized, **Area Agency on Aging 1-B** should modify its CAP and implement alternative interventions.

Weakness #2: Area Agency on Aging 1-B 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. **Area Agency on Aging 1-B** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that nine out of 29 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record. **Area Agency on Aging 1-B** reported that this was a temporary procedure issue related to allowances during the PHE.

Recommendation: As this is a new citation, HSAG recommends that **Area Agency on Aging 1-B** continue to implement its CAP of conducting staff education and ongoing chart audits. However, if improvement is not realized, **Area Agency on Aging 1-B** should modify its CAP and implement alternative interventions.

Weakness #3: Area Agency on Aging 1-B did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting newly enrolled 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

MDHHS policy and contract requirements. 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. **Area Agency on Aging 1-B** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of four applicable records did not include evidence that the waiver agency contacted the newly enrolled members/guardians to ensure service delivery in accordance with MDHHS policy and contract requirements; 19 out of 29 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP; and four out of 22 applicable records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with MDHHS policy and contract requirements, including the use of the member's backup plan or out-of-network provider. **Area Agency on Aging 1-B** reported that this is not a policy and procedure issue, but instead it is an individual supports coordinator issue, in which supports coordinators were not completing two-week follow-up calls and were not completing monitoring contacts as requested by the member, as well as due to supports coordinators' lack of timely and specific follow-up for newly implemented services.

Recommendation: MDHHS required **Area Agency on Aging 1-B** to submit a CAP to remediate the deficiencies. However, two of the three deficiencies have been noted as noncompliant for the past two years; therefore, **Area Agency on Aging 1-B**'s interventions have not led to performance improvement. HSAG recommends that **Area Agency on Aging 1-B** update its CAP to include interventions other than report cards for findings, staff education, and ongoing chart audits. For example, **Area Agency on Aging 1-B** could implement system prompts or another similar workflow that reminds supports coordinators when follow-up is due.

Weakness #4: Area Agency on Aging 1-B did not consistently follow all Contingency Plan requirements; specifically, ensuring there is a complete and up-to-date contingency plan and ensuring that the member/guardian received a copy of the contingency plan. **Area Agency on Aging 1-B** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 22 out of 29 applicable records did not demonstrate evidence that the record contained a complete and up-to-date contingency plan, and 13 out of 29 applicable records did not demonstrate evidence that the member/guardian received a copy of the contingency plan. **Area Agency on Aging 1-B** reported that IEPPs that were created prior to August 1, 2022, would not contain all case and family relations, as the IEPP report available to staff did not have this specification to pull the information from the case and family relations within the waiver agency's system. While the report change was requested on February 7, 2022, the report update was not completed and made available to staff until November 16, 2022. **Area Agency on Aging 1-B** also reported that members declining home visits and

temporary mailing procedures during the PHE contributed to members not being provided a copy of the contingency plan.

Recommendation: As these were new citations, HSAG recommends that **Area Agency on Aging 1-B** continue to implement its CAP of conducting staff education and ongoing chart audits. However, if improvement is not realized, **Area Agency on Aging 1-B** should modify its CAP and implement alternative interventions.

Weakness #5: Area Agency on Aging 1-B 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 notices of adverse benefit determination (NABDs) are important to ensure members understand their appeal rights and the process to request an appeal. **Area Agency on Aging 1-B** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 out of 22 applicable records did not demonstrate evidence that the member/guardian was provided with the AAN/ABD, and one out of 18 applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate. **Area Agency on Aging 1-B** reported that this was not a policy and procedure issue but instead was an individual supports coordinator issue where supports coordinators did not mail NABDs timely, or did not issue an NABD for all denied services such as transportation, increase in CLS, and hospitalization.

Recommendation: One of the two deficiencies was not identified as a citation by MPHI; however, the other deficiency was documented as a citation and has been noted as noncompliant for the past three years. Therefore, **Area Agency on Aging 1-B**'s interventions have not led to performance improvement in this program area. HSAG recommends that **Area Agency on Aging 1-B** update its CAP to include interventions other than report cards for findings, staff education, and ongoing chart audits. For example, **Area Agency on Aging 1-B** could implement system prompts or another similar workflow that reminds supports coordinators when to mail the AAN/ABD. Additionally, HSAG recommends that **Area Agency on Aging 1-B** ensure that remediation efforts are put in place for the deficiency not requiring a CAP.

Encounter Data Validation

Performance Results

Representatives from **Area Agency on Aging 1-B** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Area Agency on Aging 1-B**'s original questionnaire responses, and **Area Agency on Aging 1-B** responded to these specific questions. To support its questionnaire responses, **Area Agency on Aging 1-B** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Area Agency on Aging 1-B** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-16 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-16—EDV Results for Area Agency on Aging 1-B

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Area Agency on Aging 1-B** uses WellSky as its primary software for claim adjudication and encounter preparation. • **Area Agency on Aging 1-B** has implemented procedures to detect and identify duplicate claims. Notably, its electronic medical record (EMR) system, WellSky, enforces strict rules to prevent the submission of claims without valid authorizations. Encounters in need of adjustments are identified through various channels, including self-reported errors by subcontractors, internal staff identification, data mining, and the review of rejections received. The adjustment process includes voiding erroneous claims and replacing them with new claims. • **Area Agency on Aging 1-B** enters and stores provider and member enrollment information details in WellSky, where WellSky is responsible for maintaining site availability, connectivity, and security.

Analysis	Key Findings
Payment Structures	• **Area Agency on Aging 1-B** utilizes both line-by-line and per diem methods for its claim payment strategies. • **Area Agency on Aging 1-B** indicated that TPL details are gathered through interRAI home care assessments during enrollment, annual reviews, and changes. Subcontractors collect TPL data for private duty nursing services and, to date, no claims have required coordination of benefits. The agency verifies policy information with insurance companies and stores payment details in the EMR system.
Encounter Data Quality Monitoring	• **Area Agency on Aging 1-B** and/or its subcontractors perform various data quality checks on encounter data collected by subcontractors, including claim volume by submission month, field-level completeness and validity, and timeliness.
Administrative Profile	
Encounter Data Completeness	• **Area Agency on Aging 1-B** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Area Agency on Aging 1-B** had a low volume of duplicate encounters, with 0.8 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Area Agency on Aging 1-B** did not demonstrate timely submission for professional encounters. Within 60 days, **Area Agency on Aging 1-B** submitted 50 percent of professional encounters to MDHHS after the payment date. Within 180 days, **Area Agency on Aging 1-B** submitted 69.5 percent of encounters to MDHHS, and within 270 days, it submitted > 99.9 percent of encounters.
Field-Level Completeness and Accuracy	• In **Area Agency on Aging 1-B**'s submitted professional encounters, the billing provider NPI was populated 100 percent of the time, and the rendering provider NPI was populated 33.1 percent of the time. • All other data elements in **Area Agency on Aging 1-B**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Area Agency on Aging 1-B**'s submitted data, 99 percent were identified in the enrollment data. • Of all identified provider NPIs in **Area Agency on Aging 1-B**'s submitted data, 100 percent were identified in the provider data.

Analysis	Key Findings
Encounter Data Logic	• No major concerns were noted for **Area Agency on Aging 1-B**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Area Agency on Aging 1-B demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Area Agency on Aging 1-B has a robust system dedicated to monitoring encounter data submissions, designed to ensure the accuracy, completeness, and timely submission of encounter data to MDHHS. [**Quality**]

Strength #3: Across all professional encounters, all key data elements for **Area Agency on Aging 1-B** were populated at high rates, and most data elements were over 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1-B did not submit professional encounters timely, where 50 percent of professional encounters were submitted within 60 days of payment, and not reaching greater than 99.9 percent of professional encounters submitted until within 270 days of payment. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Area Agency on Aging 1-B should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #2: Although not required to be populated, 33.1 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]
Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Area Agency on Aging 1-B should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-17 presents **Area Agency on Aging 1-B**'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 3-17 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-17—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	86.6%	91.2%	91.8%
Recommendation Measures	93.9%	90.1%	92.1%
Staff are Reliable and Helpful	92.1%	89.0%	92.1%
Staff Listen and Communicate Well	98.0%	94.4%	94.6%
Case Manager is Helpful	99.0%	**87.7% ↓**	95.8%
Choosing the Services that Matter to You	93.8%	86.3% ↓	90.8%
Transportation to Medical Appointments	92.0%	91.4%	92.4%
Personal Safety and Respect	98.3%	97.2%	97.4%
Planning Your Time and Activities	78.6%	77.6%	78.5%
Met Need	95.2%	95.3%	93.0%

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 1-B achieved a score higher than the statewide results in the *Met Need* domain, indicating that **Area Agency on Aging 1-B** provides services in a manner that meets or exceeds members' expectations in this domain. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging 1-B scored more than 5 percentage points below the statewide average on the *Case Manager is Helpful* domain at 87.7 percent compared with the statewide average of 95.8 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, **Area Agency on Aging 1-B** scored below the statewide average for the remaining two questions, *Able to contact this case manager when needed* and *Case manager helped when asked for help with getting other changes to services*.

Recommendation: HSAG recommends that **Area Agency on Aging 1-B** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores significantly contributed to the low satisfaction score within the *Case Manager is Helpful* domain, specifically the statements related to the member being able to contact the case manager and the case manager helping when needed; develop interventions to improve the *Case Manager is Helpful* domain; and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #2: Although **Area Agency on Aging 1-B** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, which was therefore not identified as a substantial weakness, this domain received the lowest statewide average score compared to all domains. [**Quality**]
Why the weakness exists: This section is not applicable as this domain was not identified as a substantial weakness for **Area Agency on Aging 1-B**.
Recommendation: HSAG recommends that **Area Agency on Aging 1-B** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores contributed to the low satisfaction score within the *Planning Your Time and Activities* domain; develop interventions to improve the *Planning Your Time and Activities* domain; and evaluate the results of the interventions regularly, making changes as necessary.

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

HSAG performed a comprehensive assessment of **Area Agency on Aging 1-B**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Area Agency on Aging 1-B** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Area Agency on Aging 1-B**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-18 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Area Agency on Aging 1-B**'s MI Choice members.

Table 3-18—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Area Agency on Aging 1-B** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members by addressing risks and providing information regarding abuse,

Performance Area	Overall Performance Impact
	neglect, and exploitation. Additionally, through the CQAR activity, **Area Agency on Aging 1-B** received a *Substantial* compliance level in the Critical Incidents focus area. Further, through the CAHPS HCBS survey, **Area Agency on Aging 1-B** showed a strong focus on member health and safety through a high rating in the *Physical Safety Measure* domain. Lastly, through the PIP activity, **Area Agency on Aging 1-B**'s rate for the *Prevalence of Any Injuries* PIP decreased from the prior year, and the waiver agency met the statewide goal, indicating its interventions for decreasing the prevalence of injuries were effective. However, through the CAHPS HCBS activity, while the *Personal Safety and Respect* domain had a rating of 97.2 percent, it remained below the statewide average and decreased from the prior year's rate. Additionally, through its implementation of the *Prevalence of Falls* PIP, **Area Agency on Aging 1-B**'s rate increased and did not meet the statewide goal, which indicated its implemented interventions were not effective for this PIP. These findings could imply that while **Area Agency on Aging 1-B** ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments. **Area Agency on Aging 1-B** reported that its interventions were member-specific after a member had a fall; however, HSAG recommends that **Area Agency on Aging 1-B** explore implementing systemic interventions to all members to potentially prevent falls before they ever occur.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the PMV activity, Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, demonstrated high performance in ensuring appropriate and timely person-centered service planning, although both rates decreased from the prior year. Additionally, through the CQAR Assessment and Person-Centered Service Planning focus areas, **Area Agency on Aging 1-B** also demonstrated high performance in ensuring appropriate and timely person-centered service planning. Further, through the CAHPS HCBS survey, **Area Agency on Aging 1-B**'s rate for the *Global Ratings Measures—Global Rating of Case Manager* domain demonstrated that members are generally satisfied with the case managers. However, the *Case Manager is Helpful* and *Choosing the Services that Matter to You* domains scored below the statewide averages, and both measures decreased from the prior year's rates. This suggests that **Area Agency on Aging 1-B** conducts care coordination and person-centered service planning according to policies and procedures, but members do not always find case managers to be helpful or allow them to choose which services are most important to the member. **Area Agency on Aging 1-B** should review these domains to identify barriers to member satisfaction and develop appropriate interventions to address the barriers.

Performance Area	Overall Performance Impact
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Area Agency on Aging 1-B** demonstrated a *Substantial* compliance level in the MI Choice Services and Linking and Coordinating focus areas. Additionally, through the CAHPS HCBS survey, **Area Agency on Aging 1-B** scored higher than the statewide average for the *Met Need* domain. However, through the PMV activity, three performance measures scored below the statewide averages: Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*; Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*; and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*. Performance Measures 15 and 20 also decreased significantly from the prior year's rates. Further, through the CAHPS HCBS survey, **Area Agency on Aging 1-B**'s rates for the *Staff are Reliable and Helpful* and *Transportation to Medical Appointments* domains scored below the statewide averages. These findings suggest that while **Area Agency on Aging 1-B**'s supports coordinators generally are able to coordinate care for members, waiver and non-waiver services may not be available to many members. Some of these deficiencies have been noted as noncompliant over the past two years; therefore, **Area Agency on Aging 1-B** should implement interventions other than report cards for findings, staff education, and ongoing chart audits to encourage future improvement. Additionally, as several measures related to access to waiver services were below statewide averages, **Area Agency on Aging 1-B** should review its network and ensure it has enough contracted providers to provide timely waiver services to its membership.

Area Agency on Aging of Northwest Michigan

Validation of Performance Improvement Projects

Performance Results

Table 3-19 displays the PIPs in place during SFY 2022. Table 3-19 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Area Agency on Aging of Northwest Michigan** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Area Agency on Aging of Northwest Michigan** did not meet the statewide goal or the *New Goal*. Any interventions described within **Area Agency on Aging of Northwest Michigan**'s QMP reports are also provided in Table 3-19. The results in Table 3-19 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-19—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 27.2% SFY 2022 = 29.20% ☒
Interventions: • Addition of one full time equivalent employee, dedicated to quality improvement work, data collection, and data monitoring for fall data. • Routine chart reviews to identify individual participants with a documented fall. • Enhanced data collection and reporting methods. • Targeted chart reviews to identify trends of falls and additional targeted interventions. • Implementation of STEADI resources from the CDC - resources for participants and caregivers aimed to decrease fall and injuries. • Staff training and education on falls, including documentation, quality measure, and interventions to reduce risks of falls. • Evaluation of other meaningful data metrics that capture improvement/fall reduction versus prevalence.		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging of Northwest Michigan**: • The Statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the waiver agency's participants. Both of your QI goals would not meet the statewide goals.		

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 4.8% SFY 2022 = 7.00% ☒
Interventions: • Addition of one full time equivalent employee, dedicated to quality improvement work, data collection, and data monitoring for injury data. • Routine chart reviews to identify individual participants with a documented injury. • Enhanced data collection and reporting methods. • Targeted chart reviews to identify trends of injuries and additional targeted interventions. • Implementation of STEADI resources from the CDC - resources for participants and caregivers aimed to decrease fall and injuries. • Staff training and education on injuries, including documentation, quality measure, and interventions to reduce injuries. • Evaluation of other meaningful data metrics that capture improvement/injury reduction vs. prevalence.		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging of Northwest Michigan**: • The Statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the waiver agency's participants. Both of your QI goals would not meet the statewide goals.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-20 displays the two PIPs **Area Agency on Aging of Northwest Michigan** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-20 is displayed as reported by **Area Agency on Aging of Northwest Michigan** and was not validated by HSAG.

Table 3-20—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the risk of falls with injury when falls occur to 10% or less.	Baseline: Not reported SFY 2023: Not yet reported
Interventions: • Review of possible data and metrics available based on sources available within current systems. • Local regional quality collaborative discussion to obtain participant perspective on falls with injury. • Development of a consistent measure at **Area Agency on Aging of Northwest Michigan**. • Chart audits to evaluate falls with injury. • Best Practice and literature search for evidence-based practices. • Development of clinical policies and procedures as deemed necessary. • Training and educating of staff on best practice interventions and organizational procedures for interventions. • Development of quarterly metrics to report to Quality Committee and internal staff on a routine basis. • Provide individual feedback and organizational opportunities for improvement based on data analysis.		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging of Northwest Michigan**: • Can you provide a quantitative goal/target?		
Fall Prevention Interventions	Implement and provide fall interventions strategies (documented intervention) to 80% of participants who experienced a fall by September 2024.	Baseline: Not reported SFY 2023: Not yet reported
Interventions • Review of possible data and metrics available based on sources available within current systems. • Local regional quality collaborative discussion to obtain participant perspective on falls intervention strategies. • Development of a consistent measure at **Area Agency on Aging of Northwest Michigan** to assess for interventions (documented intervention). • Chart audits to evaluate documented fall interventions. • Best Practice and literature search for evidence-based practices. • Development of clinical policies and procedures as deemed necessary. • Training and educating of staff on best practice interventions and organizational procedures for interventions, specific to documenting interventions. • Development of quarterly metrics to report to Quality Committee and internal staff on a routine basis on rate of documented intervention and associated falls. • Provide individual feedback and organizational opportunities for improvement based on data analysis.		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging of Northwest Michigan**: • Can you provide a quantitative goal/target?		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for both of **Area Agency on Aging of Northwest Michigan**'s PIPs increased from the baseline measurement, suggesting that the implemented interventions did not positively impact member outcomes. Therefore, no strengths were identified for **Area Agency on Aging of Northwest Michigan**. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Area Agency on Aging of Northwest Michigan** did not appear to be effective in improving outcomes as the prevalence rates increased for both SFY 2022 PIPs, and **Area Agency on Aging of Northwest Michigan** did not reach the MDHHS-established goals (i.e., statewide goals) for either SFY 2022 PIP. **Area 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 PIPs. [**Quality**]

Why the weakness exists: **Area Agency on Aging of Northwest Michigan** cited increased awareness among staff of reporting and documentation requirements. This improved awareness led to more falls and injuries being documented despite the implementation of interventions to reduce the number of falls and injuries.

Recommendation: HSAG recommends that **Area Agency on Aging of Northwest Michigan** implement an auditing and monitoring process to ensure all falls and injuries are being documented appropriately (i.e., timely, detailed, etc.) to improve the consistency with which falls and injuries are documented across all staff members. Additionally, although **Area Agency on Aging of Northwest Michigan** conducted a barrier analysis, interventions implemented did not appear to address those barriers. HSAG recommends that **Area 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). **Area Agency on Aging of Northwest Michigan** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and address these barriers to improve outcomes. Further, **Area Agency on Aging of Northwest Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **Area 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 #2: Area Agency on Aging of Northwest Michigan's SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: Area Agency on Aging of Northwest Michigan calculated its PIP results on a different timing schedule than MDHHS (i.e., **Area Agency on Aging of Northwest Michigan** calculated its results based on the full state fiscal year, and MDHHS calculated the results only on the first half of the state fiscal year for baseline and remeasurement).

Recommendation: HSAG continues to recommend that **Area Agency on Aging of Northwest Michigan** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Area Agency on Aging of Northwest Michigan** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Area Agency on Aging of Northwest Michigan**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Area Agency on Aging of Northwest Michigan** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Area Agency on Aging of Northwest Michigan** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Quality Assessment Performance Improvement (QAPI) Plan AAANM FY 2023–2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Area Agency on Aging of Northwest Michigan**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Area Agency on Aging of Northwest Michigan** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Area Agency on Aging of Northwest Michigan** in a methodologically sound manner. HSAG further recommends that **Area Agency on Aging of Northwest Michigan**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Area Agency on Aging of Northwest Michigan** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Area Agency on Aging of Northwest Michigan** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Area Agency on Aging of Northwest Michigan** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-21 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-21 also provides the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Area 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-21, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-21—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**63.64%**	**100% ↑**	**86.65%**
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	**97.50%**	**95.96%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**N/A**	**100%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**97.73%**	**95.92%**	**94.76%**
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	**100%**	**95.45%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**72.73%**	**86.36% ↑**	**82.72%**
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	**91.55%**	**92.41%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**72.22%**	**93.75% ↑**	**88.74%**
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	**86.67%**	**100% ↑**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**100%**	**90.91% ↓**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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%**	**100%**
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	—	**54.55%**	**42.67%**

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Area Agency on Aging of Northwest Michigan**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures, not calculated through CQAR record reviews, that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Area Agency on Aging of Northwest Michigan received a 100 percent performance rating for CQAR-related Performance Measures 1, 4, 7, 20, 22, 24, and 38, indicating that service plans were completed timely; LOCDs were made appropriately; LOCDs were made by a qualified evaluator; members received all services identified in their PCSPs; choice of waiver providers 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 **Timeliness**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness as **Area Agency on Aging of Northwest Michigan**'s rates were equal to or higher than the statewide rates for all CQAR-related performance measures.

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

Recommendation: Although **Area Agency on Aging of Northwest Michigan** met or exceeded the statewide performance rate for all performance measures, HSAG recommends that **Area Agency on Aging of Northwest Michigan** focus interventions on performance measures that demonstrate a decline of 5 percentage points from the prior year; specifically, Performance Measures 21 and 30.

Compliance Review

Performance Results

Table 3-22 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 interviews. Table 3-22 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-22—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	72.73%		**1.00**	2.00
Focus 3	Release of Information	45.45%		**1.00**	3.00
Focus 4	Status	100%		**4.00**	4.00
Focus 5	Pre-Planning	96.12%	100%	**4.00**	4.00
Focus 6	Assessment	97.00%	100%	**4.00**	4.00
Focus 7	Medication Record	84.75%	100%	**3.35**	2.06
Focus 8	Person-Centered Service Planning	88.13%	100%	**4.00**	4.00
Focus 9	MI Choice Services	96.67%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	95.83%	100%	**4.00**	4.00
Focus 11	Follow-Up and Monitoring	81.82%	100%	**3.35**	2.71
Focus 12	Service Provider	100%		**4.00**	1.00
Focus 13	Contingency Plan	61.54%	100%	**2.06**	4.00
Focus 14	Critical Incidents	N/A	100%	**NA**	2.06
Focus 15	Adverse Benefit Determination	N/A		**NA**	2.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 16	Complaints and Grievances	100%		**4.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**90.22%**	**100%**	**3.79**	3.62

Indicates the standard was not reviewed as part of the record review or home visit.
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: A review of six home visits was 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 were receiving services in accordance with their service plans and preferences and were 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 Contingency Plan. [**Quality**]

Strength #2: Area Agency on Aging of Northwest Michigan achieved a substantial compliance rating in 12 of the applicable 15 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore,

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

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging of Northwest Michigan 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. **Area Agency on Aging of Northwest Michigan** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three out of 11 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **Area Agency on Aging of Northwest Michigan** identified inconsistent staff education and knowledge related to valid and complete FOC documentation. Lack of consistency in completion of the FOC form attributed to a change in practice and the suspension of home visits during the COVID-19 PHE.

Recommendation: MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. However, this deficiency has been noted as noncompliant for the past two years; therefore, **Area Agency on Aging of Northwest Michigan**'s interventions have not led to performance improvement. HSAG recommends that **Area Agency on Aging of Northwest Michigan** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Area Agency on Aging of Northwest Michigan** could consider creating a "hard stop" in the member record where a supports coordinator must complete an FOC form section within the assessment or PCSP before proceeding.

Weakness #2: Area Agency on Aging of Northwest Michigan 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. **Area Agency on Aging of Northwest Michigan** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Some, Needs Improvement* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that six out of 11 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record. **Area Agency on Aging of Northwest Michigan** identified inconsistent training and knowledge related to the completion of the ROI form in its entirety. In-home visits were suspended which also caused a reliance on ROI documents being mailed and returned by the member.

Recommendation: MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. However, this deficiency has been noted as noncompliant for the past two years; therefore, **Area Agency on Aging of Northwest Michigan**'s interventions have not

led to performance improvement. HSAG recommends that **Area Agency on Aging of Northwest Michigan** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Area Agency on Aging of Northwest Michigan** could consider creating a "hard stop" in the member record where a supports coordinator must complete an ROI form section within the assessment or PCSP before proceeding.

Weakness #3: Area Agency on Aging of Northwest Michigan did not consistently follow all Contingency Plan requirements; specifically, ensuring there is a complete and up-to-date contingency plan, ensuring that the member/guardian received a copy of the contingency plan, and ensuring that other allies received a copy of the contingency plan. Contingency plans are important to ensure that if the member's PCSP services are unavailable, the member will still have services in place until planned services can resume. **Area Agency on Aging of Northwest Michigan** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that five out of 11 applicable records did not demonstrate evidence that the record contained a complete and up-to-date contingency plan; four out of 11 applicable records did not demonstrate evidence that the member/guardian received a copy of the contingency plan; and one out of three applicable records did not demonstrate evidence that other allies included in the plan received a copy of the contingency plan as preferred by the member/guardian. **Area Agency on Aging of Northwest Michigan** identified a lack of consistent staff knowledge on backup plan updates.

Recommendation: As these were new citations, HSAG recommends that **Area Agency on Aging of Northwest Michigan** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **Area Agency on Aging of Northwest Michigan** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Area Agency on Aging of Northwest Michigan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Area Agency on Aging of Northwest Michigan**'s original questionnaire responses, and **Area Agency on Aging of Northwest Michigan** responded to these specific questions. To support its questionnaire responses, **Area Agency on Aging of Northwest Michigan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Area Agency on Aging of Northwest Michigan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-23 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-23—EDV Results for Area Agency on Aging of Northwest Michigan

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Area Agency on Aging of Northwest Michigan** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Area Agency on Aging of Northwest Michigan** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that claims paid with funding sources other than MI Choice Waiver Program are not sent to MDHHS. In cases requiring adjustments, **Area Agency on Aging of Northwest Michigan** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Area Agency on Aging of Northwest Michigan** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.

Analysis	Key Findings
Payment Structures	• **Area Agency on Aging of Northwest Michigan** utilizes line-by-line method for its claim payment strategies. • **Area Agency on Aging of Northwest Michigan**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Area Agency on Aging of Northwest Michigan** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Area Agency on Aging of Northwest Michigan** encounters.
Encounter Data Quality Monitoring	• **Area Agency on Aging of Northwest Michigan** and/or its subcontractors perform various data quality checks on encounter data collected by subcontractors, which include analyzing claim volume by submission month, assessing field-level completeness and validity, evaluating timeliness, and ensuring alignment of payment fields in the claims with financial reports.
Administrative Profile	
Encounter Data Completeness	• **Area Agency on Aging of Northwest Michigan** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Area Agency on Aging of Northwest Michigan** had a low volume of duplicate encounters, with 0.4 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Area Agency on Aging of Northwest Michigan** demonstrated timely submission for professional encounters. Within 60 days, **Area Agency on Aging of Northwest Michigan** submitted greater than 99.9 percent of professional encounters to MDHHS after the payment date. Within 150 days, **Area Agency on Aging of Northwest Michigan** submitted 100 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• In **Area Agency on Aging of Northwest Michigan**'s submitted professional encounters, the billing provider NPI was populated 11.9 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Area Agency on Aging of Northwest Michigan**'s submitted data had high rates of population and validity.

Analysis	Key Findings
Encounter Referential Integrity	• Of all identified member IDs in **Area Agency on Aging of Northwest Michigan**'s submitted data, 99.4 percent were identified in the enrollment data. • Of all identified provider NPIs in **Area Agency on Aging of Northwest Michigan**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Area Agency on Aging of Northwest Michigan**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Area Agency on Aging of Northwest Michigan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Area Agency on Aging of Northwest Michigan has a robust system dedicated to monitoring encounter data submissions, designed to ensure the accuracy, completeness, and timely submission of encounter data to MDHHS. [**Quality**]

Strength #3: Area Agency on Aging of Northwest Michigan submitted professional encounters in a timely manner from the payment date, with greater than 99.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #4: Across all professional encounters, most key data elements for **Area Agency on Aging of Northwest Michigan** were populated at high rates, and most data elements were greater than 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Although not required to be populated, 11.9 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Area Agency on Aging of Northwest Michigan should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-24 presents **Area 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 3-24 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-24—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	95.9%	93.2%	91.8%
Recommendation Measures	96.4%	94.2%	92.1%
Staff are Reliable and Helpful	95.3%	94.2%	92.1%
Staff Listen and Communicate Well	96.6%	96.8%	94.6%
Case Manager is Helpful	91.0%	97.9% ↑	95.8%
Choosing the Services that Matter to You	93.0%	92.7%	90.8%
Transportation to Medical Appointments	95.0%	**98.0%**	92.4%
Personal Safety and Respect	99.1%	99.2%	97.4%

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Planning Your Time and Activities	74.4%	80.6% ↑	78.5%
Met Need	95.7%	94.1%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 Northwest Michigan achieved scores higher than the statewide results in the following domains: *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*, and *Met Need*, indicating that **Area Agency on Aging of Northwest Michigan** provides services in a manner that meets or exceeds members' expectations in many domains. **Area Agency on Aging of Northwest Michigan** also demonstrated improvement in rates across all measures, with two measure rates, *Case Manager is Helpful* and *Planning Your Time and Activities*, increasing by 5 percentage points or more. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Area 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.

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

Recommendation: Although **Area Agency on Aging of Northwest Michigan** scored above the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Area Agency on Aging of Northwest Michigan** should prioritize improvement efforts on questions within this domain that received low scores.

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

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

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

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Area Agency on Aging of Northwest Michigan** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members by addressing risks and providing information regarding abuse, neglect, and exploitation. Additionally, through the CAHPS HCBS survey, **Area Agency on Aging of Northwest Michigan** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. However, while **Area Agency on Aging of Northwest Michigan**, through the Home Interview section of the CQAR activity, demonstrated high performance in the Critical Incidents focus area, no records applied to this focus area during the Record Review section to

Performance Area	Overall Performance Impact
	assess **Area Agency on Aging of Northwest Michigan**'s compliance level. Further, through its implementation of PIPs, **Area Agency on Aging of Northwest Michigan** outcomes increased for the *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs and did not meet the statewide goals, which indicated its implemented interventions were not effective. These findings could imply that while **Area Agency on Aging of Northwest Michigan** ensures the health and safety of members when providing services directly to the member, it lacks the appropriate follow-up and action when falls and injuries occur outside of the waiver agency's control. **Area Agency on Aging of Northwest Michigan** should develop new, evidence-based improvement efforts that address the waiver agency's identified barriers, continue to test and evaluate, and make changes to the interventions based on their effectiveness.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the PMV activity, Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, and through the CQAR Assessment and Person-Centered Service Planning focus areas, **Area Agency on Aging of Northwest Michigan** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the CAHPS HCBS survey, **Area Agency on Aging of Northwest Michigan**'s rates for the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* demonstrated that members are generally satisfied with the case managers and person-centeredness of the service planning provided to them. This suggests that **Area Agency on Aging of Northwest Michigan** conducts care coordination and person-centered service planning according to policies and procedures and ensures person-centered case management services are provided to each individual member.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Area Agency on Aging of Northwest Michigan** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, and Follow-Up and Monitoring focus areas. Additionally, through the CAHPS HCBS survey, **Area Agency on Aging of Northwest Michigan** scored higher than the statewide averages for the *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, and *Met Need* domains. Further, three performance measures scored above the statewide averages: Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*; Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*; and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*. Performance Measure 20 also improved over the prior year's rate. However, the

Performance Area	Overall Performance Impact
	CQAR Contingency Plan focus area scored a *Not Full or Substantial* compliance level. These findings could imply that although **Area Agency on Aging of Northwest Michigan** generally ensures access to waiver services, **Area Agency on Aging of Northwest Michigan** does not consistently ensure members have a backup plan in place if services are not available. **Area Agency on Aging of Northwest Michigan** should implement its CAP to conduct staff education and ongoing chart audits, and explore additional interventions to improve performance if performance improvement is not realized.

Area Agency on Aging of Western Michigan

Validation of Performance Improvement Projects

Performance Results

Table 3-26 displays the PIPs in place during SFY 2022. Table 3-26 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Area Agency on Aging of Western Michigan** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Area Agency on Aging of Western Michigan** did not meet the statewide goal or the *New Goal*. Any interventions described within **Area Agency on Aging of Western Michigan**'s QMP reports are also provided in Table 3-26. The results in Table 3-26 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-26—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 26.7% SFY 2022 = 19.80% ☑
Interventions: • Conducted root cause analysis for individual falls. • Created a template for supports coordinators to use at the time of the assessment to reduce risks within the member's environment, medications, etc. • Monitored unplanned transitions monthly. • Created a Falls Prevention Protocol in December 2022. We are now monitoring monthly for "repeat fallers" month-to-month and those who have two (2) or more falls in a month		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging of Western Michigan**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to your description, quality control methods, monitoring, evaluating, and corrective action plans? • MDHHS has included the Statewide average and **Area Agency on Aging of Western Michigan** information below. The Statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the waiver agency's participants. The goals listed in your QMP were 27% and 5.5% which are above the statewide averages. It is also not clear what you are going to do to address Prevalence of Falls or Prevalence of Injuries.		

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 5.1% SFY 2022 = 3.70% ☒
Interventions: • Supports coordinator education on documentation. • Conducted root cause analysis for individual injuries. • Monitored unplanned transitions monthly. • Update to system so questions are automatically reset for each assessment.		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging of Western Michigan**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to your description, quality control methods, monitoring, evaluating, and corrective action plans? • MDHHS has included the Statewide average and **Area Agency on Aging of Western Michigan** information below. The Statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the waiver agency's participants. The goals listed in your QMP were 27% and 5.5% which are above the statewide averages. It is also not clear what you are going to do to address Prevalence of Falls or Prevalence of Injuries.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.
±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.
☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.
☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.
Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-27 displays the two PIPs **Area Agency on Aging of Western Michigan** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-27 is displayed as reported by **Area Agency on Aging of Western Michigan** and was not validated by HSAG.

Table 3-27—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the number of falls with injuries experienced by MI Choice participants to 5% or less.	Baseline: 0.008% SFY 2023: Not yet reported
Interventions: • Root cause analysis • Chart audits • Metrics to be reviewed monthly • Develop a plan for improvement • Staff education • Participant education		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging of Western Michigan**: • Please include narrative as outlined in the QAPI outline and include goals.		
Advance Benefit Notice (ABN) Accuracy	Increase ABN accuracy by ensuring ABNs are sent when required, completed correctly, and sent timely to 90%.	Baseline: 66% SFY 2023: Not yet reported
Interventions: • Root cause analysis • Chart audits • Metrics to be reviewed monthly • Develop a plan for improvement • Staff education		
PIP Validation Feedback: MDHHS provided the following feedback to **Area Agency on Aging of Western Michigan**: • Please include narrative as outlined in the QAPI outline and include goals.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 the MDHHS-established goal (i.e., statewide goal) for the *Prevalence of Falls* PIP. The reduction in the prevalence rate for this PIP was

primarily attributed to the implementation of a process to monitor members who have two or more falls within a month as indicated by the waiver agency. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Area Agency on Aging of Western Michigan** did not appear to be effective in improving outcomes for the *Prevalence of Any Injuries* PIP as the prevalence rate increased, and **Area Agency on Aging of Western Michigan** did not reach the MDHHS-established goal (i.e., statewide goal). **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 PIP. [**Quality**]

Why the weakness exists: **Area Agency on Aging of Western Michigan** discovered some supports coordinators were not resetting the questions in the "Next Assessment" to "Not Present." This resulted in injuries that were resolved continuing to show up and being erroneously included in the quality indicators report.

Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** implement an auditing and monitoring process to ensure all injuries are being documented appropriately (i.e., timely, detailed, etc.) to improve the consistency with which injuries are documented across all staff members. HSAG also 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). Additionally, **Area Agency on Aging of Western Michigan** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **Area Agency on Aging of Western Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **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 #2: **Area Agency on Aging of Western Michigan**'s SFY 2022 PIP results differed from those reported by MDHHS.

Why the weakness exists: **Area Agency on Aging of Western Michigan** did not document its methodology in its QMP documentation (e.g., the time frames for measurement). As such, it is unclear if **Area Agency on Aging of Western Michigan** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Area Agency on Aging of Western Michigan** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Area Agency on Aging of Western Michigan** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Area Agency on Aging of Western Michigan**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Area Agency on Aging of Western Michigan** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.
Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Area Agency on Aging of Western Michigan** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Area Agency on Aging of Western Michigan QAPI Plan FY2023 to FY2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Area Agency on Aging of Western Michigan**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.
Recommendation: HSAG recommends that **Area Agency on Aging of Western Michigan** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Area Agency on Aging of Western Michigan** in a methodologically sound manner. HSAG further recommends that **Area Agency on Aging of Western Michigan**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Area Agency on Aging of Western Michigan** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Area Agency on Aging of Western Michigan** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Area Agency on Aging of Western Michigan** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-28 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-28 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-28, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-28—Waiver Agency Impact to Statewide Performance Measure Rates

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	100%	77.42% ↓	86.65%
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	98.48%	96.72%	93.72%
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	100%	100%	98.95%
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	100%	100%	100%
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	100%	100%	100%
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	98.31%	96.18%	94.76%
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	100%	91.94% ↓	93.19%
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	91.38%	90.32%	82.72%
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	97.07%	92.00% ↓	91.10%
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	96.00%	80.77% ↓	88.74%

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**93.02%**	**97.14%**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**86.21%**	**90.32%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**41.94%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Area Agency on Aging of Western Michigan**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures, not calculated through CQAR record reviews, that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Area Agency on Aging of Western Michigan received a 100 percent performance rating for Performance Measures 4, 7, 8, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging of Western 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 9.23 percentage points below the statewide rate and a decrease of 22.58 percentage points from **Area Agency on Aging of Western Michigan**'s SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that seven of the 31 applicable records did not demonstrate that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements. **Area Agency on Aging of Western Michigan** noted that this is the first time CQAR has identified that a hospice referral/admission and a diagnosis of Alzheimer's disease should be considered a significant change and a significant change reassessment is needed. Additionally, **Area Agency on Aging of Western Michigan** identified issues related to the timely completion of the reassessment and/or Person-Centered Planning meetings.

Recommendation: While **Area Agency on Aging of Western Michigan**'s CAP included staff education and monthly audits of records, HSAG recommends that the education include clear definitions for significant change events so staff know when a reassessment is required. **Area Agency on Aging of Western Michigan** should also update its policies and procedures to include all events that are considered a significant change. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Area Agency on Aging of Western 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 7.97 percentage points below the statewide rate and a decrease of 15.23 percentage points from **Area Agency on Aging of Western Michigan**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that seven of the 31 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and three of the 21 applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements. **Area Agency on Aging of Western Michigan** noted that this is the first time CQAR has identified that a hospice referral/admission and a diagnosis of Alzheimer's disease should be considered a significant change and a significant change reassessment is needed. Additionally, **Area Agency on Aging of Western Michigan** identified issues related to timely completion of the reassessment and/or Person-Centered Planning meetings and supports coordinators not recognizing when an appropriate MI Choice service or alternative was to be offered to the member.

Recommendation: While **Area Agency on Aging of Western Michigan**'s CAP included staff education and monthly audits of records, HSAG recommends that the education include updated and clear definitions for significant change events so staff know when a reassessment is required. The education should also specifically include when an MI Choice service or alternative service should be offered to the member. Additionally, **Area Agency on Aging of Western Michigan** should update its policies and procedures to include all events that are considered a significant change. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-29 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 interviews. Table 3-29 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-29—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	90.32%		**4.00**	4.00
Focus 3	Release of Information	90.32%		**4.00**	4.00
Focus 4	Status	100%		**4.00**	4.00
Focus 5	Pre-Planning	97.19%	100%	**4.00**	4.00
Focus 6	Assessment	93.93%	100%	**4.00**	4.00
Focus 7	Medication Record	87.88%	100%	**4.00**	3.34
Focus 8	Person-Centered Service Planning	87.83%	100%	**4.00**	4.00
Focus 9	MI Choice Services	94.32%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	86.30%	95.83%	**3.34**	4.00
Focus 11	Follow-Up and Monitoring	81.82%	100%	**3.34**	4.00
Focus 12	Service Provider	95.65%		**4.00**	4.00
Focus 13	Contingency Plan	68.89%	100%	**2.02**	4.00
Focus 14	Critical Incidents	45.00%	100%	**2.02**	2.02

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	76.92%		**3.00**	4.00
Focus 16	Complaints and Grievances	75.00%		**2.00**	4.00
Focus 17	Home and Community Based		98.33%	**4.00**	4.00
	Totals	**90.12%**	**99.64%**	**3.72**	3.86

Indicates the standard was not reviewed as part of the record review or home visit.
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 13 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to 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 Contingency Plan requirements; specifically, ensuring there is a complete and up-to-date contingency plan, ensuring that the member/guardian received a copy of the contingency plan, and

ensuring that other allies received a copy of the contingency plan. Contingency plans are important to ensure that if the member's PCSP services are unavailable, the member will still have services in place until planned services can resume. **Area Agency on Aging of Western Michigan** also received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 18 out of 31 applicable records did not demonstrate evidence that the record contained a complete and up-to-date contingency plan; eight out of 31 applicable records did not demonstrate evidence that the member/guardian received a copy of the contingency plan; and two out of 18 applicable records did not demonstrate evidence that other allies included in the plan received a copy of the contingency plan as preferred by the member/guardian. **Area Agency on Aging of Western Michigan** reported that supports coordinators did not adhere to **Area Agency on Aging of Western Michigan** internal procedures.

Recommendation: One of the deficiencies was not identified as a citation by MPHI and the other two were new citations. As such, HSAG recommends that **Area Agency on Aging of Western Michigan** continue to implement its CAP to conduct staff education and ongoing chart audits. Additionally, HSAG recommends that **Area Agency on Aging of Western Michigan** ensure that remediation efforts are put in place for the deficiency not requiring a CAP. However, if improvement is not realized, **Area Agency on Aging of Western Michigan** should modify its CAP and other remediation efforts and implement alternative interventions.

Weakness #2: Area Agency on Aging of Western Michigan did not consistently follow all Critical Incident 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 two out of five applicable records did not demonstrate evidence that the supports coordinator addressed the incident with the member/guardian; four out of five 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 five out of 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. **Area Agency on Aging of Western Michigan** reported that supports coordinators did not adhere to **Area Agency on Aging of Western Michigan** internal procedures. Additionally, **Area Agency on Aging of Western Michigan** was not consistently reporting falls that were not caused by abuse or neglect.

Recommendation: MDHHS required **Area Agency on Aging of Western Michigan** to submit a CAP to remediate the deficiencies. However, the three deficiencies have been noted as noncompliant for the past two years; therefore, **Area Agency on Aging of Western Michigan**'s interventions have not led to performance improvement. HSAG recommends that **Area Agency on Aging of Western Michigan** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Area Agency on Aging of Western Michigan** could develop a critical incident

template that must be completed by the supports coordinator for every incident. This template should include all required tasks that must be completed when a critical incident occurs. Management could review the templates as they are completed to immediately address any gaps with the supports coordinator in real time.

Weakness #3: Area Agency on Aging of Western Michigan did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. **Area Agency on Aging of Western Michigan** also received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of eight applicable records did not demonstrate evidence that the member/guardian was made aware of the resolution of complaints or grievances as warranted. **Area Agency on Aging of Western Michigan** reported that supports coordinators did not adhere to **Area Agency on Aging of Western Michigan** internal procedures.

Recommendation: As this was a new citation, HSAG recommends that **Area Agency on Aging of Western Michigan** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **Area Agency on Aging of Western Michigan** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Area Agency on Aging of Western Michigan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Area Agency on Aging of Western Michigan**'s original questionnaire responses, and **Area Agency on Aging of Western Michigan** responded to these specific questions. To support its questionnaire responses, **Area Agency on Aging of Western Michigan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Area Agency on Aging of Western Michigan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-30 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-30—EDV Results for Area Agency on Aging of Western Michigan

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Area Agency on Aging of Western Michigan** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Area Agency on Aging of Western Michigan** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Area Agency on Aging of Western Michigan** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Area Agency on Aging of Western Michigan** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.

Analysis	Key Findings
Payment Structures	• **Area Agency on Aging of Western Michigan** utilizes line-by-line method for its claim payment strategies. • **Area Agency on Aging of Western Michigan**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Area Agency on Aging of Western Michigan** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Area Agency on Aging of Western Michigan** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Area Agency on Aging of Western Michigan**'s encounters, **Area Agency on Aging of Western Michigan** indicated that it did not store data sent to MDHHS. • **Area Agency on Aging of Western Michigan** and/or its subcontractors conducted claim volume by submission month, and field-level completeness and validity for its HCBS encounters. For non-emergency medical transportation (NEMT) encounters, only claim volume by submission month was conducted as part of the data quality process.
Administrative Profile	
Encounter Data Completeness	• **Area Agency on Aging of Western Michigan** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Area Agency on Aging of Western Michigan** had a low volume of duplicate encounters, with 0.2 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Area Agency on Aging of Western Michigan** demonstrated timely submission for professional encounters. Within 30 days, **Area Agency on Aging of Western Michigan** submitted 90.1 percent of professional encounters to MDHHS after the payment date. After 60 days, **Area Agency on Aging of Western Michigan** submitted greater than 99.9 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• In **Area Agency on Aging of Western Michigan**'s submitted professional encounters, the billing provider NPI was populated 6 percent of the time, and the rendering provider NPI was populated 0 percent of the time.

Analysis	Key Findings
	• All other data elements in **Area Agency on Aging of Western Michigan**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Area Agency on Aging of Western Michigan**'s submitted data, 98.8 percent were identified in the enrollment data. • Of all identified provider NPIs in **Area Agency on Aging of Western Michigan**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Area Agency on Aging of Western Michigan**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Area Agency on Aging of Western Michigan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Area Agency on Aging of Western Michigan submitted professional encounters in a timely manner from the payment date, with greater than 99.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, all key data elements for **Area Agency on Aging of Western Michigan** were populated at high rates, and most data elements were greater than 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging of Western Michigan indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Area Agency on Aging of Western Michigan**'s claims systems is essential for maintaining data quality, ensuring accurate

claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Area Agency on Aging of Western Michigan**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Area Agency on Aging of Western Michigan did not indicate conducting timeliness checks for its HCBS and NEMT encounters or field-level completeness and validity quality checks for its NEMT encounters. [**Quality**]

Why the weakness exists: Area Agency on Aging of Western Michigan showed a gap in its monitoring practices by lacking timeliness checks for both HCBS and NEMT encounters. While claim volume and field-level completeness checks were conducted for HCBS encounters, the absence of timeliness checks poses a risk to ensuring compliance with submission deadlines.

Recommendation: To address this weakness, it is recommended that **Area Agency on Aging of Western Michigan** implement a standardized process for timeliness checks on both HCBS and NEMT encounters. This involves establishing automated monitoring systems capable of tracking submission dates, generating alerts for any delays, and generating reports to provide insights into the timeliness of encounter submissions. Periodic reviews and adjustments of timeliness quality checks based on performance data and changes in regulations or contractual requirements should be considered to enhance the monitoring process.

Weakness #3: Although not required to be populated, 6 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Area Agency on Aging of Western Michigan should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-31 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 3-31 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-31—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	89.2%	87.5%	91.8%
Recommendation Measures	85.8%	88.9%	92.1%
Staff are Reliable and Helpful	92.4%	93.9%	92.1%
Staff Listen and Communicate Well	94.0%	91.1%	94.6%
Case Manager is Helpful	96.0%	93.9%	95.8%
Choosing the Services that Matter to You	94.5%	88.5% ↓	90.8%
Transportation to Medical Appointments	93.3%	90.7%	92.4%
Personal Safety and Respect	96.1%	95.7%	97.4%
Planning Your Time and Activities	77.3%	77.9%	78.5%
Met Need	95.0%	90.2%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 a score higher than the statewide results in the *Staff are Reliable and Helpful* domain, indicating that **Area Agency on Aging of Western Michigan** provides services in a manner that meets or exceeds members' expectations in this domain. [**Quality**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Area Agency on Aging of Western 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.

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 of Western Michigan** scored below the statewide average on the *Global Ratings Measures*, *Recommendation Measures*, *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*, and *Met Need* domains; therefore, HSAG recommends that **Area Agency on Aging of Western Michigan** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within these domains, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **Area Agency on Aging of Western Michigan** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Area Agency on Aging of Western Michigan** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Area Agency on Aging of Western Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Area Agency on Aging of Western Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Area Agency on Aging of Western Michigan**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-32 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Area Agency on Aging of Western Michigan**'s MI Choice members.

Table 3-32—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Area Agency on Aging of Western Michigan** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information regarding abuse, neglect, and exploitation. Additionally, through the CAHPS HCBS survey, **Area Agency on Aging of Western Michigan** showed a strong focus on member health and safety through a high rating in the *Physical Safety Measure* domain. Further, through the PIP activity, **Area Agency on Aging of Western Michigan**'s *Prevalence of Falls* rate decreased from the prior year, and the waiver agency met the statewide goal, indicating its interventions for decreasing the prevalence of falls were effective. However, through the CAHPS HCBS activity, while the *Personal Safety and Respect* domain had a rating of 95.7 percent, it remained below the statewide average and decreased from the prior year's rate. Additionally, through its implementation of the *Prevalence of Any Injuries* PIP, although **Area Agency on Aging of Western Michigan**'s rate decreased, it did not meet the statewide goal, which indicated its implemented interventions were not very effective for this PIP. Further, through the PMV activity, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. Lastly, through the CQAR activity, **Area Agency on Aging of Western Michigan** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. These findings could imply that while **Area Agency on Aging of Western Michigan** ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols and risk mitigation for members in their home/community environments and does not consistently follow all requirements to properly report, investigate, and take action on critical incidents. HSAG recommends that **Area Agency on Aging of Western**

Performance Area	Overall Performance Impact
	Michigan review its barriers for all measures falling below thresholds and implement interventions other than staff education and ongoing chart audits to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the PMV activity, Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, demonstrated high performance in ensuring appropriate and timely person-centered service planning, although both rates decreased from the prior year. Additionally, through the CQAR Assessment and Person-Centered Service Planning focus areas, **Area Agency on Aging of Western Michigan** also demonstrated high performance in ensuring appropriate and timely person-centered service planning. Further, through the CAHPS HCBS survey, **Area Agency on Aging of Western Michigan**'s rate for *Recommendation Measures—Recommendation of Case Manager* demonstrated that members would recommend their case managers. However, the *Global Ratings Measures—Global Rating of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored below the statewide averages; and one measure decreased significantly from the prior year's rate. This suggests that **Area Agency on Aging of Western Michigan** conducts care coordination and person-centered service planning according to policies and procedures, but members do not always find case managers to be helpful or allow them to choose which services are most important to the member. **Area Agency on Aging of Western Michigan** should review these domains to identify barriers to member satisfaction and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Area Agency on Aging of Western Michigan** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, and Follow-Up and Monitoring focus areas. Additionally, through the PMV activity, Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored higher than the statewide averages, although Performance Measure 15 decreased from the prior year. Further, through the CAHPS HCBS survey, **Area Agency on Aging of Western Michigan**'s rate for the *Staff are Reliable and Helpful* domain scored above the statewide average. However, the CQAR Contingency Plan focus area scored a *Not Full or Substantial* compliance level. Additionally, through the CAHPS HCBS survey, the *Transportation to Medical Appointments* and *Met Need* domains scored below the statewide average and decreased from the prior year's rate. Further, Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*,

Performance Area	Overall Performance Impact
	scored below the statewide average. These findings suggest that while **Area Agency on Aging of Western Michigan**'s supports coordinators generally are able to coordinate care for members and services are generally available, **Area Agency on Aging of Western Michigan** did not consistently ensure members have a backup plan in place if services are not available, and members do not always have access to transportation and needs are not always met. **Area Agency on Aging of Western Michigan** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Detroit Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-33 displays the PIPs in place during SFY 2022. Table 3-33 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Detroit Area Agency on Aging** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Detroit Area Agency on Aging** did not meet the statewide goal or the *New Goal*. Any interventions described within **Detroit Area Agency on Aging**'s QMP reports are also provided in Table 3-33. The results in Table 3-33 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-33—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Maintain or reduce the current rate of falls at 16.7% and continue to meet the state standard (23%). *New Goal*: 16.7% or lower	SFY 2021 = 16.7% SFY 2022 = 17.80% ☒
Interventions: • Supports coordinators assessed for falls at every assessment as well as every monthly contact. • Supports coordinators evaluated for and provided assistive devices as needed to help reduce falls. • Supports coordinators evaluated for and provided a personal emergency response system (PERS) when necessary. • Fall prevention training took place at the consumer advisory council in Fiscal Year 2022. • Fall prevention strategies were discussed during provider meetings as part of our educational meetings.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Detroit Area Agency on Aging**.		
Prevalence of Any Injuries	Maintain or reduce the current the current rate of injuries at 2.6% and continue to meet the state standard (3%). *New Goal*: 2.6% or lower	SFY 2021 = 2.6% SFY 2022 = 2.70% ☒

PIP Topic	Goal*	Measurement and Outcome±
Interventions: • Supports coordinators assessed for fractures and skin breakage at each assessment. • If issues were identified, supports coordinators made appropriate referrals to physician, wound nurse, etc. and re-assessed monthly. • Assessment for proper assistive devices was completed and ordered to promote healing. • All participants were screened for any skin abnormalities.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Detroit Area Agency on Aging**.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.
±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.
☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.
☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.
Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-34 displays the two PIPs **Detroit Area Agency on Aging** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-34 is displayed as reported by **Detroit Area Agency on Aging** and was not validated by HSAG.

Table 3-34—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce or maintain falls with injury to 5% or less by the end of fiscal year 2023	Baseline: Less than 1%* SFY 2023: Not yet reported
Interventions: • Educate on fall prevention in collaboration with staff, and will discuss monthly with participants. • Falls will be discussed during monthly calls, and long-term care (LTC) department will analyze for fall risk during environment inspections, and coordinate fall prevention items being put into the homes with home repair.		
PIP Validation Feedback: MDHHS provided the following feedback to **Detroit Area Agency on Aging**: • Can you please provide additional details to describe both the clinical and non-clinical PIP? Please see below for items that should be included as stated in the outline.		

PIP Topic	Goal	Measurement and Outcome
○ Within the QAPI program description, the waiver agencies should describe how their performance improvement project is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. ○ As part of this description, they should explain the methodology they are using to support these requirements (e.g., PDSA [plan-do-study-act], IHI [Institute for Healthcare Improvement] Model for Improvement). ○ Their work plan should include measurement of performance (quality indicators) for each PIP, and interventions implemented to support program improvement. ○ The evaluation must include an assessment of each PIP and the successes and failures, and how the PIP interventions contributed to any successes. Please note that the waiver agencies may want to look into the IHI open school, as it may be good training for their quality staff members.) ○ Do you have a current goal/target for each PIP? Are the percentages listed under the clinical PIP the percent for prevalence of falls vs. falls with injuries?		
Complete Critical Incident timely and per requirement.	Improve the critical incident process with timely filing and accurate filing.	Baseline: 91% SFY 2023: Not yet reported
Interventions: • Quality and LTC will ensure critical incidents are filed in a timely manner. • Quality and LTC will complete critical incident process and close the loop for each incident.		
PIP Validation Feedback: MDHHS provided the following feedback to **Detroit Area Agency on Aging**: • Can you please provide additional details to describe both the clinical and non-clinical PIP. Please see below for items that should be included as stated in the outline. ○ Within the QAPI program description, the waiver agencies should describe how their performance improvement project is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. ○ As part of this description, they should explain the methodology they are using to support these requirements (e.g., PDSA, IHI Model for Improvement). ○ Their work plan should include measurement of performance (quality indicators) for each PIP, and interventions implemented to support program improvement. ○ The evaluation must include an assessment of each PIP and the successes and failures, and how the PIP interventions contributed to any successes. Please note that the waiver agencies may want to look into the IHI open school, as it may be good training for their quality staff members.) ○ Do you have a current goal/target for each PIP? Are the percentages listed under the clinical PIP the percent for prevalence of falls vs. falls with injuries?		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.
* While the waiver agency reported its baseline rate as less than 1 percent, HSAG calculated a baseline rate of 1.91 percent based on the waiver agency's reported numerator of 25 and denominator of 1,308.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for both of **Detroit Area Agency on Aging**'s PIPs increased from the baseline measurement, 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: The interventions implemented by **Detroit Area Agency on Aging** did not appear to be effective in improving outcomes as the prevalence rates increased for both SFY 2022 PIPs, and **Detroit Area Agency on Aging** did not reach the MDHHS-established goals (i.e., *New Goals*). **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 PIPs. [**Quality**]

Why the weakness exists: **Detroit Area Agency on Aging** did not conduct a barrier or root cause analysis to determine why prevalence rates increased for both PIPs.

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). **Detroit Area Agency on Aging** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. **Detroit Area Agency on Aging** should also analyze and interpret results at multiple points in time and test for statistical significance. Finally, **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 #2: **Detroit Area Agency on Aging**'s SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: **Detroit Area Agency on Aging** did not document its methodology in its QMP documentation. As such, it is unclear if **Detroit Area Agency on Aging** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Detroit Area Agency on Aging** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally,

HSAG recommends that both **Detroit Area Agency on Aging** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Detroit Area Agency on Aging**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Detroit Area Agency on Aging** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Detroit Area Agency on Aging** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The QAPI Waiver Agency: Detroit Area Agency on Aging FY: 2023 & FY2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Detroit Area Agency on Aging**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Detroit Area Agency on Aging** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Detroit Area Agency on Aging** in a methodologically sound manner. HSAG further recommends that **Detroit Area Agency on Aging**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Detroit Area Agency on Aging** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Detroit Area Agency on Aging** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Detroit Area Agency on Aging** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-35 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-35 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-35, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-35—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**75.61%**	**73.68%**	**86.65%**
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	**92.66%**	**91.97%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**92.26%**	**96.15%**	**94.76%**
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	**98.78%**	**92.11% ↓**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**89.02%**	**76.32% ↓**	**82.72%**
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	**91.36%**	**89.16%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**78.57%**	**72.88% ↓**	**88.74%**
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	**92.86%**	**91.49%**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.12%**	**76.32% ↓**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**97.56%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	—	**44.74%**	**42.67%**

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Detroit Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures, not calculated through CQAR record reviews, that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Detroit Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 7, 8, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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**]

Weaknesses and Recommendations

Weakness #1: Detroit Area Agency on Aging 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 12.97 percentage points below the statewide rate and a decrease of 1.93 percentage points from **Detroit Area Agency on Aging**'s SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 of the 38 applicable records did not demonstrate that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements. **Detroit Area Agency on Aging** identified supports coordinators not having a clear understanding of the PCSP process and recruitment and retention issues as the root causes of noncompliance with these requirements.

Recommendation: While **Detroit Area Agency on Aging**'s CAP included improvements in the hiring and orientation processes, HSAG recommends that **Detroit Area Agency on Aging** explore potential system enhancements or another avenue for automatic reminders to supports coordinators when PCSPs are coming due. **Detroit Area Agency on Aging** could also consider ongoing training in addition to its monthly record reviews. Additionally, HSAG recommends that the waiver agency

continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Detroit Area Agency on Aging 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 6.4 percentage points below the statewide rate and a decrease of 12.7 percentage points from **Detroit Area Agency on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 18 of the 38 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **Detroit Area Agency on Aging** identified supports coordinators not having a clear understanding of the PCSP process and recruitment and retention issues as the root causes of noncompliance with these requirements.

Recommendation: While **Detroit Area Agency on Aging**'s CAP included improvements in the hiring and orientation processes and monthly record reviews, HSAG recommends that **Detroit Area Agency on Aging** consider ongoing training to ensure staff members continue to have a clear understanding of all requirements. Additionally, **Detroit Area Agency on Aging** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #3: 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 15.86 percentage points below the statewide rate and a decrease of 5.69 percentage points from **Detroit Area Agency on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 of the 38 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and six of the 21 applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements. **Detroit Area Agency on Aging** identified supports coordinators not having a clear understanding of the PCSP process and recruitment and retention issues as the root causes of noncompliance with these requirements. **Detroit Area Agency on Aging** also identified that supports coordinators need additional training regarding MI Choice services.

Recommendation: While **Detroit Area Agency on Aging**'s CAP included improvements in the hiring and orientation processes and additional staff education, HSAG recommends that **Detroit Area Agency on Aging** explore potential system enhancements or another avenue for automatic reminders to supports coordinators when PCSPs are coming due. **Detroit Area Agency on Aging** could also consider ongoing training in addition to its monthly record reviews. Additionally, HSAG

recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #4: Detroit Area Agency on Aging 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 12.95 percentage points below the statewide rate and a decrease of 18.8 percentage points from **Detroit Area Agency on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that nine of the 38 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian a choice of appropriate MI Choice Waiver Program services. **Detroit Area Agency on Aging** identified that supports coordinators need additional training regarding MI Choice services.

Recommendation: While **Detroit Area Agency on Aging**'s CAP included additional staff education, HSAG recommends that **Detroit Area Agency on Aging** also consider ongoing training in addition to its monthly record reviews. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-36 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 interviews. Table 3-36 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-36—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	92.11%		**4.00**	1.00
Focus 3	Release of Information	89.47%		**4.00**	2.00
Focus 4	Status	85.37%		**3.00**	4.00
Focus 5	Pre-Planning	96.42%	100%	**4.00**	4.00
Focus 6	Assessment	92.06%	98.25%	**4.00**	4.00
Focus 7	Medication Record	89.95%	100%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	85.85%	100%	**4.00**	4.00
Focus 9	MI Choice Services	90.52%	99.25%	**4.00**	4.00
Focus 10	Linking and Coordinating	87.06%	98.33%	**3.33**	4.00
Focus 11	Follow-Up and Monitoring	68.24%	98.68%	**2.00**	2.02
Focus 12	Service Provider	90.48%		**4.00**	4.00
Focus 13	Contingency Plan	71.43%	97.37%	**2.67**	4.00
Focus 14	Critical Incidents	50.00%	100%	**2.00**	2.02

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	63.64%		**1.00**	1.00
Focus 16	Complaints and Grievances	66.67%		**1.00**	4.00
Focus 17	Home and Community Based		NA	**NA**	NA
	Totals	**88.19%**	**99.34%**	**3.60**	3.73

Indicates the standard was not reviewed as part of the record review or home visit.
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: A review of 19 home visits was conducted; all reviews achieved full compliance except for six deficiencies, and no focus areas received a citation requiring a CAP. 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 nearly full compliance, the record review identified conflicting results in the areas of Follow-Up and Monitoring and Critical Incidents. [**Quality**]

Strength #2: Detroit Area Agency on Aging achieved a substantial compliance rating in 10 of the applicable 16 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were 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 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 four out of nine applicable records did not include evidence that the waiver agency contacted the newly enrolled members/guardians to ensure service delivery in accordance with MDHHS policy and contract requirements; 23 out of 38 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP; and one out of the applicable 19 home visits did not indicate that the member was satisfied with his/her MI Choice services. **Detroit Area Agency on Aging** reported that supports coordinators did not adhere to MI Choice waiver policies and procedures.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. However, one of the three deficiencies has been noted as noncompliant for the past two years, and one has been noted as noncompliant for the past six years; therefore, **Detroit Area Agency on Aging**'s interventions have not led to performance improvement. HSAG recommends that **Detroit Area Agency on Aging** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Detroit Area Agency on Aging** could implement system prompts or another similar workflow that reminds supports coordinators when follow-up is due.

Weakness #2: Detroit Area Agency on Aging did not consistently follow all Critical Incident requirements. Specifically, **Detroit Area Agency on Aging** did not ensure it was 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 supports coordinator took appropriate action and discussed methods to prevent further occurrence with the member/guardian; and 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. **Detroit**

Area Agency on Aging did not identify a root cause for this deficiency but concluded that responsible staff need additional training.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. However, one of the two deficiencies has been noted as noncompliant for the past four years; therefore, **Detroit Area Agency on Aging**'s interventions have not led to performance improvement. HSAG recommends that **Detroit Area Agency on Aging** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Detroit Area Agency on Aging** could develop a critical incident template that must be completed by the supports coordinator for every incident. This template should include all required tasks that must be completed when a critical incident occurs. Management could review the templates as they are completed to immediately address any gaps with the supports coordinator in real time.

Weakness #3: 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 NABDs are important to ensure members understand their appeal rights and the process to request an appeal. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that nine out of 23 applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and seven out of 20 applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate. **Detroit Area Agency on Aging** reported that staff inconsistently created gaps in the ABD process, which resulted in untimely delivery of documents and staff were not consistently filling out the forms accurately.

Recommendation: MDHHS required **Detroit Area Agency on Aging** to submit a CAP to remediate the deficiencies. However, one of the two deficiencies has been noted as noncompliant for the past 11 years, and the other deficiency has been noted as noncompliant for the past four years; therefore, **Detroit Area Agency on Aging**'s interventions have not led to performance improvement. HSAG recommends that **Detroit Area Agency on Aging** update its CAP to include interventions other than a new process, staff education, and ongoing chart audits. For example, **Area Agency on Aging 1-B** could implement system prompts or another similar workflow that reminds supports coordinators when to mail the AAN/ABD.

Weakness #4: Detroit Area Agency on Aging did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. **Detroit Area Agency on Aging** also received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one out of three applicable records did not demonstrate evidence that the member/guardian was made aware of the resolution of

complaints or grievances as warranted. **Detroit Area Agency on Aging** did not identify a root cause for this deficiency but concluded training is required on grievances and complaints.

Recommendation: As this was a new citation, HSAG recommends that **Detroit Area Agency on Aging** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **Detroit Area Agency on Aging** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Detroit Area Agency on Aging** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Detroit Area Agency on Aging**'s original questionnaire responses, and **Detroit Area Agency on Aging** responded to these specific questions. To support its questionnaire responses, **Detroit Area Agency on Aging** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Detroit Area Agency on Aging** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-37 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-37—EDV Results for Detroit Area Agency on Aging

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Detroit Area Agency on Aging** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Detroit Area Agency on Aging** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Detroit Area Agency on Aging** explained that the system automatically addresses these claims by categorizing them as replacement or void claims.

Analysis	Key Findings
	• **Detroit Area Agency on Aging** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Detroit Area Agency on Aging** utilizes line-by-line method for its claim payment strategies. • **Detroit Area Agency on Aging**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Detroit Area Agency on Aging** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Detroit Area Agency on Aging** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Detroit Area Agency on Aging**'s encounters, **Detroit Area Agency on Aging** indicated that it did not store data sent to MDHHS. • **Detroit Area Agency on Aging** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Detroit Area Agency on Aging** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Detroit Area Agency on Aging** had a low volume of duplicate encounters, with 0.2 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Detroit Area Agency on Aging** did not display timely submission for professional encounters. Within 60 days, **Detroit Area Agency on Aging** submitted 86.3 percent of professional encounters to MDHHS after the payment date, and within 180 days, **Detroit Area Agency on Aging** submitted 89.8 percent of encounters to MDHHS. Within 300 days, **Detroit Area Agency on Aging** submitted 99.8 percent of encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **Detroit Area Agency on Aging**'s submitted professional encounters, the billing provider NPI was populated 26.2 percent of the time, and the rendering provider NPI was populated 0 percent of the time.

Analysis	Key Findings
	• All other data elements in **Detroit Area Agency on Aging**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Detroit Area Agency on Aging**'s submitted data, 99.6 percent were identified in the enrollment data. • Of all identified provider NPIs in **Detroit Area Agency on Aging**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Detroit Area Agency on Aging**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Detroit Area Agency on Aging demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Across all professional encounters, most key data elements for **Detroit Area Agency on Aging** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Detroit Area Agency on Aging indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Detroit Area Agency on Aging**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Detroit Area Agency on Aging**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Detroit Area Agency on Aging reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Detroit Area Agency on Aging appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Detroit Area Agency on Aging should consider enhancing its data management practices. HSAG recommends that **Detroit Area Agency on Aging** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Detroit Area Agency on Aging did not submit professional encounters timely, where 86.3 percent of professional encounters were submitted within 60 days of payment, and not reaching greater than 99 percent of encounters submitted until within 300 days of payment. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Detroit Area Agency on Aging should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #4: Although not required to be populated, 26.2 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Detroit Area Agency on Aging should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-38 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 3-38 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-38—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	94.6%	92.9%	91.8%
Recommendation Measures	96.7%	94.4%	92.1%
Staff are Reliable and Helpful	91.5%	93.1%	92.1%
Staff Listen and Communicate Well	97.4%	97.5%	94.6%
Case Manager is Helpful	99.1%	100%	95.8%
Choosing the Services that Matter to You	94.0%	93.4%	90.8%
Transportation to Medical Appointments	87.2%	90.1%	92.4%
Personal Safety and Respect	100%	98.3%	97.4%
Planning Your Time and Activities	71.5%	77.2% ↑	78.5%
Met Need	99.1%	95.4%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *Global Rating 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*, and *Met Need*, indicating that **Detroit Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Detroit 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.

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, **Detroit Area Agency on Aging** scored below the statewide average on the *Transportation to Medical Appointments* and *Planning Your Time and Activities* domains; therefore, HSAG recommends that **Detroit Area Agency on Aging** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within these domains, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **Detroit Area Agency on Aging** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Detroit Area Agency on Aging** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Detroit Area Agency on Aging**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Detroit Area Agency on Aging** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Detroit Area Agency on Aging**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-39 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Detroit Area Agency on Aging**'s MI Choice members.

Table 3-39—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Detroit Area Agency on Aging** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information regarding abuse, neglect, and exploitation. Additionally, through the CAHPS HCBS survey, **Detroit Area Agency on Aging** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. However, through the PIP activity, **Detroit Area Agency on Aging**'s *Prevalence of Falls* and *Prevalence of Any Injuries* rates increased from the prior year, so the waiver agency's goals were not met, indicating the interventions implemented did not sustain **Detroit Area Agency on Aging**'s previous high performance. Additionally, through the PMV activity, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. Lastly, through the CQAR activity, **Detroit Area Agency on Aging** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. These findings could imply that while **Detroit Area Agency on Aging** ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols and risk mitigation for members in their home/community environments and does not consistently follow all requirements to properly report, investigate, and take action on critical incidents. HSAG recommends that **Detroit Area Agency on Aging** review its barriers for all measures falling below thresholds and implement interventions other than staff education and ongoing chart audits to address the barriers.

Performance Area	Overall Performance Impact
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Detroit Area Agency on Aging** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the CAHPS HCBS survey, **Detroit Area Agency on Aging**'s rates for the *Case Manager is Helpful* and *Choosing the Services that Matter to You* domains scored higher than the statewide averages, and *Case Manager is Helpful* scored higher than the prior year. However, *Recommendation Measures—Recommendation of Case Manager* and *Global Ratings Measures—Global Rating of Case Manager* scored below the statewide averages. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, fell below the statewide averages and both measures decreased from the prior year's rates. These findings suggest that **Detroit Area Agency on Aging** generally helps members and works with the members to choose the appropriate services, but members would not always recommend their case managers, and **Detroit Area Agency on Aging** does not consistently conduct care coordination and person-centered service planning according to policies and procedures. **Detroit Area Agency on Aging** should review all measures related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Detroit Area Agency on Aging** demonstrated a *Substantial* compliance level in the MI Choice Services and Linking and Coordinating focus areas. Additionally, through the PMV activity, three performance measures scored higher than the statewide averages: Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*; Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*; and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*. However, Performance Measure 20 decreased from the prior year. Further, through the CAHPS HCBS survey, **Detroit Area Agency on Aging**'s rates for the *Staff are Reliable and Helpful* and *Met Need* domains scored above the statewide average. However, the CQAR Follow-Up and Monitoring focus area scored a *Not Full or Substantial* compliance level, the Contingency Plan focus area scored a *Some Compliance, Needs Improvement* compliance level, and the Adverse Benefit Determination focus area scored a *Not Demonstrated* compliance level. Additionally, through the CAHPS HCBS survey, although the current rate increased from the prior year's rate, the *Transportation to Medical Appointments* domain scored below the statewide average. These findings suggest that while **Detroit Area Agency on Aging**'s supports coordinators generally are able to coordinate care for

Performance Area	Overall Performance Impact
	members and services are generally available, **Detroit Area Agency on Aging** does not consistently ensure members have a backup plan in place if services are not available, members' needs are not always met, members do not always have access to transportation, and **Detroit Area Agency on Aging** does not consistently follow up on services that have been requested. **Detroit Area Agency on Aging** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Easterseals/MORC

Validation of Performance Improvement Projects

Performance Results

Table 3-40 displays the PIPs in place during SFY 2022. Table 3-40 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Easterseals/MORC** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Easterseals/MORC** did not meet the statewide goal or the *New Goal*. Any interventions described within **Easterseals/MORC**'s QMP reports are also provided in Table 3-40. The results in Table 3-40 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-40—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less. *New Goal*: 18.7% or lower	SFY 2021 = 18.7% SFY 2022 = 25.30% ☒
Interventions: • Quality and Training managers sent out quarterly Quality Indicator reports to supports coordinators to review participants that had reported falls and ensure adequate interventions were in place. • The waiver agency scheduled a presentation/training from an Occupational Therapist on Fall Prevention. • Quality and Training managers created and rolled out a Fall Prevention checklist for supports coordinators to use in the event a participant reports a fall. This checklist included follow up questions to ask and interventions to implement.		
PIP Validation Feedback: MDHHS provided the following feedback to **Easterseals/MORC**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to quality control methods, monitoring, evaluating, and corrective action plans? • Please include your baseline and goals. Your falls goal should reflect 18.7% or lower and 3.0% or lower for injuries. Please include the baseline, goals, and show it is going to be reported as a numerator/denominator (listed in the instructions). Please also summarize your activities and strategies.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 3.8% SFY 2022 = 1.40% ☑

PIP Topic	Goal*	Measurement and Outcome±
Interventions: • Quality and Training managers sent out quarterly Quality Indicator reports to supports coordinators to review participants that had reported injuries and ensure adequate interventions were in place. • Quality and Training managers ran the Quality Indicator report quarterly to assess compliance, if the agency was not meeting the goal, further interventions were be put in place to attempt to improve.		
PIP Validation Feedback: MDHHS provided the following feedback to **Easterseals/MORC**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to quality control methods, monitoring, evaluating, and corrective action plans? • Please include your baseline and goals. Your falls goal should reflect 18.7% or lower and 3.0% or lower for injuries. Please include the baseline, goals, and show it is going to be reported as a numerator/denominator (listed in the instructions). Please also summarize your activities and strategies.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.
±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.
☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.
☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.
Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-41 displays the two PIPs **Easterseals/MORC** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-41 is displayed as reported by **Easterseals/MORC** and was not validated by HSAG.

Table 3-41—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the risk of falls with injury when falls occur to 10% or less annually.	Baseline: Not reported* SFY 2023: Not yet reported
Interventions: • In depth root-cause analysis. • Focus groups to discuss falls with injury. • Quality Council discussion to obtain participant perspective on falls with injury. • Chart Audits to evaluate all falls with injury. • Best Practice and literature search for evidence-based practices.		

PIP Topic	Goal	Measurement and Outcome
• Development of clinical protocols as deemed necessary. • Development of Quarterly Metrics to report to Quality Committees internally and within MHCSN [Michigan Home and Community Services Network] Association. • Adoption or development of teaching tools for program participants and their informal supports. • Staff training on Falls with Injury. • Development of a metric that focuses on falls with injury.		
PIP Validation Feedback: MDHHS provided the following feedback to **Easterseals/MORC**: • Non-Clinical PIP mislabeled as clinical.		
Follow up and Monitoring	Increase follow up completion to 90% or greater on documented participant follow ups and increase participant satisfaction with follow up as needed as identified in multi-year CQAR Citations.	Baseline (SFY 2022): Not reported* SFY 2023: Not yet reported
Interventions: • In depth root cause analysis. • Focus groups to discuss reasons for not complying with requirement. • Quality council discussions to obtain participant perspective on follow up and timeliness. • Complete support coordination monitoring monthly reports. • Chart audits to evaluate follow up and monitoring timeliness. • Best practice definition developed. • Development of Quarterly Metrics to report to Quality Committees internally and within MHCSN Association. • Development of improvement options to implement.		
PIP Validation Feedback: MDHHS provided the following feedback to **Easterseals/MORC**: • Non-Clinical PIP mislabeled as clinical.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.
* The waiver agency included an estimated baseline only; however, as it was not a true baseline measurement of the waiver agency's performance, HSAG did not include the estimated baseline in this EQR technical report.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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: Easterseals/MORC met the MDHHS-established goal for the *Prevalence of Any Injuries* PIP. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Easterseals/MORC** did not appear to be effective in improving outcomes for the *Prevalence of Falls* PIP as the prevalence rate increased, and **Easterseals/MORC** did not reach the MDHHS-established goal (i.e., *New Goal*). **Easterseals/MORC**'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 PIP. [**Quality**]

Why the weakness exists: Easterseals/MORC did not conduct a barrier or root cause analysis to determine why the prevalence rate increased for this PIP.

Recommendation: HSAG recommends that **Easterseals/MORC** 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). **Easterseals/MORC** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and address these barriers to improve outcomes. Further, **Easterseals/MORC** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **Easterseals/MORC** 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: Easterseals/MORC's SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: Easterseals/MORC did not document its methodology in its QMP documentation. As such, it is unclear if **Easterseals/MORC** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Easterseals/MORC** calculate its results using the same timing and methodology as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Easterseals/MORC** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across

different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Easterseals/MORC**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Easterseals/MORC** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.
Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Easterseals/MORC** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The QAPI (formerly QMP) Outline Waiver Agency: MORC Home Care FY: 23 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Easterseals/MORC**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.
Recommendation: HSAG recommends that **Easterseals/MORC** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Easterseals/MORC** in a methodologically sound manner. HSAG further recommends that **Easterseals/MORC**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Easterseals/MORC** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Easterseals/MORC** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Easterseals/MORC** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-42 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-42 also provides the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Easterseals/MORC**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-42, as only statewide rates were calculated by MDHHS and made available to HSAG.

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

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**100%**	**100%**	**86.65%**
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	**99.07%**	**98.04%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**100%**	**94.76%**
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	**100%**	**100%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**95.00%**	**90.00% ↓**	**82.72%**
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	**98.85%**	**98.47%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**94.74%**	**93.75%**	**88.74%**
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	**100%**	**100%**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**100%**	**100%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	—	**60.00%**	**42.67%**

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Easterseals/MORC**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures, not calculated through CQAR record reviews, that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Easterseals/MORC received a 100 percent performance rating for Performance Measures 1, 4, 7, 8, 15, 16, 20, 21, 22, 24, and 38, indicating that service plans were completed timely; LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; PCSPs included services and supports that aligned with members' assessed needs; PCSPs had strategies to address members' assessed health and safety risks; members received all services and supports identified 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 as **Easterseals/MORC**'s rates were equal to or higher than the statewide rates for all CQAR-related performance measures.

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

Recommendation: Although **Easterseals/MORC** met or exceeded the statewide performance rate for all performance measures, HSAG recommends that **Easterseals/MORC** focus interventions on performance measures demonstrating a 5 percentage point decline from the prior year; specifically, Performance Measure 17.

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 interviews. Table 3-43 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-43—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	90.00%		**4.00**	4.00
Focus 3	Release of Information	90.00%		**4.00**	4.00
Focus 4	Status	100%		**4.00**	4.00
Focus 5	Pre-Planning	100%	100%	**4.00**	4.00
Focus 6	Assessment	96.67%	100%	**4.00**	4.00
Focus 7	Medication Record	86.27%	100%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	97.30%	100%	**4.00**	4.00
Focus 9	MI Choice Services	98.21%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	100%	100%	**4.00**	4.00
Focus 11	Follow-Up and Monitoring	77.27%	100%	**2.67**	4.00
Focus 12	Service Provider	100%		**4.00**	4.00
Focus 13	Contingency Plan	84.62%	100%	**4.00**	4.00
Focus 14	Critical Incidents	91.67%	100%	**4.00**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	87.50%		**4.00**	4.00
Focus 16	Complaints and Grievances	66.67%		**1.00**	4.00
Focus 17	Home and Community Based		93.33%	**4.00**	4.00
	Totals	**95.23%**	**99.60%**	**3.90**	4.00

Indicates the standard was not reviewed as part of the record review or home visit.
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: Easterseals/MORC achieved a substantial compliance rating in 15 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to 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: Easterseals/MORC did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of

any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. **Easterseals/MORC** also received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one out of three applicable records did not demonstrate evidence that the member/guardian was made aware of the resolution of complaints or grievances as warranted. **Easterseals/MORC** reported that the supports coordinator did not follow up with the service provider as needed.

Recommendation: As this was a new citation, HSAG recommends that **Easterseals/MORC** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **Easterseals/MORC** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Easterseals/MORC** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Easterseals/MORC**'s original questionnaire responses, and **Easterseals/MORC** responded to these specific questions. To support its questionnaire responses, **Easterseals/MORC** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Easterseals/MORC** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-44 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-44—EDV Results for Easterseals/MORC

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Easterseals/MORC** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input.

Analysis	Key Findings
	• **Easterseals/MORC** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Easterseals/MORC** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Easterseals/MORC** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Easterseals/MORC** utilizes line-by-line method for its claim payment strategies. • **Easterseals/MORC**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Easterseals/MORC** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Easterseals/MORC** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Easterseals/MORC**'s encounters, **Easterseals/MORC** indicated that it did not store data sent to MDHHS. • **Easterseals/MORC** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Easterseals/MORC** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Easterseals/MORC** had a high volume of duplicate encounters, with 4.5 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Easterseals/MORC** demonstrated timely submission for professional encounters. Within 60 days, **Easterseals/MORC** submitted 99.5 percent of professional encounters to MDHHS after the payment date. Within 150 days, **Easterseals/MORC** submitted 99.9 percent of encounters to MDHHS.

Analysis	Key Findings
Field-Level Completeness and Accuracy	• In **Easterseals/MORC**'s submitted professional encounters, the billing provider NPI was populated 22.1 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Easterseals/MORC**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Easterseals/MORC**'s submitted data, 99 percent were identified in the enrollment data. • Of all identified provider NPIs in **Easterseals/MORC**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Easterseals/MORC**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Easterseals/MORC demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Easterseals/MORC submitted professional encounters in a timely manner from the payment date, with 99.5 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Easterseals/MORC** were populated at high rates, and most data elements were greater than 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Easterseals/MORC indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Easterseals/MORC**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Easterseals/MORC**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Easterseals/MORC reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Easterseals/MORC appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Easterseals/MORC should consider enhancing its data management practices. HSAG recommends that **Easterseals/MORC** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 22.1 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Easterseals/MORC should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Weakness #4: Easterseals/MORC had a high occurrence of duplicate encounters (4.5 percent) within its data compared to the all waiver agency average (0.6 percent). [**Quality**]

Why the weakness exists: Existing duplicate encounters can potentially lead to misinterpretations during data analysis.

Recommendation: HSAG recommends **Easterseals/MORC** improve data quality by reviewing internal processes.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-45 presents **Easterseals/MORC**'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 3-45 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-45—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	89.1%	92.5%	91.8%
Recommendation Measures	89.2%	87.6%	92.1%
Staff are Reliable and Helpful	88.4%	**97.4%** ↑	92.1%
Staff Listen and Communicate Well	90.5%	92.7%	94.6%
Case Manager is Helpful	98.9%	100%	95.8%
Choosing the Services that Matter to You	93.8%	88.3% ↓	90.8%
Transportation to Medical Appointments	90.0%	92.3%	92.4%
Personal Safety and Respect	99.2%	95.2%	97.4%
Planning Your Time and Activities	78.7%	81.3%	78.5%
Met Need	100%	94.9% ↓	93.0%
Physical Safety Measure	97.5%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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: Easterseals/MORC achieved scores higher than the statewide results in the following domains: *Global Ratings Measures*, *Staff are Reliable and Helpful*, *Case Manager is Helpful*, *Planning Your Time and Activities*, and *Met Need*, indicating that **Easterseals/MORC** provides services in a manner that meets or exceeds members' expectations in many domains. **Easterseals/MORC** also demonstrated improvement in rates across several measures, with one measure rate, *Staff are Reliable and Helpful*, increasing by 5 percentage points or more. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Easterseals/MORC 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.

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, **Easterseals/MORC** scored below the statewide average on the *Recommendation Measures*, *Staff Listen and Communicate Well*, *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, and *Personal Safety and Respect* domains; therefore, HSAG recommends that **Easterseals/MORC** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within these domains, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **Easterseals/MORC** scored above the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Easterseals/MORC** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Easterseals/MORC**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Easterseals/MORC** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Easterseals/MORC**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-46 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Easterseals/MORC**'s MI Choice members.

Table 3-46—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Easterseals/MORC** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members. Additionally, through the CQAR activity, **Easterseals/MORC** received a *Substantial* compliance level in the Critical Incidents focus area. Further, through the PIP activity, **Easterseals/MORC** demonstrated high performance in the *Prevalence of Any Injuries* PIP, as the waiver agency met the statewide goal. Lastly, through the CAHPS HCBS survey, **Easterseals/MORC** showed a strong focus on member health and safety through a high rating in the *Physical Safety Measure* domain. However, through the PIP activity, **Easterseals/MORC**'s *Prevalence of Falls* rate increased from the prior year, and the waiver agency did not meet its goal or the statewide goal, indicating the interventions implemented did not sustain **Easterseals/MORC**'s previous high performance. Additionally, through the CAHPS HCBS activity, the *Personal Safety and Respect* domain scored lower than the statewide average, and the rate decreased from the prior year. These findings could imply that while **Easterseals/MORC** ensures the health and safety of members when providing services directly to the member and appropriately follows up when critical incidents occur, it lacks the appropriate safety protocols and risk mitigation for members in their home/community environments. HSAG recommends that **Easterseals/MORC** review its barriers for all measures falling below thresholds and implement interventions other than staff education and ongoing chart audits to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Easterseals/MORC** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service*

Performance Area	Overall Performance Impact
	plan includes goals and preferences desired by the participant, and 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*, scored higher than the statewide averages. Further, through the CAHPS HCBS survey, **Easterseals/MORC**'s rates for the *Global Ratings Measures—Global Rating of Case Manager* and *Case Manager is Helpful* domains scored higher than the statewide averages, and *Case Manager is Helpful* scored higher than the prior year. However, the *Recommendation Measures—Recommendation of Case Manager* and *Choosing the Services that Matter to You* domains scored below the statewide averages, and *Choosing the Services that Matter to You* scored lower than the prior year. These findings suggest that **Easterseals/MORC** generally conducts care coordination and person-centered service planning according to policies and procedures, but members would not always recommend their case managers and do not always feel that they get to choose their services. **Easterseals/MORC** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Easterseals/MORC** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, Contingency Plan, and Adverse Benefit Determination focus areas. Additionally, through the PMV activity, three performance measures scored higher than the statewide averages: Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*; Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan;* and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*. Further, through the CAHPS HCBS survey, **Easterseals/MORC**'s rates for the *Staff are Reliable and Helpful* and *Met Need* domains scored above the statewide average, although the *Met Need* domain decreased from the prior year. However, the Follow-Up and Monitoring focus area scored a *Some Compliance, Needs Improvement* compliance level. Additionally, through the CAHPS HCBS survey, although the rate increased from the prior year, the *Transportation to Medical Appointments* domain scored below the statewide average. These findings suggest that, while **Easterseals/MORC** supports coordinators generally are able to coordinate care for members and services are generally available, members do not always have access to transportation, and **Easterseals/MORC** does not consistently follow up on services that have been requested. **Easterseals/MORC** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Milestone Senior Services

Validation of Performance Improvement Projects

Performance Results

Table 3-47 displays the PIPs in place during SFY 2022. Table 3-47 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Milestone Senior Services** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Milestone Senior Services** did not meet the statewide goal or the *New Goal*. Any interventions described within **Milestone Senior Services**' QMP reports are also provided in Table 3-47. The results in Table 3-47 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-47—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 30.7% SFY 2022 = 32.00% ☒
Interventions: • **Milestone Senior Services** has chartered a Falls Prevention CQI [continuous quality improvement] Focus Improvement Project Team with a goal of achieving a minimum 53% improvement during the scope of this QMP. The team will utilize STEADI assessment tools during assessments and monthly contacts to collect data and identify trends to PDSA causes for corrective and preventative actions.		
PIP Validation Feedback: MDHHS provided the following feedback to **Milestone Senior Services**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to your description, quality control methods, monitoring, evaluating, and corrective action plans? • The Statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the Grantee's participants. Your falls goal would not meet this goal. It is also not clear what you are going to do to address Prevalence of Falls or Prevalence of Injuries.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 4.3% SFY 2022 = 4.10% ☒
Interventions: • **Milestone Senior Services** will charter an Injury Prevention CQI Focus Improvement Project with a goal of achieving 50% improvement during the scope of this QMP.		
PIP Validation Feedback: MDHHS provided the following feedback to **Milestone Senior Services**:		

PIP Topic	Goal*	Measurement and Outcome±
• The information provided for your PIPs was vague. Can you please provide clarifying details related to your description, quality control methods, monitoring, evaluating, and corrective action plans? • The Statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the Grantee's participants. Your falls goal would not meet this goal. It is also not clear what you are going to do to address Prevalence of Falls or Prevalence of Injuries.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-48 displays the two PIPs **Milestone Senior Services** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-48 is displayed as reported by **Milestone Senior Services** and was not validated by HSAG.

Table 3-48—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Maintain number of reported participant falls resulting in injury at 3% (to continue meeting the state goal of 3%).	Baseline: 3.0% SFY 2023: Not yet reported
Interventions: • Documenting/collecting fall data weekly. • Track and trend reasons for falls monthly and report to waiver leadership and support coordinators. • Develop workgroup to utilize Plan, Do, Study, Act (PDSA) continuous improvement tool on implementation of various interventions and other options/ideas for assisting participants in reducing their risk of falls. • Define/develop best practices to reduce the risks of falls specific to the community served. • Report progress of improvement on reducing participants falls and falls resulting in injury to organization specifically to Waiver Team for transparency as well as additional discussion, input, and suggestions for other improvement ideas and interventions.		
PIP Validation Feedback: MDHHS provided the following feedback to **Milestone Senior Services**:		

PIP Topic	Goal	Measurement and Outcome
• Can you please clarify goals/baselines? Baseline for falls with injuries is 3.0% with goal to reduce falls with injuries by 1.5% (to meet the state goal of 4.3%). Current state goal is 3%.		
Timeliness of Monitoring Contacts	Increase monitoring contacts timeliness by supports coordinators to 100% compliance.	Baseline: 80% SFY 2023: Not yet reported
Interventions: • In depth root-cause analysis. • Focus groups to discuss reasons for not complying with requirement. • Quality Council discussion to obtain participant perspective on Follow-up and timeliness. • Chart Audits to evaluate follow-up and monitoring timeliness. • Best Practice definition developed. • Development of Quarterly Metrics to report to Quality Committees internally and within MHCSN Association. • Development of improvement options to implement. • Deployment of improvement options.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Milestone Senior Services**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for **Milestone Senior Services**' PIPs did not meet the MDHHS-established goals, suggesting that the implemented interventions did not positively impact member outcomes. Therefore, no strengths were identified for **Milestone Senior Services**. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Milestone Senior Services** did not appear to be effective in improving outcomes for either SFY 2022 PIP, and **Milestone Senior Services** did not reach the MDHHS-established goals (i.e., statewide goals). **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 PIPs. [**Quality**]

Why the weakness exists: **Milestone Senior Services** did not conduct a barrier or root cause analysis to determine why the prevalence rate increased for these PIPs.

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 and should address these barriers to improve outcomes. **Milestone Senior Services** should also analyze and interpret results at multiple points in time and test for statistical significance. Further, **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 #2: **Milestone Senior Services**' SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: **Milestone Senior Services** did not document its methodology in its QMP documentation. As such, it is unclear if **Milestone Senior Services** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Milestone Senior Services** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Milestone Senior Services** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Milestone Senior Services**' PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Milestone Senior Services** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Milestone Senior Services** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Quality Assurance & Performance Improvement Plan FY 2023–2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Milestone Senior Services**' PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Milestone Senior Services** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Milestone Senior Services** in a methodologically sound manner. HSAG further recommends that **Milestone Senior Services**' documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Milestone Senior Services** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Milestone**

Senior Services to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Milestone Senior Services** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-49 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-49 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-49, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-49—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**90.00%**	**80.00% ↓**	**86.65%**
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	**90.10%**	**93.91%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**90.00%**	**100% ↑**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**95.00%**	**95.12%**	**94.76%**
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	**95.00%**	**95.00%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**95.00%**	**70.00% ↓**	**82.72%**
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	**88.80%**	**93.08%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**88.24%**	**87.50%**	**88.74%**
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	**100%**	**92.86% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**90.00%**	**90.00%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	—	**40.00%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Milestone Senior Services**' overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures, not calculated through CQAR record reviews, that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Milestone Senior Services received a 100 percent performance rating for Performance Measures 4, 7, 8, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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**]

Weaknesses and Recommendations

Weakness #1: Milestone Senior Services 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 6.65 percentage points below the statewide rate and a decrease of 10 percentage points from **Milestone Senior Services**' SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the 10 applicable records did not demonstrate that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements. **Milestone Senior Services** identified that it did not have a standard operating procedure related to the PCSP process.

Recommendation: While **Milestone Senior Services**' CAP included the development of a formal standard operating procedure, staff education, and a probe sample of 10 records covering all supports coordinators, HSAG recommends that **Milestone Senior Services** conduct regular monitoring of records to ensure continuous compliance and consistency across supports coordinators. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Milestone Senior Services 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 12.72 percentage points below the statewide rate and a decrease of 25 percentage points from **Milestone Senior Services**' SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that six of the 10 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **Milestone Senior Services** identified that it did not have a standard operating procedure related to the PCSP process.

Recommendation: While **Milestone Senior Services**' CAP included the development of a formal standard operating procedure, staff education, and a probe sample of 10 records covering all supports coordinators, HSAG recommends that **Milestone Senior Services** conduct regular monitoring of records to ensure continuous compliance and consistency across supports coordinators. Additionally, **Milestone Senior Services** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-50 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 interviews. Table 3-50 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-50—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	96.15%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	80.00%		**2.00**	1.00
Focus 3	Release of Information	100.00%		**4.00**	1.00
Focus 4	Status	88.89%		**3.00**	3.00
Focus 5	Pre-Planning	98.89%	100%	**4.00**	4.00
Focus 6	Assessment	98.89%	100%	**4.00**	3.33
Focus 7	Medication Record	87.04%	100%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	88.97%	100%	**4.00**	4.00
Focus 9	MI Choice Services	94.64%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	91.67%	100%	**4.00**	4.00
Focus 11	Follow-Up and Monitoring	87.50%	100%	**4.00**	2.00
Focus 12	Service Provider	50.00%		**1.00**	1.00
Focus 13	Contingency Plan	74.07%	100%	**2.67**	4.00
Focus 14	Critical Incidents	75.00%	100%	**2.00**	2.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	72.73%		**2.00**	1.00
Focus 16	Complaints and Grievances	100.00%		**4.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**91.21%**	**100%**	**3.74**	3.59

Indicates the standard was not reviewed as part of the record review or home visit.
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: A review of five home visits was 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. [**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. The purpose of the record review 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 to 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 two out of 10 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **Milestone Senior Services** reported that it lacked a standard operating procedure related to completing the FOC form.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. However, this deficiency has been noted as noncompliant for the past two years; therefore, **Milestone Senior Services**' interventions have not led to performance improvement. HSAG recommends that **Milestone Senior Services** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Milestone Senior Services** could consider creating a "hard stop" in the member record where a supports coordinator must complete an FOC form section within the assessment or PCSP before proceeding.

Weakness #2: 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 out of six 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. **Milestone Senior Services** reported that it identified the need for further education to contracted providers regarding reporting requirements for health and welfare issues.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. However, the deficiency has been noted as noncompliant for the past two years; therefore, **Milestone Senior Services**' interventions have not led to performance improvement. HSAG recommends that **Milestone Senior Services** update its CAP to include interventions other than provider education and ongoing staff chart audits. For example, **Milestone Senior Services** could implement random and/or targeted provider audits to ensure providers consistently report health and welfare issues to supports coordinators.

Weakness #3: Milestone Senior Services did not consistently follow all Critical Incident 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. **Milestone Senior Services** reported that it lacked a standard operating procedure related to critical incidents.

Recommendation: MDHHS required **Milestone Senior Services** to submit a CAP to remediate the deficiencies. However, the deficiency has been noted as noncompliant for the past two years; therefore, **Milestone Senior Services**' interventions have not led to performance improvement. Although the waiver agency has implemented a standard operating procedure, if improvement is not realized, **Milestone Senior Services** should modify its CAP and implement alternative interventions.

Weakness #4: 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 NABDs are important to ensure members understand their appeal rights and the process to request an appeal. [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of six applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and one out of five applicable records did not demonstrate evidence that the AAN and/or ABD was complete and accurate. **Milestone Senior Services** reported that it lacked a standard operating procedure related to the AAN/ABD.

Recommendation: One of the deficiencies was not identified as a citation by MPHI; however, the other deficiency was documented as a citation and has been noted as noncompliant for the past three years. Therefore, **Milestone Senior Services**' interventions have not led to performance improvement in this program area. **Milestone Senior Services** implemented a standard operating procedure to improve performance; however, HSAG recommends that **Milestone Senior Services** also ensure that remediation efforts are put in place for the deficiency not requiring a CAP. If improvement is not realized, **Milestone Senior Services** should modify its CAP and/or implement additional remediation plans and alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Milestone Senior Services** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Milestone Senior Services**' original questionnaire responses, and **Milestone Senior Services** responded to these specific questions. To support its questionnaire responses, **Milestone Senior Services** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Milestone Senior Services** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-51 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-51—EDV Results for Milestone Senior Services

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Milestone Senior Services** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Milestone Senior Services** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Milestone Senior Services** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Milestone Senior Services** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Milestone Senior Services** utilizes line-by-line method for its claim payment strategies. • **Milestone Senior Services**, with CIM as its subcontractor, collects TPL data during financial

Analysis	Key Findings
	eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Milestone Senior Services** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Milestone Senior Services** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Milestone Senior Services**' encounters, **Milestone Senior Services** indicated that it did not store data sent to MDHHS. • **Milestone Senior Services** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Milestone Senior Services** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Milestone Senior Services** had a low volume of duplicate encounters, with 0.6 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Milestone Senior Services** demonstrated timely submission for professional encounters. Within 60 days, **Milestone Senior Services** submitted 99.4 percent of professional encounters to MDHHS after the payment date. Within 180 days, **Milestone Senior Services** was able to submit 100 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• In **Milestone Senior Services**' submitted professional encounters, the billing provider NPI was populated 4.9 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Milestone Senior Services**' submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Milestone Senior Services**' submitted data, 98.5 percent were identified in the enrollment data. • Of all identified provider NPIs in **Milestone Senior Services**' submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Milestone Senior Services**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Milestone Senior Services demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Milestone Senior Services submitted professional encounters in a timely manner from the payment date, with 99.4 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Milestone Senior Services** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Milestone Senior Services indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Milestone Senior Services**' claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Milestone Senior Services**' overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Milestone Senior Services reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Milestone Senior Services appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Milestone Senior Services should consider enhancing its data management practices. HSAG recommends that **Milestone Senior Services** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a

comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 4.9 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Milestone Senior Services should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-52 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 3-52 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-52—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	90.8%	92.8%	91.8%
Recommendation Measures	91.9%	94.2%	92.1%
Staff are Reliable and Helpful	91.4%	92.9%	92.1%
Staff Listen and Communicate Well	95.4%	96.2%	94.6%
Case Manager is Helpful	93.8%	95.0%	95.8%
Choosing the Services that Matter to You	91.6%	88.8%	90.8%
Transportation to Medical Appointments	93.0%	92.7%	92.4%

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Personal Safety and Respect	97.5%	99.1%	97.4%
Planning Your Time and Activities	75.2%	78.5%	78.5%
Met Need	92.0%	91.0%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, and *Personal Safety and Respect*, indicating that **Milestone Senior Services** provides services in a manner that meets or exceeds members' expectations in many domains. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

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.

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 *Case Manager is Helpful*, *Choosing the Services that Matter to You*, and *Met Need* domains; therefore, HSAG recommends that **Milestone Senior Services** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within these domains, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **Milestone Senior Services** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Milestone Senior Services** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Milestone Senior Services**' aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Milestone Senior Services** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Milestone Senior Services**' overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-53 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Milestone Senior Services**' MI Choice members.

Table 3-53—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Milestone Senior Services** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members. Additionally, through the CAHPS HCBS survey, **Milestone Senior Services** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure*

Performance Area	Overall Performance Impact
	domains. However, through the PIP activity, **Milestone Senior Services**' *Prevalence of Falls* and *Prevalence of Any Injuries* rates did not meet the statewide goals, and the *Prevalence of Falls* rate increased, indicating the interventions implemented did not sustain **Milestone Senior Services**' previous high performance. Additionally, through the CQAR activity, **Milestone Senior Services** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. These findings could imply that while **Milestone Senior Services** ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols and risk mitigation for members in their home/community environments, and **Milestone Senior Services** does not consistently report, investigate, and follow up on critical incidents. HSAG recommends that **Milestone Senior Services** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Milestone Senior Services** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, the rate for 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*, scored higher than the statewide average and increased from the prior year. However, Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, scored below the statewide average and decreased from the prior year. Additionally, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored below the statewide averages. These findings suggest that **Milestone Senior Services** generally conducts care coordination and person-centered service planning according to policies and procedures but does not always consider member preferences, and members are not generally satisfied with case management services. **Milestone Senior Services** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Milestone Senior Services** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, and Follow-Up and Monitoring focus areas. Additionally, through the PMV activity, Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored higher than the statewide averages, although Performance Measure 20 decreased from the prior year. Further, through the CAHPS HCBS survey, **Milestone Senior Services**' rates

Performance Area	Overall Performance Impact
	for the *Staff are Reliable and Helpful* and *Transportation to Medical Appointments* domains scored above the statewide average, although the *Transportation to Medical Appointments* domain decreased from the prior year. However, through the CQAR review, the Contingency Plan focus area scored a *Some Compliance, Needs Improvement* compliance level, and the Adverse Benefit Determination focus area scored a *Not Full or Substantial* compliance level. Additionally, through the PMV activity, Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored below the statewide average. Further, through the CAHPS HCBS survey, the *Met Need* domain scored below the statewide average and decreased from the prior year. These findings suggest that while **Milestone Senior Services** supports coordinators generally are able to coordinate care for members and services are generally available, **Milestone Senior Services** does not consistently ensure the member has a contingency plan when services are not available, and members do not always feel their needs are met. **Milestone Senior Services** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Northern Health Care Management

Validation of Performance Improvement Projects

Performance Results

Table 3-54 displays the PIPs in place during SFY 2022. Table 3-54 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Northern Health Care Management** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Northern Health Care Management** did not meet the statewide goal or the *New Goal*. Any interventions described within **Northern Health Care Management**'s QMP reports are also provided in Table 3-54. The results in Table 3-54 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-54—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 32.3% SFY 2022 = 29.30% ☒
Interventions: • When a fall was reported to a supports coordinator, they reviewed to determine what the potential causes were and supports coordinators assisted with determining interventions to reduce future falls.		
PIP Validation Feedback: MDHHS provided the following feedback to **Northern Health Care Management**: • The information provided for the PIPs was vague. Please provide clarifying details related to the description, quality control methods, monitoring, evaluating, and corrective action plans. • Please add baseline rate.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 5.1% SFY 2022 = 4.70% ☒
Interventions: • When an injury was reported to a supports coordinator, they reviewed to determine what the potential causes were and supports coordinators assisted with determining interventions to reduce future injuries.		
PIP Validation Feedback: MDHHS provided the following feedback to **Northern Health Care Management**: • The information provided for the PIPs was vague. Please provide clarifying details related to the description, quality control methods, monitoring, evaluating, and corrective action plans.		

PIP Topic	Goal*	Measurement and Outcome±
• Please add your baseline.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-55 displays the two PIPs **Northern Health Care Management** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-55 is displayed as reported by **Northern Health Care Management** and was not validated by HSAG.

Table 3-55—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the risk of falls with injury when falls occur to 10% or less annually.	Baseline: 3.54% SFY 2023: Not yet reported
Interventions: • In depth root-cause analysis. • Focus groups to discuss falls with injury. • Quality Council discussion to obtain participant perspective on falls with injury. • Chart Audits to evaluate all falls with injury. • Best Practice and literature search for evidence-based practices. • Development of clinical protocols as deemed necessary. • Development of Quarterly Metrics to report to Quality Committees internally and within MHCSN Association. • Adoption or development of teaching tools for program participants and their informal supports. • Staff training on Falls with Injury. • Development of a metric that focuses on falls with injury. • PDSA will be used to develop plan enhancements, implementation of new interventions/actions, study the results and identify corrective action needs when needed and act by deploying improvements as identified.		

PIP Topic	Goal	Measurement and Outcome
• Fall Talk: Falls Talk, an evidence-based behavioral intervention which equips individuals to recognize fall threats.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Northern Health Care Management**.		
Timeliness of Monitoring Contacts	Increase Monitoring Contacts timeliness by supports coordinators to 100% compliance.	Baseline: 93.92% SFY 2023: Not yet reported
Interventions (from MI CHOICE Quality Assurance Performance Improvement Plan (QAPI) Fiscal Year (FY) 2023-2024)**:** • In depth root-cause analysis. • Focus groups to discuss reasons for not complying with requirement. • Quality Council discussion to obtain participant perspective on Follow-up and timeliness. • Chart Audits to evaluate follow-up and monitoring timeliness. • Best Practice definition developed. • Development of Quarterly Metrics to report to Quality Committees internally and within MHCSN Association. • Development of improvement options to implement. • PDSA will be used to develop plan enhancements, implementation of new interventions/actions, study the results and identify corrective action needs when needed and act by deploying improvements as identified.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Northern Health Care Management**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for **Northern Health Care Management**'s PIPs did not meet the MDHHS-established goals (i.e., statewide goals), suggesting that the implemented interventions did not positively impact member outcomes. Therefore, no strengths were identified for **Northern Health Care Management**. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Northern Health Care Management** during SFY 2022 did not appear to be effective in improving outcomes as **Northern Health Care Management** did not reach the MDHHS-established goals for either SFY 2022 PIP. **Northern Health Care 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 PIPs. [**Quality**]

Why the weakness exists: **Northern Health Care Management** did not conduct an aggregated barrier or root cause analysis to determine why the waiver agency did not meet its goals for either PIP. Barriers reported by **Northern Health Care Management** included, but were not limited to, a decreased knowledge of CMS EQR Protocols, decreased knowledge of what documentation should be included in the QMP outside of MDHHS report outline instructions, and a lack of a sufficient time frame to make improvements prior to the subsequent state fiscal year.

Recommendation: HSAG recommends that **Northern Health Care 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 Health Care Management** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **Northern Health Care Management** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **Northern Health Care 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 #2: **Northern Health Care Management**'s SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: **Northern Health Care Management** did not document its methodology in its Outcomes & Activities Report. As such, it is unclear if **Northern Health Care Management** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Northern Health Care Management** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Northern Health Care Management** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Northern Health Care Management**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Northern Health Care Management** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Northern Health Care Management** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The MI CHOICE Quality Assurance Performance Improvement Plan (QAPI) Fiscal year (FY) 2023-2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Northern Health Care Management**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Northern Health Care Management** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Northern Health Care Management** in a methodologically sound manner. HSAG further recommends that **Northern Health Care Management**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Northern Health Care Management** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Northern Health Care Management** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Northern Health Care Management** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-56 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-56 also provides the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Northern Health Care Management**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-56, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-56—Waiver Agency Impact to Statewide Performance Measure Rates

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	80.00%	70.00% ↓	86.65%
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	87.01%	93.20% ↑	93.72%
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	92.08%	100% ↑	98.95%
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	100%	100%	100%
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	100%	100%	100%
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	97.62%	95.24%	94.76%
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	100%	90.00% ↓	93.19%
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	75.00%	60.00% ↓	82.72%
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	93.89%	86.05% ↓	91.10%
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	82.35%	77.78%	88.74%

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**78.57% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**90.00%**	**70.00% ↓**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**30.00%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Northern Health Care Management**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Northern Health Care Management received a 100 percent performance rating for Performance Measures 4, 7, 8, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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**]

Weaknesses and Recommendations

Weakness #1: Northern Health Care Management 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 16.65 percentage points below the statewide rate and a decrease of 10 percentage points from **Northern Health Care Management**'s SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that three of the 10 applicable records did not demonstrate that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements. **Northern Health Care Management** reported that

there were different reasons for each of the three records that were noncompliant. One record did not address the member's request for a change in the frequency of contacts, one record had contact with a family member who was not listed on the PCSP, and one record's PCSP was completed one day late.

Recommendation: While **Northern Health Care Management**'s CAP included staff education, including specific education related to the reasons why the records were noncompliant, HSAG recommends that **Northern Health Care Management** explore potential system enhancements or another avenue for automatic reminders to supports coordinators when PCSPs are coming due. HSAG also recommends that **Northern Health Care Management** ensure that its record reviews each month include a specific review of the accuracy of documentation. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: **Northern Health Care 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 22.72 percentage points below the statewide rate and a decrease of 15 percentage points from **Northern Health Care Management**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that eight of the 10 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **Northern Health Care Management** reported that three records had non-waiver services included in the PCSP, and one record was missing medical issues/risk factors.

Recommendation: While **Northern Health Care Management**'s CAP included staff education, including specific education related to the reasons why the records were noncompliant, HSAG recommends that **Northern Health Care Management** ensure that its record reviews each month include a specific review of the accuracy and completeness of documentation. Additionally, **Northern Health Care Management** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #3: **Northern Health Care Management** 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 5.05 percentage points below the statewide rate and a decrease of 7.84 percentage points from **Northern Health Care Management**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that:

- One of the six applicable records did not demonstrate evidence that the supports coordinator considered sensory and/or communication limitations and provided accommodations for the planning process as preferred by the member/guardian.
- Five 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 throughout care planning and service delivery.
- One 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.
- Three of the 10 applicable records did not demonstrate 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 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.
- Eight 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 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.
- Two of the 10 applicable records did not demonstrate evidence that the member/guardian received a copy of the PCSP.
- Six 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 authorized services were consistent with the member's needs.
- Three of the 10 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian all appropriate services.
- One of the 10 applicable records did not demonstrate evidence that the authorized services met service standard requirements.

Northern Health Care Management reported that supports coordinators were not documenting all applicable information in the PCSPs.

Recommendation: While **Northern Health Care Management**'s CAP included staff education, including specific education related to the reasons why the records were noncompliant, HSAG recommends that **Northern Health Care Management** ensure that its record reviews each month include a specific review of the accuracy and completeness of documentation. HSAG also recommends that **Northern Health Care Management** explore potential system enhancements or a

checklist or template for supports coordinators to help them remember to include appropriate information in the PCSP. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #4: Northern Health Care 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 10.96 percentage points below the statewide rate and a decrease of 4.57 percentage points from **Northern Health Care Management**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three of the 10 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and one of the eight applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements. **Northern Health Care Management** reported that there were different reasons for each of the three records that were noncompliant. One record did not address the member's request for a change in the frequency of contacts, one record had contact with a family member who was not listed on the PCSP, and one record's PCSP was completed one day late. Additionally, one supports coordinator did not document additional attempts to contact providers for implementation of CLS services.

Recommendation: While **Northern Health Care Management**'s CAP included staff education, including specific education related to the reasons why the records were noncompliant, HSAG recommends that **Northern Health Care Management** explore potential system enhancements or another avenue for automatic reminders to supports coordinators when PCSPs are coming due. HSAG also recommends that **Northern Health Care Management** ensure that its record reviews each month include a specific review of the completeness and accuracy of documentation. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #5: Northern Health Care Management 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 11.74 percentage points below the statewide rate and a decrease of 21.43 percentage points from **Northern Health Care Management**'s SFY 2021 rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the three 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 eight 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. **Northern Health Care Management** reported that one supports coordinator did not complete

follow-up within the required time frame, and some PCSPs did not include accurate documentation of services or timely follow-up to needed services.

Recommendation: While **Northern Health Care Management**'s CAP included staff education, including specific education related to the reasons why the records were noncompliant, HSAG recommends that **Northern Health Care Management** explore potential system enhancements or another avenue for automatic reminders to supports coordinators when follow-up is due. HSAG also recommends that **Northern Health Care Management** ensure that its record reviews each month include a specific review of the completeness and accuracy of documentation. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #6: Northern Health Care 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 19.27 percentage points below the statewide rate and a decrease of 20 percentage points from **Northern Health Care Management**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three 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. **Northern Health Care Management** reported that there was a lack of appropriate documentation and supports coordinator misunderstanding of waiver services.

Recommendation: While **Northern Health Care Management**'s CAP included staff education, including specific education related to the reasons why the records were noncompliant, HSAG recommends that **Northern Health Care Management** ensure that its record reviews each month include a specific review of the completeness and accuracy of documentation. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #7: Northern Health Care Management 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 12.67 percentage points below the statewide rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that seven of the 10 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan. **Northern Health Care Management** reported that five records included backup plans that were not written in plain language, and other noncompliance was related to incorrect documentation and the exclusion of non-waiver services.

Recommendation: While **Northern Health Care Management**'s CAP included staff education, HSAG recommends that the education be specific to the reasons that the records were found

noncompliant. HSAG also recommends that **Northern Health Care Management** ensure that its record reviews each month include a specific review of the completeness and accuracy of documentation. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-57 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 interviews. Table 3-57 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-57—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	70.00%		**1.00**	4.00
Focus 3	Release of Information	80.00%		**3.00**	1.00
Focus 4	Status	96.55%		**4.00**	2.00
Focus 5	Pre-Planning	97.75%	100%	**4.00**	4.00
Focus 6	Assessment	91.11%	100%	**4.00**	4.00
Focus 7	Medication Record	90.57%	100%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	80.69%	100%	**3.33**	4.00
Focus 9	MI Choice Services	89.66%	100%	**3.33**	4.00
Focus 10	Linking and Coordinating	68.18%	93.33%	**2.00**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 11	Follow-Up and Monitoring	66.67%	100%	**2.00**	4.00
Focus 12	Service Provider	80.00%		**4.00**	4.00
Focus 13	Contingency Plan	72.41%	100%	**2.67**	4.00
Focus 14	Critical Incidents	70.00%	100%	**2.00**	NA
Focus 15	Adverse Benefit Determination	69.23%		**1.00**	3.00
Focus 16	Complaints and Grievances	40.00%		**1.00**	NA
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**85.28%**	**99.60%**	**3.40**	3.89

Indicates the standard was not reviewed as part of the record review or home visit.
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 Health Care Management achieved a substantial compliance rating in nine of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to 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 Health Care Management 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. **Northern Health Care Management** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three out of 10 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **Northern Health Care Management** reported that the supports coordinator did not attempt to obtain the member's written signature after obtaining a verbal authorization of FOC until following the receipt of the CQAR Participant List for audit.

Recommendation: As this is a new citation, HSAG recommends that **Northern Health Care Management** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **Northern Health Care Management** should modify its CAP and implement alternative interventions.

Weakness #2: Northern Health Care Management did not consistently follow all Linking and Coordinating requirements. Specifically, ensuring the supports coordinator assessed the presence of existing non-waiver services, and then, as preferred by the member, provided the member/guardian with information and/or assistance linking to non-waiver services or resources, and/or provided ongoing coordination and monitoring; and if the member/guardian experienced difficulty in securing a non-waiver service, the supports coordinator continued to assist as warranted. It is important to ensure care coordinators assist members with obtaining appropriate non-waiver services to ensure all service needs continue to be met. **Northern Health Care Management** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined six out of 10 applicable records did not demonstrate evidence that the supports coordinator assessed the presence of existing non-waiver services, and then, as preferred by the member, provided the member/guardian with information and/or assistance linking to non-waiver services or resources, and/or provided ongoing coordination and monitoring. The one applicable record did not demonstrate evidence that if the member/guardian experienced difficulty in securing a non-waiver service, the supports coordinator continued to assist as warranted; and one out of the applicable five home visits did not indicate that the supports coordinator evaluated the member's need for non-waiver services. **Northern Health Care Management** reported that there was a lack of documentation regarding linking the member to appropriate non-waiver services.

Recommendation: As these were new citations, HSAG recommends that **Northern Health Care Management** continue to implement its CAP to conduct staff education and ongoing chart audits.

However, if improvement is not realized, **Northern Health Care Management** should modify its CAP and implement alternative interventions.

Weakness #3: Northern Health Care Management did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting newly enrolled 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 MDHHS policy and contract requirements, including the use of the member's backup plan or an 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. **Northern Health Care Management** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one out of three applicable records did not include evidence that the waiver agency contacted the newly enrolled members/guardians to ensure service delivery in accordance with MDHHS policy and contract requirements; five out of 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; and two out of eight applicable records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with MDHHS policy and contract requirements, including the use of the member's backup plan or out-of-network provider. **Northern Health Care Management** reported that supports coordinators did not always follow time frame and documentation requirements for follow-up and monitoring.

Recommendation: As these were new citations, HSAG recommends that **Northern Health Care Management** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **Northern Health Care Management** should modify its CAP and implement alternative interventions.

Weakness #4: Northern Health Care Management did not consistently follow all Critical Incident 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 out of five applicable records did not demonstrate evidence that the supports coordinator addressed the incident with the member/guardian; two out of five 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 three out of 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. **Northern Health Care Management** reported that supports coordinators did not always document discussing a critical incident with the member, implement methods to prevent further critical incidents, or report and enter critical incidents into the Critical Incident Management System.

Recommendation: As these were new citations, HSAG recommends that **Northern Health Care Management** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **Northern Health Care Management** should modify its CAP and implement alternative interventions.

Weakness #5: Northern Health Care Management 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. Complete and accurate NABDs are important to ensure members understand their appeal rights and the process to request an appeal. **Northern Health Care Management** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Some Compliance, Needs Improvement* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that four out of seven applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD. **Northern Health Care Management** reported that supports coordinators did not always send a NABD when MI Choice services were denied, decreased, held, or terminated.

Recommendation: MDHHS required **Area Agency on Aging 1-B** to submit a CAP to remediate the deficiencies. However, this deficiency has been noted as noncompliant for the past two years; therefore, **Area Agency on Aging 1-B**'s interventions have not led to performance improvement. HSAG recommends that **Area Agency on Aging 1-B** update its CAP to include interventions other than report cards for findings, staff education, and ongoing chart audits. For example, **Area Agency on Aging 1-B** could implement system prompts or another similar workflow that reminds supports coordinators when to mail the AAN/ABD.

Weakness #6: Northern Health Care Management did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three out of five applicable records did not demonstrate evidence that the member/guardian was made aware of the resolution of complaints or grievances as warranted. **Northern Health Care Management** reported that supports coordinators did not always document efforts to discuss complaints with members or what the supports coordinator did to assist the member in resolving the issue.

Recommendation: As this was a new citation, HSAG recommends that **Northern Health Care Management** continue to implement its CAP of conducting staff education and ongoing chart audits. However, if improvement is not realized, **Northern Health Care Management** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Northern Health Care Management** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Northern Health Care Management**'s original questionnaire responses, and **Northern Health Care Management** responded to these specific questions. To support its questionnaire responses, **Northern Health Care Management** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Northern Health Care Management** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-58 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-58—EDV Results for Northern Health Care Management

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Northern Health Care Management** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Northern Health Care Management** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Northern Health Care Management** explained that the system automatically addresses these claims by categorizing them as replacement or void claims.

Analysis	Key Findings
	• **Northern Health Care Management** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Northern Health Care Management** utilizes line-by-line method for its claim payment strategies. • **Northern Health Care Management**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Northern Health Care Management** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Northern Health Care Management** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Northern Health Care Management**'s encounters, **Northern Health Care Management** indicated that it did not store data sent to MDHHS. • **Northern Health Care Management** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Northern Health Care Management** displayed consistent encounter volume for both professional and institutional encounters throughout the measurement year. • **Northern Health Care Management** had a low volume of duplicate encounters, with 0.1 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Northern Health Care Management** demonstrated timely submission for professional encounters. Within 60 days, **Northern Health Care Management** submitted 98.8 percent of professional encounters to MDHHS after the payment date. Within 180 days, **Northern Health Care Management** submitted 100 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• In **Northern Health Care Management**'s submitted professional encounters, the billing provider NPI was populated 16.4 percent of the time, and the rendering provider NPI was populated 0.4 percent of the time.

Analysis	Key Findings
	• All other data elements in **Northern Health Care Management**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Northern Health Care Management**'s submitted data, 99.3 percent were identified in the enrollment data. • Of all identified provider NPIs in **Northern Health Care Management**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Northern Health Care Management**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Northern Health Care Management demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Northern Health Care Management submitted professional encounters in a timely manner from the payment date, with 98.8 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Northern Health Care Management** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Northern Health Care Management indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Northern Health Care Management**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Northern Health Care Management**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Northern Health Care Management reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Northern Health Care Management appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Northern Health Care Management should consider enhancing its data management practices. HSAG recommends that **Northern Health Care Management** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 16.4 percent of professional encounters contained a billing provider NPI and 0.4 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Northern Health Care Management should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-59 presents **Northern Health Care 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 3-59 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-59—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	90.1%	89.7%	91.8%
Recommendation Measures	94.0%	**85.2% ↓**	92.1%
Staff are Reliable and Helpful	91.8%	93.0%	92.1%
Staff Listen and Communicate Well	96.7%	94.0%	94.6%
Case Manager is Helpful	89.1%	**87.9%**	95.8%
Choosing the Services that Matter to You	92.6%	88.7%	90.8%
Transportation to Medical Appointments	92.6%	94.4%	92.4%
Personal Safety and Respect	95.7%	98.0%	97.4%
Planning Your Time and Activities	75.8%	76.0%	78.5%
Met Need	99.2%	97.2%	93.0%
Physical Safety Measure	97.5%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 Health Care Management achieved scores higher than the statewide results in the following domains: *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, and *Met Need*, indicating that **Northern Health Care Management** provides services in a manner that meets or exceeds members' expectations in several domains. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Northern Health Care Management scored more than 5 percentage points below the statewide average on the *Recommendation Measures* domain at 85.2 percent compared with the statewide average of 92.1 percent. [**Quality**]

Why the weakness exists: The *Recommendation Measures* domain included the *Recommendation of Personal Assistance and Behavioral Health Staff*, *Recommendation of Homemakers*, and *Recommendation of Case Manager* questions. **Northern Health Care Management** scored below the statewide average for all the measures in this domain.

Recommendation: HSAG recommends that **Northern Health Care Management** review the results of all consumer satisfaction survey questions to determine if any questions significantly contributed to the low satisfaction score within the *Recommendation Measures* domain, develop interventions to improve the *Recommendation Measures* domain, and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #2: Northern Health Care Management scored more than 5 percentage points below the statewide average on the *Case Manager is Helpful* domain at 87.9 percent compared with the statewide average of 95.8 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, **Northern Health Care Management** scored below the statewide average for the remaining two questions,

Able to contact this case manager when needed and *Case manager helped when asked for help with getting other changes to services*.

Recommendation: HSAG recommends that **Northern Health Care Management** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores significantly contributed to the low satisfaction score within the *Case Manager is Helpful* domain, specifically the statements related to contacting the case manager and the case manager helping when needed; develop interventions to improve the *Case Manager is Helpful* domain; and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #3: Although **Northern Health Care Management** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. [**Quality**]
Why the weakness exists: This section is not applicable as this domain was not identified as a substantial weakness for **Northern Health Care Management**.
Recommendation: HSAG recommends that **Northern Health Care Management** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores contributed to the low satisfaction score within the *Planning Your Time and Activities* domain; develop interventions to improve the *Planning Your Time and Activities* domain; and evaluate the results of the interventions regularly, making changes as necessary.

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

HSAG performed a comprehensive assessment of **Northern Health Care Management**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Northern Health Care Management** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Northern Health Care Management**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-60 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Northern Health Care Management**'s MI Choice members.

Table 3-60—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Northern Health Care Management** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information on critical incidents. Additionally, through

Performance Area	Overall Performance Impact
	the CAHPS HCBS survey, **Northern Health Care Management** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. However, through the PIP activity, **Northern Health Care Management**'s *Prevalence of Falls* and *Prevalence of Any Injuries* rates did not meet the statewide goals, although the rates decreased from the prior year's rates. Additionally, through the PMV activity, Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, scored below the statewide average and decreased from the prior year. Further, through the CQAR activity, **Northern Health Care Management** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. These findings could imply that while **Northern Health Care Management** ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols and risk mitigation for members in their home/community environments, and **Northern Health Care Management** does not consistently report, investigate, and follow up on critical incidents. HSAG recommends that **Northern Health Care Management** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Northern Health Care Management** demonstrated high performance in ensuring appropriate and timely person-centered service planning. However, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, scored below the statewide average and decreased from the prior year. Additionally, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored below the statewide averages. These findings suggest that **Northern Health Care Management** does not consistently conduct care coordination and person-centered service planning according to policies and procedures nor consider member preferences during care coordination, and members are not generally satisfied with case management services. **Northern Health Care Management** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Northern Health Care Management** demonstrated a *Substantial* compliance level in the MI Choice Services focus area. Additionally, through the PMV activity, Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their*

Performance Area	Overall Performance Impact
	assessed needs, scored higher than the statewide average, although the rate decreased from the prior year. Further, through the CAHPS HCBS survey, **Northern Health Care Management**'s rates for the *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, and *Met Need* domains scored above the statewide average, although the *Met Need* domain decreased from the prior year. However, through the CQAR review, the Contingency Plan focus area scored a *Some Compliance, Needs Improvement* compliance level, the Linking and Coordinating and Follow-Up and Monitoring focus areas scored a *Not Full or Substantial* compliance level, and the Adverse Benefit Determination focus area scored a *Not Demonstrated* compliance level. Additionally, through the PMV activity, the rates for Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored below the statewide averages. These findings suggest that while **Northern Health Care Management** supports coordinators generally are able to coordinate care for members and services are generally available, **Northern Health Care Management** does not consistently coordinate the appropriate services for members, follow up on requested services, or ensure the member has a contingency plan when services are not available. **Northern Health Care Management** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Region 3B Area Agency on Aging/Carewell Services

Validation of Performance Improvement Projects

Performance Results

Table 3-61 displays the PIPs in place during SFY 2022. Table 3-61 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Region 3B Area Agency on Aging/Carewell Services** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Region 3B Area Agency on Aging/Carewell Services** did not meet the statewide goal or the *New Goal*. Any interventions described within **Region 3B Area Agency on Aging/Carewell Services**' QMP reports are also provided in Table 3-61. The results in Table 3-61 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-61—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less. *New Goal*: 19.3% or lower	SFY 2021 = 19.3% SFY 2022 = 20.30% ☒
Interventions: • Educated the participant/designated representative when a fall has been reported during a follow up assessment to increase awareness of the reason for the fall(s) and offer fall prevention techniques. • Evaluated if there is a need for DME, provided education regarding the need for DME, and assisted in acquiring DME, if necessary. • Monitored falls during monitoring contacts with the participant/designated representative. • Reviewed the Quality Indicators, including prevalence of falls with participants during the quarterly CAC [Consumer Advisory Council] meetings.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Region 3B Area Agency on Aging/Carewell Services**.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 4.2% SFY 2022 = 0.80% ☑
Interventions: • Investigated and documented a complete description of the injury and reason for the injury in the assessment. • Educated the participant/designated representative on ways to prevent future injuries.		

PIP Topic	Goal*	Measurement and Outcome±
• Continued monitoring of injuries and/or cause of injuries during monitoring contacts with the participant/designated representative. • Reported injuries into the Critical Incident portal • Reviewed the Quality Indicators for injuries with participants during the quarterly CAC meetings.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Region 3B Area Agency on Aging/Carewell Services**.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-62 displays the two PIPs **Region 3B Area Agency on Aging/Carewell Services** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-62 is displayed as reported by **Region 3B Area Agency on Aging/Carewell Services** and was not validated by HSAG.

Table 3-62—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce falls with injury to 17.4%.	Baseline: 17.6% SFY 2023: Not yet reported
Interventions: • The Quality Coordinator 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.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region 3B Area Agency on Aging/Carewell Services**: • Clinical PIP should be Falls with Injury. It is currently listed as prevalence of falls. This requires that prevalence of falls data and injury data are cross referenced to determine current goal and baseline for falls with injuries.		

PIP Topic	Goal	Measurement and Outcome
Completion of ABDs	70% of ABDs completed on time and correctly.	Baseline: 56% SFY 2023: Not yet reported
Interventions: • Training—A mandatory training on how to fill the ABD form out correctly along with as needed training based on monthly audit findings. • Process Improvement—A new process and monitoring tool on making sure documents are properly uploaded into our participant files so that we can monitor them monthly. • Audit—Quality Coordinator will audit two ABDs per supports coordinator per month. Findings will be shared with support coordinator and Clinical Director.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Region 3B Area Agency on Aging/Carewell Services**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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/Carewell Services met the MDHHS-established goal (i.e., statewide goal) for the *Prevalence of Any Injuries* PIP. The reduction in prevalence rates for this PIP was primarily attributed to consistent monitoring and training with staff each month as reported by the waiver agency. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Region 3B Area Agency on Aging/Carewell Services** did not appear to be effective in improving outcomes for the *Prevalence of Falls* PIP as the prevalence rate increased, and **Region 3B Area Agency on Aging/Carewell Services** did not reach the MDHHS-established goal (i.e., *New Goal*). **Region 3B Area Agency on Aging/Carewell 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 PIP. [**Quality**]

Why the weakness exists: Region 3B Area Agency on Aging/Carewell Services cited several mismarked falls each month as a major barrier to achieving the goal for this PIP.

Recommendation: HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** implement an auditing and monitoring process to ensure all falls are being documented appropriately (i.e., timely, detailed, etc.) to improve the consistency with which falls are documented across all staff members. Additionally, although **Region 3B Area Agency on Aging/Carewell Services** conducted a barrier analysis, interventions implemented did not appear to address those barriers. HSAG recommends that **Region 3B Area Agency on Aging/Carewell 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). **Region 3B Area Agency on Aging/Carewell Services** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **Region 3B Area Agency on Aging/Carewell Services** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **Region 3B Area Agency on Aging/Carewell 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 #2: Region 3B Area Agency on Aging/Carewell Services' PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: Region 3B Area Agency on Aging/Carewell Services did not document its methodology (e.g., the time frames for measurement) in its QMP documentation. As such, it is unclear if **Region 3B Area Agency on Aging/Carewell Services** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Region 3B Area Agency on Aging/Carewell Services** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Region 3B Area Agency on Aging/Carewell Services** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Region 3B Area Agency on Aging/Carewell Services**' PIPs did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Region 3B Area Agency on Aging/Carewell Services** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Region 3B Area Agency on Aging/Carewell Services** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The QAPI (formerly QMP) Outline Waiver Agency: Region 3B Area Agency on Aging d/b/a CareWell Services SW FY: 2023 demonstrated some improvement in the design of the

new SFY 2023 PIPs. However, **Region 3B Area Agency on Aging/Carewell Services**' PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Region 3B Area Agency on Aging/Carewell Services** in a methodologically sound manner. HSAG further recommends that **Region 3B Area Agency on Aging/Carewell Services**' documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Region 3B Area Agency on Aging/Carewell Services** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Region 3B Area Agency on Aging/Carewell Services** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Region 3B Area Agency on Aging/Carewell Services** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-63 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-63 also provides the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Region 3B Area Agency on Aging/Carewell Services**' percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-63, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-63—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**93.33%**	**92.86%**	**86.65%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**99.38%**	**95.80%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**92.86% ↓**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**100%**	**93.22% ↓**	**94.76%**
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	**90.00%**	**96.43% ↑**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**100%**	**67.86% ↓**	**82.72%**
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	**97.68%**	**91.16% ↓**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**92.00%**	**95.24%**	**88.74%**
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	**89.47%**	**100% ↑**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**100%**	**92.86% ↓**	**89.27%**

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**50.00%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Region 3B Area Agency on Aging/Carewell Services**' overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Region 3B Area Agency on Aging/Carewell Services received a 100 percent performance rating for Performance Measures 7, 8, 20, 22, 24, and 38, indicating that LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; members received all services and supports identified in their 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**]

Weaknesses and Recommendations

Weakness #1: Region 3B Area Agency on Aging/Carewell Services performed substantially worse than other waiver agencies on Performance Measure 4, *number and percent of appropriate LOCDs found after MDHHS review*, as indicated by a performance rate of 6.09 percentage points below the statewide rate and a decrease of 7.14 percentage points from **Region 3B Area Agency on Aging/Carewell Services**' SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the 14 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 the Community Health Automated Medicaid Processing System (CHAMPS).

Recommendation: MDHHS did not require **Region 3B Area Agency on Aging/Carewell Services** to submit a CAP to remediate the one deficiency associated with Performance Measure 4. However, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Region 3B Area Agency on Aging/Carewell Services 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 14.86 percentage points below the statewide rate and a decrease of 32.14 percentage points from **Region 3B Area Agency on Aging/Carewell Services**' SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that nine of the 14 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **Region 3B Area Agency on Aging/Carewell Services** reported that training issues were the cause of noncompliance.

Recommendation: While **Region 3B Area Agency on Aging/Carewell Services**' CAP included staff education, HSAG recommends that this education include clear direction regarding the PCSP process for minimizing risk factors, planning, and supporting the member. Additionally, **Region 3B Area Agency on Aging/Carewell Services** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-64 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 interviews. Table 3-64 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-64—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	93.75%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	92.86%		**4.00**	4.00
Focus 3	Release of Information	64.29%		**1.00**	3.00
Focus 4	Status	100%		**4.00**	4.00
Focus 5	Pre-Planning	97.60%	100%	**4.00**	4.00
Focus 6	Assessment	94.49%	100%	**4.00**	4.00
Focus 7	Medication Record	83.78%	100%	**3.33**	4.00
Focus 8	Person-Centered Service Planning	90.05%	100%	**4.00**	4.00
Focus 9	MI Choice Services	94.81%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	84.38%	100%	**2.67**	4.00
Focus 11	Follow-Up and Monitoring	93.55%	100%	**4.00**	2.04
Focus 12	Service Provider	100%		**4.00**	4.00
Focus 13	Contingency Plan	77.78%	100%	**3.33**	4.00
Focus 14	Critical Incidents	50.00%	92.86%	**2.00**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	83.33%		**4.00**	4.00
Focus 16	Complaints and Grievances	33.33%		**1.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**90.76%**	**99.71%**	**3.71**	3.91

Indicates the standard was not reviewed as part of the record review or home visit.
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: A review of seven home visits was conducted; all reviews achieved full compliance except for one deficiency, and no focus areas received a citation requiring a CAP. 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 were receiving services in accordance with their service plans and preferences and were satisfied with those services. [**Quality**]

Strength #2: Region 3B Area Agency on Aging/Carewell Services achieved a substantial compliance rating in 13 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member;

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

Weaknesses and Recommendations

Weakness #1: Region 3B Area Agency on Aging/Carewell 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. **Region 3B Area Agency on Aging/Carewell Services** also received a *Not Demonstrated* compliance level compared to a *Some Compliance, Needs Improvement* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that five out of 14 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record. **Region 3B Area Agency on Aging/Carewell Services** reported staffing issues and high turnover as the root cause of deficiencies.

Recommendation: MDHHS required **Region 3B Area Agency on Aging/Carewell Services** to submit a CAP to remediate the deficiencies. However, this deficiency has been noted as noncompliant for the past five years; therefore, **Region 3B Area Agency on Aging/Carewell Services**' interventions have not led to performance improvement. HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Region 3B Area Agency on Aging/Carewell Services** could implement system prompts or another similar workflow that reminds supports coordinators to obtain the ROI form.

Weakness #2: Region 3B Area Agency on Aging/Carewell Services did not consistently follow all Critical Incident 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 out of two applicable records did not demonstrate evidence that the supports coordinator addressed the incident with the member/guardian; one out of two applicable records did not demonstrate evidence that the supports coordinator took appropriate action and discussed methods to prevent further occurrence with the member/guardian; the two 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; and one out of the applicable seven home visits did not indicate that the supports coordinator reviewed what critical incidents are and how to report them with the member. **Region 3B Area Agency on Aging/Carewell Services** reported training issues as the root cause of the deficiencies.

Recommendation: As these were new citations, HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** continue to implement its CAP to conduct staff education and ongoing

chart audits. However, if improvement is not realized, **Region 3B Area Agency on Aging/Carewell Services** should modify its CAP and implement alternative interventions.

Weakness #3: Region 3B Area Agency on Aging/Carewell Services did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. **Region 3B Area Agency on Aging/Carewell Services** also received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of three applicable records did not demonstrate evidence that the member/guardian was made aware of the resolution of complaints or grievances as warranted. **Region 3B Area Agency on Aging/Carewell Services** reported training issues as the root cause of deficiencies.

Recommendation: As this was a new citation, HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** continue to implement its CAP to conduct staff education and ongoing chart audits. However, if improvement is not realized, **Region 3B Area Agency on Aging/Carewell Services** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Region 3B Area Agency on Aging/Carewell Services** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Region 3B Area Agency on Aging/Carewell Services**' original questionnaire responses, and **Region 3B Area Agency on Aging/Carewell Services** responded to these specific questions. To support its questionnaire responses, **Region 3B Area Agency on Aging/Carewell Services** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Region 3B Area Agency on Aging/Carewell Services** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-65 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-65—EDV Results for Region 3B Area Agency on Aging/Carewell Services

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Region 3B Area Agency on Aging/Carewell Services** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Region 3B Area Agency on Aging/Carewell Services** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Region 3B Area Agency on Aging/Carewell Services** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Region 3B Area Agency on Aging/Carewell Services** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Region 3B Area Agency on Aging/Carewell Services** utilizes line-by-line method for its claim payment strategies. • **Region 3B Area Agency on Aging/Carewell Services**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Region 3B Area Agency on Aging/Carewell Services** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Region 3B Area Agency on Aging/Carewell Services** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Region 3B Area Agency on Aging/Carewell Services**' encounters, **Region 3B Area Agency on Aging/Carewell Services** indicated that it did not store data sent to MDHHS. • **Region 3B Area Agency on Aging/Carewell Services** and/or its subcontractors conducted field-level completeness and validity checks, timeliness assessments, and evaluated the alignment of payment fields in the claims with financial reports for its HCBS encounters. For NEMT encounters, timeliness checks were performed, and evaluations included the

Analysis	Key Findings
	alignment of payment fields in the claims with financial reports, but field-level completeness and validity checks were not conducted as part of the data quality process.
Administrative Profile	
Encounter Data Completeness	• **Region 3B Area Agency on Aging/Carewell Services** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Region 3B Area Agency on Aging/Carewell Services** had a low volume of duplicate encounters, with 0.5 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Region 3B Area Agency on Aging/Carewell Services** demonstrated timely submission for professional encounters. Within 60 days, **Region 3B Area Agency on Aging/Carewell Services** submitted 98.8 percent of professional encounters to MDHHS after the payment date. Within 120 days, **Region 3B Area Agency on Aging/Carewell Services** submitted 99.9 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• In **Region 3B Area Agency on Aging/Carewell Services**' submitted professional encounters, the billing provider NPI was populated 14.5 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Region 3B Area Agency on Aging/Carewell Services**' submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Region 3B Area Agency on Aging/Carewell Services**' submitted data, 98.5 percent were identified in the enrollment data. • Of all identified provider NPIs in **Region 3B Area Agency on Aging/Carewell Services**' submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Region 3B Area Agency on Aging/Carewell Services**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Region 3B Area Agency on Aging/Carewell Services demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Region 3B Area Agency on Aging/Carewell Services submitted professional encounters in a timely manner from the payment date, with 98.8 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Region 3B Area Agency on Aging/Carewell Services** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region 3B Area Agency on Aging/Carewell Services indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Region 3B Area Agency on Aging/Carewell Services**' claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Region 3B Area Agency on Aging/Carewell Services**' overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Region 3B Area Agency on Aging/Carewell Services did not indicate conducting the claim volume submission for its HCBS and NEMT encounters or field-level completeness and validity quality checks for its NEMT encounters. [**Quality**]

Why the weakness exists: The omission of conducting the claim volume submission for the HCBS encounters suggests a potential gap in the waiver agency's monitoring processes, as verifying the accuracy and completeness of claim volumes is crucial for ensuring data integrity and compliance

with regulatory requirements. Additionally, the absence of field-level completeness and validity quality checks for NEMT encounters further underscores a vulnerability in its data validation procedures.

Recommendation: Region 3B Area Agency on Aging/Carewell Services should consider implementing structured and routine claim volume submission checks for both HCBS and NEMT encounters, ensuring alignment with expectations and compliance with deadlines. Additionally, the waiver agency should introduce field-level completeness and validity quality checks specifically tailored for NEMT encounters, employing comprehensive validation protocols and incorporating automated checks. Regular checks, automated monitoring, and periodic reviews will collectively strengthen its data management practices, enhancing the accuracy, completeness, and timeliness of encounter data submissions and ensuring regulatory compliance.

Weakness #3: Although not required to be populated, 14.5 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Region 3B Area Agency on Aging/Carewell Services should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-66 presents **Region 3B Area Agency on Aging/Carewell 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 3-66 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-66—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	Statewide Average Score
Global Ratings Measures	97.1%	91.6% ↓	91.8%
Recommendation Measures	96.2%	**97.1%**	92.1%
Staff are Reliable and Helpful	95.4%	95.8%	92.1%
Staff Listen and Communicate Well	97.9%	94.8%	94.6%
Case Manager is Helpful	94.6%	100% ↑	95.8%
Choosing the Services that Matter to You	92.0%	91.8%	90.8%
Transportation to Medical Appointments	93.0%	93.9%	92.4%
Personal Safety and Respect	99.1%	94.0% ↓	97.4%
Planning Your Time and Activities	70.6%	79.7% ↑	78.5%
Met Need	94.7%	89.9%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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/Carewell Services achieved scores higher than the statewide results in the following domains: *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 *Planning Your Time and Activities*, indicating that **Region 3B Area Agency on Aging/Carewell Services** provides services in a manner that meets or exceeds members' expectations in many domains. **Region 3B Area Agency on Aging/Carewell Services** also demonstrated improvement in rates across several measures, with two measure rates, *Case Manager is Helpful* and *Planning Your Time and Activities*, increasing by 5 percentage points or more. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region 3B Area Agency on Aging/Carewell 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.

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/Carewell Services** scored below the statewide average on the *Global Ratings Measures*, *Personal Safety and Respect*, and *Met Need* domains; therefore, HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within these domains, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **Region 3B Area Agency on Aging/Carewell Services** scored above the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Region 3B Area Agency on Aging/Carewell Services** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Region 3B Area Agency on Aging/Carewell Services**' aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Region 3B Area Agency on Aging/Carewell Services** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Region 3B Area Agency on Aging/Carewell Services**' overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-67 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Region 3B Area Agency on Aging/Carewell Services**' MI Choice members.

Table 3-67—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Region 3B Area Agency on Aging/Carewell Services** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members by identifying risks and providing information on critical incidents. Additionally, through the CAHPS HCBS survey, **Region 3B Area Agency on Aging/Carewell Services** showed a strong focus on member health and safety through a high rating in the *Physical Safety Measure* domain. Further, through the PIP activity, **Region 3B Area Agency on Aging/Carewell Services**' *Prevalence of Any Injuries* rate met the statewide goal and decreased from the prior year's rate, indicating the interventions implemented were effective in decreasing injuries. However, through the PIP activity, **Region 3B Area Agency on Aging/Carewell Services**' *Prevalence of Falls* rate did not meet its goal as the rate increased over the prior year, indicating the interventions implemented were not effective in sustaining its performance. Additionally, through the CQAR activity, **Region 3B Area Agency on Aging/Carewell Services** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. Further, through the CAHPS HCBS activity, **Region 3B Area Agency on Aging/Carewell Services** scored below the statewide average on the *Personal Safety and Respect* domain, and the rate decreased from the prior year. These findings could imply that while **Region 3B Area Agency on Aging/Carewell Services** ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments, and **Region 3B Area Agency on Aging/Carewell Services** does not consistently report, investigate, and follow up on critical incidents. HSAG recommends that **Region 3B Area Agency on**

Performance Area	Overall Performance Impact
	Aging/Carewell Services review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Region 3B Area Agency on Aging/Carewell Services** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, 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*, scored above the statewide average, although the rate decreased from the prior year. Further, through the CAHPS HCBS survey, the *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored above the statewide averages, and the *Case Manager is Helpful* domain increased from the prior year. However, through the PMV activity, the rate for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, scored below the statewide average and decreased from the prior year. Additionally, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager* domain scored below the statewide average. These findings suggest that while **Region 3B Area Agency on Aging/Carewell Services** generally conducts care coordination according to policies and procedures, and members are generally happy with their case managers, **Region 3B Area Agency on Aging/Carewell Services** does not consistently consider member preferences during care coordination. **Region 3B Area Agency on Aging/Carewell Services** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Region 3B Area Agency on Aging/Carewell Services** demonstrated a *Substantial* compliance level in the MI Choice Services, Follow-Up and Monitoring, and Contingency Plan focus areas. Additionally, through the PMV activity, the rates for Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored above the statewide averages, and Performance Measure 20 scored higher than the prior year. Further, through the CAHPS HCBS survey, **Region 3B Area Agency on Aging/Carewell Services**' rates for the *Staff are Reliable and Helpful* and *Transportation to Medical Appointments* domains scored above the statewide average. However, through the CQAR review, the Linking and Coordinating focus area scored a *Some Compliance, Needs Improvement* compliance level. Additionally, through the PMV activity, Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align*

Performance Area	Overall Performance Impact
	with their assessed needs, scored below the statewide average and decreased from the prior year. Further, through the CAHPS HCBS activity, **Region 3B Area Agency on Aging/Carewell Services**' rate for the *Met Need* domain fell below the statewide average and decreased from the prior year's rate. These findings suggest that while services are generally available for **Region 3B Area Agency on Aging/Carewell Services**' members, supports coordinators are not always able to link and coordinate care for members, and members' needs are not always met. **Region 3B Area Agency on Aging/Carewell Services** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Region IV Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-68 displays the PIPs in place during SFY 2022. Table 3-68 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Region IV Area Agency on Aging** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Region IV Area Agency on Aging** did not meet the statewide goal or the *New Goal*. Any interventions described within **Region IV Area Agency on Aging**'s QMP reports are also provided in Table 3-68. The results in Table 3-68 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-68—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 25.0% SFY 2022 = 24.50% ☒
Interventions: • [Conducting] iHC assessment, Person-Centered Planning meetings, and monitoring calls with participants to identify risks that can be mitigated or strategies to access assistance if falls occur. • Staff education of preventive intervention as needed. • Coordination and support of strength building and risk reducing activities. • Qualitative and quantitative analysis of interventions, goals, evidence-based practices to achieve goals and barriers that hindered the success of the activity.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region IV Area Agency on Aging**. • The statewide quality improvement goal for "Prevalence of Falls" is below 23.0% of the waiver agency's participants. If the waiver agency was already below 23.0% for this quality indicator at the start of fiscal year 2022, the waiver agency must maintain or decrease its percentage for this quality indicator. • Please update your Statewide averages listed in your QMP for both areas and your Prevalence of any Injury goal should reflect 2.6% or lower. It is currently listed at 3% or lower.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less. *New Goal*: 2.6% or lower	SFY 2021 = 2.6% SFY 2022 = 2.50% ☑

PIP Topic	Goal*	Measurement and Outcome±
Interventions: • [Conducting] iHC assessment, Person-Centered Planning meetings, and monitoring calls with participants to identify risks that can be mitigated or strategies to access assistance if falls occur. • Staff education of preventive intervention as needed. • Coordination and support of strength building and risk reducing activities. • Qualitative and quantitative analysis of interventions, goals, evidence-based practices to achieve goals and barriers that hindered the success of the activity.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region IV Area Agency on Aging**. • The statewide quality improvement goal for "Prevalence of any Injuries" is below 3.0% of the waiver agency's participants. If the waiver agency was already below 3.0% for this quality indicator at the start of fiscal year 2022, the grantee must maintain or decrease its percentage for this quality indicator. • Please update your Statewide averages listed in your QMP for both areas and your Prevalence of any Injury goal should reflect 2.6% or lower. It is currently listed at 3% or lower.		

*The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-69 displays the two PIPs **Region IV Area Agency on Aging** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-69 is displayed as reported by **Region IV Area Agency on Aging** and was not validated by HSAG.

Table 3-69—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the number of falls with injuries experienced by participants enrolled in MI Choice Waiver to 5% or less.	Baseline: 0% SFY 2023: Not yet reported
Interventions: • Root Cause analysis • Chart audits		

PIP Topic	Goal	Measurement and Outcome
• Metrics to be reviewed monthly • PDSA to develop a plan for improvement • Staff education • Participant education		
PIP Validation Feedback: MDHHS did not provide any feedback to **Region IV Area Agency on Aging**.		
Required Adult Foster Care (AFC) Documentation	Obtain 100% of Residential Care Agreements, Health Appraisals, and Assessment Plans for participant in an AFC care setting.	Baseline: 54% SFY 2023: Not yet reported
Interventions: • Root Cause analysis • Chart audits • Metrics to be reviewed quarterly • PDSA to develop a plan for improvement • Staff education • Participant education		
PIP Validation Feedback: MDHHS did not provide any feedback to **Region IV Area Agency on Aging**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 MDHHS-established goals (i.e., *New Goal*) for the *Prevalence of Any Injuries* PIP. The reduction in the prevalence rate for this PIP was primarily attributed to educating supports coordinators on proper coding and correcting coding errors as reported by the waiver agency. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Region IV Area Agency on Aging** did not appear to be effective in improving outcomes for the *Prevalence of Falls* PIP as **Region IV Area Agency on Aging** did not reach the MDHHS-established goal (i.e., statewide goal). **Region IV 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 PIP. [**Quality**]

Why the weakness exists: **Region IV Area Agency on Aging** cited inaccurate data collection due to the software's inability to report data for more than a six-month period as the primary barrier to improvement in the *Prevalence of Falls* PIP.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** work with MDHHS to identify and mitigate any issues with the software system. HSAG also 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 also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **Region IV Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **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 #2: **Region IV Area Agency on Aging**'s SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: **Region IV Area Agency on Aging** calculated its PIP results on a different timing schedule than MDHHS (i.e., **Region IV Area Agency on Aging** calculated its results based on the full state fiscal year, and MDHHS calculated the results only on the first half of the state fiscal year for baseline and remeasurement).

Recommendation: HSAG continues to recommend that **Region IV Area Agency on Aging** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Region IV Area Agency on Aging** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Region IV Area Agency on Aging**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Region IV Area Agency on Aging** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Region IV Area Agency on Aging** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Region IV Area Agency on Aging MI Choice Waiver Quality Assurance Performance Improvement Plan FY 2023 & 2024 demonstrated some improvement in the design of the new SFY 2023 PIPs.

However, **Region IV Area Agency on Aging**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Region IV Area Agency on Aging** in a methodologically sound manner. HSAG further recommends that **Region IV Area Agency on Aging**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Region IV Area Agency on Aging** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Region IV Area Agency on Aging** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Region IV Area Agency on Aging** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-70 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-70 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-70, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-70—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.24%**	**100% ↑**	**86.65%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**97.77%**	**96.32%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**95.65%**	**97.10%**	**94.76%**
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	**97.06%**	**97.06%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.18%**	**67.65% ↓**	**82.72%**
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	**96.54%**	**94.10%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**87.10%**	**92.59% ↑**	**88.74%**
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	**94.74%**	**90.48%**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.01%**	**94.12%**	**89.27%**

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**23.53%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Region IV Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Region IV Area Agency on Aging received a 100 percent performance rating for Performance Measures 1, 4, 7, 8, 22, 24, and 38, indicating that services plans were completed on time; LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; choice was offered among waiver service providers; members/guardians were provided with education about how to report abuse, neglect, exploitation, and other critical incidents; and service plans supported paid services. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region IV Area Agency on Aging 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 15.07 percentage points below the statewide rate and a decrease of 23.53 percentage points from **Region IV Area Agency on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 11 of the 17 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **Region IV Area Agency on Aging** reported that it did not understand that this requirement related to all non-waiver services rather than just those non-waiver services considered essential to members' health and welfare.

Recommendation: While **A&D Home Health Care**'s CAP included staff education, HSAG recommends that this education include clear guidance that all non-waiver services should be included in the members' PCSPs. Additionally, **Region IV Area Agency on Aging** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of

noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Region IV 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 19.14 percentage points below the statewide rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 13 of the 17 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan. **Region IV Area Agency on Aging** reported that it did not understand that this requirement related to all non-waiver services rather than just those non-waiver services considered essential to members' health and welfare; therefore, backup plans were not created for all non-waiver services.

Recommendation: While **Region IV Area Agency on Aging**'s CAP included staff education, HSAG recommends that this education include clear guidance that all non-waiver services should be included in the members' PCSPs and include a backup plan. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

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 interviews. Table 3-71 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-71—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	82.35%		**2.00**	2.00
Focus 3	Release of Information	94.12%		**4.00**	4.00
Focus 4	Status	100%		**4.00**	4.00
Focus 5	Pre-Planning	99.34%	100%	**4.00**	4.00
Focus 6	Assessment	94.81%	98.15%	**4.00**	4.00
Focus 7	Medication Record	90.32%	100%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	91.06%	98.57%	**4.00**	4.00
Focus 9	MI Choice Services	94.74%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	86.49%	96.30%	**3.35**	4.00
Focus 11	Follow-Up and Monitoring	89.47%	97.22%	**4.00**	2.04
Focus 12	Service Provider	90.91%		**4.00**	4.00
Focus 13	Contingency Plan	71.11%	100%	**2.69**	4.00
Focus 14	Critical Incidents	91.67%	100%	**4.00**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	71.43%		**2.00**	4.00
Focus 16	Complaints and Grievances	100%		**4.00**	4.00
Focus 17	Home and Community Based		NA	**NA**	4.00
	Totals	**92.25%**	**99.08%**	**3.86**	3.90

Indicates the standard was not reviewed as part of the record review or home visit.
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 IV Area Agency on Aging achieved a substantial compliance rating in 13 of the applicable 16 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were 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 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 out of 17 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **Region IV Area Agency on Aging** reported that supports coordinators were not documenting verbal consent.

Recommendation: MDHHS required **Region IV Area Agency on Aging** to submit a CAP to remediate the deficiencies. Although this deficiency has been noted as noncompliant over the past two years, **Region IV Area Agency on Aging** reported that the root cause was different in previous years, and therefore required different interventions. As such, HSAG recommends that **Region IV Area Agency on Aging** continue to implement its CAP to conduct staff education and the use of a job aid. However, if improvement is not realized, **Region IV Area Agency on Aging** should modify its CAP and implement alternative interventions.

Weakness #2: **Region IV 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 NABDs are important to ensure members understand their appeal rights and the process to request an appeal. **Region IV Area Agency on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that three out of 11 applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD and three out of 10 applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate. **Region IV Area Agency on Aging** reported that the current workflow does not allow for timely mailing of NABDs and may need to be changed. **Region IV Area Agency on Aging** also reported that, for case closures, the supports coordinator notifies the eligibility specialist of the need for closure and the eligibility specialist completes the closure process. By the nature of this handoff, a day or two is lost for mailing the NABD. Additionally, **Region IV Area Agency on Aging** reported that supports coordinators were not always using plain language in the NABDs or ensuring all appropriate services were listed.

Recommendation: As these were new citations, HSAG recommends that **Region IV Area Agency on Aging** continue to implement its CAP to conduct staff education and the use of an updated workflow. However, if improvement is not realized, **Region IV Area Agency on Aging** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Region IV Area Agency on Aging** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Region IV Area Agency on Aging**'s original questionnaire responses, and **Region IV Area Agency on Aging** responded to these specific questions. To support its questionnaire responses, **Region IV Area Agency on Aging** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Region IV Area Agency on Aging** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-72 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-72—EDV Results for Region IV Area Agency on Aging

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Region IV Area Agency on Aging** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Region IV Area Agency on Aging** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Region IV Area Agency on Aging** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Region IV Area Agency on Aging** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.

Analysis	Key Findings
Payment Structures	• **Region IV Area Agency on Aging** utilizes line-by-line method for its claim payment strategies. • **Region IV Area Agency on Aging**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Region IV Area Agency on Aging** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Region IV Area Agency on Aging** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Region IV Area Agency on Aging**'s encounters, **Region IV Area Agency on Aging** indicated that it did not store data sent to MDHHS. • **Region IV Area Agency on Aging** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Region IV Area Agency on Aging** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Region IV Area Agency on Aging** had a low volume of duplicate encounters, with 0.4 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Region IV Area Agency on Aging** demonstrated timely submission for professional encounters. Within 60 days, **Region IV Area Agency on Aging** submitted 98.9 percent of professional encounters to MDHHS after the payment date. Within 150 days, **Region IV Area Agency on Aging** submitted 99.9 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• In **Region IV Area Agency on Aging**'s submitted professional encounters, the billing provider NPI was populated 13.4 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Region IV Area Agency on Aging**'s submitted data had high rates of population and validity.

Analysis	Key Findings
Encounter Referential Integrity	• Of all identified member IDs in **Region IV Area Agency on Aging**'s submitted data, 99.7 percent were identified in the enrollment data. • Of all identified provider NPIs in **Region IV Area Agency on Aging**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Region IV Area Agency on Aging**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Region IV Area Agency on Aging demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Region IV Area Agency on Aging submitted professional encounters in a timely manner from the payment date, with 98.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Region IV Area Agency on Aging** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region IV Area Agency on Aging indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Region IV Area Agency on Aging**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Region IV Area Agency on Aging**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: **Region IV Area Agency on Aging** reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: **Region IV Area Agency on Aging** appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: **Region IV Area Agency on Aging** should consider enhancing its data management practices. HSAG recommends that **Region IV Area Agency on Aging** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 13.4 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: **Region IV Area Agency on Aging** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-73 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 3-73 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-73—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	94.9%	94.4%	91.8%
Recommendation Measures	94.1%	94.6%	92.1%
Staff are Reliable and Helpful	93.0%	90.8%	92.1%
Staff Listen and Communicate Well	94.1%	92.3%	94.6%
Case Manager is Helpful	97.5%	99.0%	95.8%
Choosing the Services that Matter to You	95.4%	93.8%	90.8%
Transportation to Medical Appointments	92.2%	89.9%	92.4%
Personal Safety and Respect	96.7%	95.8%	97.4%
Planning Your Time and Activities	74.7%	76.4%	78.5%
Met Need	95.3%	**85.6% ↓**	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *Global Ratings Measures*, *Recommendation Measures*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You*, indicating that **Region IV Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in several domains. [**Quality**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region IV Area Agency on Aging scored more than 5 percentage points below the statewide average on the *Met Need* domain at 85.6 percent compared with the statewide average of 93.0 percent. Additionally, **Region IV Area Agency on Aging**'s rate decreased 9.7 percentage points below its SFY 2021 rate. [**Quality** and **Access**]

Why the weakness exists: Of the five questions within the *Met Need* domain, **Region IV Area Agency on Aging** scored below the statewide average for three questions, *Met need in meal preparation/eating*, *Met need in medication administration***,** and *Met need in toileting*.

Recommendation: HSAG recommends that the **Region IV Area Agency on Aging** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores contributed to the low satisfaction score within the *Met Need* domain, specifically the statements related to meal preparation/eating, medication administration, and toileting; develop interventions to improve the *Met Need* domain; and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #2: Although **Region IV Area Agency on Aging** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. [**Quality**]

Why the weakness exists: This section is not applicable as this domain was not identified as a substantial weakness for **Region IV Area Agency on Aging**.

Recommendation: HSAG recommends that **Region IV Area Agency on Aging** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores contributed to the low satisfaction score within the *Planning Your Time and Activities* domain; develop interventions to improve the *Planning Your Time and Activities* domain; and evaluate the results of the interventions regularly, making changes as necessary.

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

HSAG performed a comprehensive assessment of **Region IV Area Agency on Aging**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Region IV Area Agency on Aging** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Region IV Area Agency on Aging**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-74 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Region IV Area Agency on Aging**'s MI Choice members.

Table 3-74—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Region IV Area Agency on Aging** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members by identifying risks and providing information on critical incidents. Additionally, through the CAHPS HCBS survey, **Region IV Area Agency on Aging** showed a strong focus on member health and safety through a high rating in the *Physical Safety Measure* domain. Further, through the PIP activity, **Region IV Area Agency on Aging**'s *Prevalence of Any Injuries* rate met the statewide goal and decreased from the prior year's rate, indicating the interventions implemented were effective at decreasing injuries. Lastly, through the CQAR activity, **Region IV Area Agency on Aging** received a *Substantial* compliance level in the Critical Incidents focus area. However, through the PIP activity, **Region IV Area Agency on Aging**'s *Prevalence of Falls* rate did not meet its goal, indicating the interventions implemented were not effective in decreasing the prevalence of falls. Further, through the CAHPS HCBS activity, **Region IV Area Agency on Aging** scored below the statewide average on the *Personal Safety and Respect* domain, and the rate decreased from the prior year. These findings could imply that while **Region IV Area Agency on Aging** ensures the health and safety of members when providing services directly to the

Performance Area	Overall Performance Impact
	member, it lacks the appropriate safety protocols for members in their home/community environments. HSAG recommends that **Region IV Area Agency on Aging** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Region IV Area Agency on Aging** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, 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*, scored above the statewide average, although the rate decreased from the prior year. Further, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored above the statewide averages, and the *Case Manager is Helpful* domain increased from the prior year. However, through the PMV activity, the rate for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, scored below the statewide average and decreased from the prior year. These findings suggest that while **Region IV Area Agency on Aging** generally conducts care coordination according to policies and procedures, and members are generally happy with their case managers, **Region IV Area Agency on Aging** does not consistently consider member preferences during care coordination. **Region IV Area Agency on Aging** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Region IV Area Agency on Aging** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, and Follow-Up and Monitoring focus areas. Additionally, through the PMV activity, the rates for Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored above the statewide averages, and Performance Measure 15 scored higher than the prior year. However, through the CQAR review, the Contingency Plan focus area scored a *Some Compliance, Needs Improvement* compliance level. Additionally, through the PMV activity, Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored below the statewide average. Further, through the CAHPS HCBS activity, **Region IV Area Agency on Aging**'s rates for the *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, and *Met Need* domains fell below the statewide

Performance Area	Overall Performance Impact
	average and decreased from the prior year's rate. These findings suggest that while services are generally available for **Region IV Area Agency on Aging**'s members, and supports coordinators generally link and coordinate appropriate services, members do not feel that staff are helpful, supports coordinators are consistently able to help the members get transportation, and members' needs are always met. **Region IV Area Agency on Aging** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Region VII Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-75 displays the PIPs in place during SFY 2022. Table 3-75 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Region VII Area Agency on Aging** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Region VII Area Agency on Aging** did not meet the statewide goal or the *New Goal*. Any interventions described within **Region VII Area Agency on Aging**'s QMP reports are also provided in Table 3-75. The results in Table 3-75 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-75—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 25.1% SFY 2022 = 22.70% ☑
Interventions: • **Region VII Area Agency on Aging** supports coordinators assessed all MI Choice Waiver participants for falls and risk for falls during each assessment (initial, 90 day, and 360 day) and at every Monitoring Contact (every 30-60 days). Supports coordinators collaborated with participants 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** provided assistance with fall prevention to participants by increasing caregiver hours during critical activity times, purchasing durable medical equipment to improve fall safety, and evaluating participant environments in order to provide education on fall hazards. • Supports coordinators contacted participants who experienced an emergency room visit or hospitalization related to falls within five (5) days to identify any health, safety or welfare issues and offer appropriate assistance. • Contracted service providers were required by **Region VII Area Agency on Aging** to notify supports coordinators of any participants who experience a fall so that follow-up may be completed with the participant 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 Quality Management Collaborative (QMC) met once per quarter and several members also attended the statewide QMC meetings each quarter. • The December 13, 2022 meeting included a presentation on assistive technology for use around the house and garden to carry out activities without falling.		

PIP Topic	Goal*	Measurement and Outcome±
• At each of their 2022 local QMC **Region VII Area Agency on Aging**, participants 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** provided access and information to fall prevention workshops on their website www.region7aaa.org that is available to all waiver participants as well as anyone in the community. Workshop topics included: Silver Sneakers Stability – Become Stronger and Improve Balance; Arthritis Foundation Exercise Program; A Matter of Balance – Managing Concerns About Falls; among others.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region VII Area Agency on Aging**: • The waiver agency's performance in meeting quality improvement goals as specified in the Quality Management Plan for the quality indicators of "Prevalence of Falls". ○ The statewide quality improvement goal for "Prevalence of Falls" is below 23.0% of the waiver agency's participants. Current goal listed 25% or less.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 4.1% SFY 2022 = 3.40% ☒
Interventions: • **Region VII Area Agency on Aging** supports coordinators assessed all MI Choice Waiver participants for any injuries during each assessment (initial, 90 day, and 360 day) and at every monitoring contact (every 30-60 days). • Supports coordinators collaborated with participants 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** provided assistance with preventing injuries to participants by increasing caregiver hours during critical activity times, purchasing durable medical equipment to improve mobility and safety, and evaluating participant environments in order to provide education on injury hazards. • Supports coordinators contacted participants who experienced an emergency room visit or hospitalization related to injuries within five (5) days to identify any health, safety or welfare issues and offer appropriate assistance. • Contracted service providers were required by **Region VII Area Agency on Aging** to notify supports coordinators of any participants who experienced an injury so that follow-up may be completed with the participant to determine the cause of the injury, and how to prevent future injuries. • In cases where a participant chose to continue with an activity or situation that presented an ongoing risk to health, safety or welfare, supports coordinators completed an Informed Risk Agreement that was reviewed with the participant 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 reviewed 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 was identified or the injury was		

PIP Topic	Goal*	Measurement and Outcome±
not reported to **Region VII Area Agency on Aging** then the Waiver Manager and supports coordinator were both notified so that appropriate follow up to ensure health, safety and welfare could be completed immediately. Findings were 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 could be addressed with the participant in a timely manner and prevent future injuries.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region VII Area Agency on Aging**: • The waiver agency's performance in meeting quality improvement goals as specified in the Quality Management Plan for the quality indicators of "Prevalence of any Injuries". ○ The statewide quality improvement goal for "Prevalence of any Injuries" is below 3.0% of the waiver agency's participants. Current goal listed 5% or less.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-76 displays the two PIPs **Region VII Area Agency on Aging** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-76 is displayed as reported by **Region VII Area Agency on Aging** and was not validated by HSAG.

Table 3-76—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Decrease the incidence of participant falls to 23.0% or less and injuries to 3.0% or less.	Baseline: Not reported* SFY 2023: Not yet reported
Interventions: • **Region VII Area Agency on Aging** supports coordinators assess all MI Choice Waiver participants for falls and risk for falls during each assessment (initial, 90 day, 180 day and 360 day) and at every Monitoring Contact (every 30-60 days). • Supports coordinators collaborate with participants 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.		

PIP Topic	Goal	Measurement and Outcome
• **Region VII Area Agency on Aging** provides assistance with fall prevention to participants by increasing caregiver hours during critical activity times, providing durable medical equipment to improve fall safety, and evaluating participant environments in order to provide education on fall hazards. • Supports coordinators contact participants who experience an emergency room visit or hospitalization related to falls within five (5) 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 participants who encounter a Critical Incident. • Each month falls noted in the assessment process are reviewed to verify that the participant received education and support prevent further falls. This is completed by the quality manager and the results are shared with the waiver supervisors for one on one staff follow up.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region VII Area Agency on Aging**: • Both the clinical and non-clinical PIPs lack detailed descriptions. Outline instructions: Within the QAPI program description, the waiver agencies should describe how their performance improvement project is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. As part of this description, they should explain the methodology they are using to support these requirements (e.g., PDSA, IHI Model for Improvement).		
Service Summaries	Ensure service summaries contain accurate and complete information at an agency rate of greater than 90.0% based on the CQAR.	Baseline: Not reported SFY 2023: Not yet reported
Interventions: • The Quality Department will audit a minimum two (2) charts for each service coordinator quarterly to verify compliance. Any participant charts with incorrect Service Summaries will be followed up by a supervisor and the appropriate service coordinator.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region VII Area Agency on Aging**: • Both the clinical and non-clinical PIPs lack detailed descriptions. Outline instructions: Within the QAPI program description, the waiver agencies should describe how their performance improvement project is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. As part of this description, they should explain the methodology they are using to support these requirements (e.g., PDSA, IHI Model for Improvement).		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 met the MDHHS-established goal for the *Prevalence of Falls* PIP. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Region VII Area Agency on Aging** did not appear to be effective in improving outcomes for the *Prevalence of Any Injuries* PIP, and **Region VII Area Agency on Aging** did not reach the MDHHS-established goal (i.e., statewide goal). **Region VII 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 PIP. [**Quality**]

Why the weakness exists: Region VII Area Agency on Aging did not conduct a barrier or root cause analysis to determine why the prevalence rate did not meet the goal for this PIP.

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). **Region VII Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **Region VII Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **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 #2: Region VII Area Agency on Aging's SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: Region VII Area Agency on Aging did not document its methodology in its QMP documentation (e.g., the time frames for measurement). As such, it is unclear if **Region VII Area Agency on Aging** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Region VII Area Agency on Aging** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Region VII Area Agency on Aging** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls

across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Region VII Area Agency on Aging**'s PIPs did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Region VII Area Agency on Aging** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.
Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Region VII Area Agency on Aging** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The MI Choice Summary of Quality Assurance and Performance Improvement (QAPI) FY 2023 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Region VII Area Agency on Aging**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.
Recommendation: HSAG recommends that **Region VII Area Agency on Aging** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Region VII Area Agency on Aging** in a methodologically sound manner. HSAG further recommends that **Region VII Area Agency on Aging**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Region VII Area Agency on Aging** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Region VII Area Agency on Aging** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Region VII Area Agency on Aging** could provide the completed checklist to MDHHS annually for its PIP validation process.

Weakness #4: The performance measures and goals identified for the *Falls with Injury* PIP in **Region VII Area Agency on Aging**'s MI Choice Summary of Quality Assurance and Performance Improvement (QAPI) FY 2023 did not align with the PIP. As performance measures are used to monitor the performance of the PIP, track performance over time, compare performance among waiver agencies, and inform the selection and evaluation of quality improvement activities, the performance measure and goal must be relevant to the subject of the PIP. [**Quality**]

[**Quality**]

Why the weakness exists: MDHHS required all waiver agencies to conduct a *Falls with Injury* PIP. However, **Region VII Area Agency on Aging** indicated it would monitor the *Prevalence of Falls* with a goal of 23 percent and *Prevalence of Any Injuries* with a goal of 3 percent, which would not be accurate measurement for the rate of falls that result in injuries.

Recommendation: HSAG recommends that **Region VII Area Agency on Aging** consult with MDHHS to ensure the methodology for the *Falls with Injury* PIP performance measure and goals are aligned and relevant to the objective of the PIP.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-77 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-77 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-77, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-77—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**100%**	**89.29% ↓**	**86.65%**
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	**97.38%**	**95.73%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**97.41%**	**93.91%**	**94.76%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**92.86% ↓**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**94.64%**	**92.86%**	**82.72%**
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	**97.66%**	**93.56%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**95.83%**	**88.89% ↓**	**88.74%**
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	**100%**	**88.10% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**100%**	**100%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**75.00%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**96.43%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Region VII Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Region VII Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 7, 8, 21, 22, and 24, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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: HSAG did not identify any substantial trends of weakness. While Performance Measures 15, 16, 20, and 38 did not meet the statewide performance rate, none of the performance measures fell below the statewide rate by more than 5 percentage points.

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

Recommendation: Although **Region VII Area Agency on Aging** did not demonstrate any substantial trends of weakness, HSAG recommends that **Region VII Area Agency on Aging** focus interventions on performance measures that demonstrated at least a decline of 5 percentage points from the prior year; specifically, Performance Measures 16, 19, 20, and 30.

Compliance Review

Performance Results

Table 3-78 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 interviews. Table 3-78 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-78—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	89.29%		**3.00**	4.00
Focus 3	Release of Information	92.86%		**4.00**	4.00
Focus 4	Status	95.28%		**4.00**	4.00
Focus 5	Pre-Planning	99.22%	100%	**4.00**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 6	Assessment	96.44%	100%	**4.00**	4.00
Focus 7	Medication Record	91.82%	98.57%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	90.00%	100%	**4.00**	4.00
Focus 9	MI Choice Services	94.27%	98.91%	**4.00**	4.00
Focus 10	Linking and Coordinating	93.06%	100%	**4.00**	4.00
Focus 11	Follow-Up and Monitoring	81.43%	100%	**3.33**	4.00
Focus 12	Service Provider	100%		**4.00**	4.00
Focus 13	Contingency Plan	89.33%	100%	**4.00**	4.00
Focus 14	Critical Incidents	93.75%	100%	**4.00**	2.00
Focus 15	Adverse Benefit Determination	71.05%		**2.00**	4.00
Focus 16	Complaints and Grievances	100%		**4.00**	NA
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**93.05%**	**99.71%**	**3.92**	3.91

Indicates the standard was not reviewed as part of the record review or home visit.
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: A review of 14 home visits was conducted; all reviews achieved full compliance except for two deficiencies, and no focus areas received a citation requiring a CAP. 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 were receiving services in accordance with their service plans and preferences and were satisfied with those services. [**Quality**]

Strength #2: Region VII Area Agency on Aging achieved a substantial compliance rating in 15 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were being implemented in accordance with many State and federal requirements. [**Quality**, **Access**, and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Region VII 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 NABDs are important to ensure members understand their appeal rights and the process to request an appeal. **Region VII Area Agency on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that six out of 20 applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and five out of 18 applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate. **Region VII Area Agency on Aging** reported that the noncompliant records were due to incomplete, incorrect, or missing NABD paperwork. **Region VII Area Agency on Aging** also reported that its supports coordinators have indicated that the current NABD is "too busy" or "hard to read."

Recommendation: MDHHS required **Region VII Area Agency on Aging** to submit a CAP to remediate the deficiencies. However, one of the two deficiencies has been noted as noncompliant for the past two years; therefore, **Region VII Area Agency on Aging**'s interventions have not led to performance improvement. HSAG recommends that **Region VII Area Agency on Aging** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Region VII Area Agency on Aging** could develop an instruction sheet outlining the NABD requirements.

Encounter Data Validation

Performance Results

Representatives from **Region VII Area Agency on Aging** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Region VII Area Agency on Aging**'s original questionnaire responses, and **Region VII Area Agency on Aging** responded to these specific questions. To support its questionnaire responses, **Region VII Area Agency on Aging** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Region VII Area Agency on Aging** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-79 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-79—EDV Results for Region VII Area Agency on Aging

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Region VII Area Agency on Aging** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Region VII Area Agency on Aging** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Region VII Area Agency on Aging** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Region VII Area Agency on Aging** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Region VII Area Agency on Aging** utilizes line-by-line method for its claim payment strategies.

Analysis	Key Findings
	• **Region VII Area Agency on Aging**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Region VII Area Agency on Aging** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Region VII Area Agency on Aging** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Region VII Area Agency on Aging**'s encounters, **Region VII Area Agency on Aging** indicated that it did not store data sent to MDHHS. • **Region VII Area Agency on Aging** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Region VII Area Agency on Aging** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Region VII Area Agency on Aging** had a low volume of duplicate encounters, with 0.4 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Region VII Area Agency on Aging** demonstrated timely submission for professional encounters. Within 60 days, **Region VII Area Agency on Aging** submitted 99.9 percent of professional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **Region VII Area Agency on Aging**'s submitted professional encounters, the billing provider NPI was populated 7.9 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Region VII Area Agency on Aging**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Region VII Area Agency on Aging**'s submitted data, 99.3 percent were identified in the enrollment data. • Of all identified provider NPIs in **Region VII Area Agency on Aging**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Region VII Area Agency on Aging**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Region VII Area Agency on Aging demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Region VII Area Agency on Aging submitted professional encounters in a timely manner from the payment date, with 99.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Region VII Area Agency on Aging** were populated at high rates, and most data elements were over 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region VII Area Agency on Aging indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Region VII Area Agency on Aging**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Region VII Area Agency on Aging**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Region VII Area Agency on Aging reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Region VII Area Agency on Aging appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Region VII Area Agency on Aging should consider enhancing its data management practices. HSAG recommends that **Region VII Area Agency on Aging** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 7.9 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Region VII Area Agency on Aging should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-80 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 3-80 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-80—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	92.1%	94.3%	91.8%
Recommendation Measures	96.5%	95.5%	92.1%
Staff are Reliable and Helpful	94.7%	89.9%	92.1%
Staff Listen and Communicate Well	97.5%	95.7%	94.6%
Case Manager is Helpful	91.1%	96.4% ↑	95.8%
Choosing the Services that Matter to You	91.1%	92.2%	90.8%
Transportation to Medical Appointments	95.3%	92.5%	92.4%
Personal Safety and Respect	96.7%	96.6%	97.4%
Planning Your Time and Activities	79.9%	78.5%	78.5%
Met Need	95.3%	92.6%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 the statewide results in the following domains: *Global Ratings Measures*, *Recommendation Measures*, *Staff Listen and Communicate Well*, *Case Manager is Helpful*, *Choosing the Services that Matter to You*, and *Transportation to Medical Appointments*, indicating that **Region VII Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. **Region VII Area Agency on Aging** also demonstrated improvement in three rates, with one measure rate, *Case Manager is Helpful*, increasing by 5 percentage points or more. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

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.

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 *Staff are Reliable and Helpful*, *Personal Safety and Respect*, and *Met Need* domains; therefore, HSAG recommends that **Region VII Area Agency on Aging** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within these domains, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. It should be noted that the *Planning Your Time and Activities* domain received the lowest statewide score across all domains, and **Region VII Area Agency on Aging** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Region VII Area Agency on Aging**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Region VII Area Agency on Aging** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Region VII Area Agency on Aging**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-81 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Region VII Area Agency on Aging**'s MI Choice members.

Table 3-81—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Region VII Area Agency on Aging** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information on critical incidents. Additionally, through the CQAR activity, **Region VII Area Agency on Aging** received a *Substantial* compliance level in the Critical Incidents focus area. Further, through the CAHPS HCBS survey, **Region VII Area Agency on Aging** showed a strong focus on member health and safety through a high rating in the *Physical Safety Measure* domain. Lastly, through the PIP activity, **Region VII Area Agency on Aging**'s *Prevalence of Falls* rate met the statewide goal and decreased from the prior year's rate, indicating the interventions implemented were effective in decreasing falls. However, through the PIP activity, **Region VII Area Agency on Aging**'s *Prevalence of Any Injuries* rate did not meet its goal, indicating the interventions implemented were not effective in decreasing the prevalence of injuries. Additionally, through the PMV activity, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. Further, through the CAHPS HCBS activity, **Region VII Area Agency on Aging** scored below the statewide average on the *Personal Safety and Respect* domain, and the rate decreased from the prior year. These findings could imply that while **Region VII Area Agency on Aging** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments and does not consistently identify safety risks for the member. HSAG recommends that **Region VII Area Agency on Aging** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.

Performance Area	Overall Performance Impact
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Region VII Area Agency on Aging** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, scored above the statewide average, although the rates decreased from the prior year. Further, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored above the statewide averages, and the *Case Manager is Helpful* and *Choosing the Services that Matter to You* domains increased from the prior year. These findings suggest that **Region VII Area Agency on Aging** conducts care coordination according to policies and procedures, and members are generally happy with their case managers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Region VII Area Agency on Aging** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, Follow-Up and Monitoring, and Contingency Plan focus areas. Additionally, through the PMV activity, Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored above the statewide average. Further, through the CAHPS HCBS survey, **Region VII Area Agency on Aging**'s rate for the *Transportation to Medical Appointments* domain scored above the statewide average. However, through the PMV activity, the rates for Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored below the statewide averages and decreased from the prior year's rates. Additionally, through the CAHPS HCBS activity, **Region VII Area Agency on Aging**'s rates for the *Staff are Reliable and Helpful* and *Met Need* domains fell below the statewide averages and decreased from the prior year's rates. These findings suggest that while services are generally available for **Region VII Area Agency on Aging** members and supports coordinators generally link and coordinate appropriate services, members do not feel that staff are helpful, and members' needs are not always met. **Region VII Area Agency on Aging** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Region 9 Northeast MI Community Service Agency

Validation of Performance Improvement Projects

Performance Results

Table 3-82 displays the PIPs in place during SFY 2022. Table 3-82 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Region 9 Northeast MI Community Service Agency** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Region 9 Northeast MI Community Service Agency** did not meet the statewide goal or the *New Goal*. Any interventions described within **Region 9 Northeast MI Community Service Agency**'s QMP reports are also provided in Table 3-82. The results in Table 3-82 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-82—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 24.7% SFY 2022 = 18.70% ☑
Interventions: • During FY2022, **Region 9 Northeast MI Community Service Agency** found that some of the information that was reported appeared to be a result of supports coordinators failing to update the assessment data. In addition to providing education to staff on the importance of accurate information in the assessments, **Region 9 Northeast MI Community Service Agency** was successful in advocating for those data items to be reset to "no selection" so that supports coordinators are forced to enter new data at each assessment.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region 9 Northeast MI Community Service Agency**: • The statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the waiver agency's participants. Your falls and injuries goals of 24.7% and 5.1% would not meet the statewide goals. It is also not clear what you are going to do to address Prevalence of Falls or Prevalence of Injuries.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 5.1% SFY 2022 = 3.80% ☒
Interventions: • During FY2022, **Region 9 Northeast MI Community Service Agency** found that some of the information that was reported appeared to be a result of supports coordinators failing to update the assessment data. In addition to providing education to staff on the importance of accurate information in the assessments, **Region**		

PIP Topic	Goal*	Measurement and Outcome±
9 Northeast MI Community Service Agency was successful in advocating for those data items to be reset to "no selection" so that supports coordinators are forced to enter new data at each assessment.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region 9 Northeast MI Community Service Agency**: • The statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the waiver agency's participants. Your falls and injuries goals of 24.7% and 5.1% would not meet the statewide goals. It is also not clear what you are going to do to address Prevalence of Falls or Prevalence of Injuries.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-83 displays the two PIPs **Region 9 Northeast MI Community Service Agency** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-83 is displayed as reported by **Region 9 Northeast MI Community Service Agency** and was not validated by HSAG.

Table 3-83—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	**Region 9 Northeast MI Community Service Agency** will establish one metric for measuring the prevalence of falls with injury in the fiscal year 2023 and will track the metric results in the fiscal year 2024 to establish one new baseline.	Baseline: Not reported* SFY 2023: Not yet reported
Interventions: • Evaluate current data and practice standards and develop a meaningful metric to evaluate falls that result in injury. Any required changes in data-gathering activities will have action plans that may include items such as training, job aides, policy updates, and updates to job roles.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region 9 Northeast MI Community Service Agency**: • Please include a specific quantitative baseline and target with each goal.		

PIP Topic	Goal	Measurement and Outcome
Nursing Home Admission Rates	**Region 9 Northeast MI Community Service Agency** will establish one metric for measuring the prevalence of Nursing Facility Admissions in the fiscal year 2023 and track the metric results in the fiscal year 2024 to establish one new baseline.	Baseline: 13.41% SFY 2023: Not yet reported
Interventions: • Evaluate current data and practice standards and develop a meaningful metric to evaluate nursing home admission rates. Any required changes in data-gathering activities will have action plans that may include items such as training, job aides, policy updates, and updates to job roles.		
PIP Validation Feedback: MDHHS provided the following feedback to **Region 9 Northeast MI Community Service Agency**: • Please include a specific quantitative baseline and target with each goal.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.
* While the waiver agency reported baseline data for the *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs, the waiver agency did not report baseline data specifically for the *Falls with Injury* PIPs.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 Northeast MI Community Service Agency met the MDHHS-established goal for the *Prevalence of Falls* PIP. **Region 9 Northeast MI Community Service Agency** reported that staff education and system updates contributed to the improved performance. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Region 9 Northeast MI Community Service Agency** did not appear to be effective in improving outcomes for the *Prevalence of Any Injuries* PIP as **Region 9 Northeast MI Community Service Agency** did not reach the MDHHS-established goal (i.e., statewide goal). Although the waiver agency did not meet the goal, some improvement in the rate was noted. **Region 9 Northeast MI Community Service Agency**'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 PIP. [**Quality**]

Why the weakness exists: **Region 9 Northeast MI Community Service Agency** stated that the reports MDHHS used to determine the numerators and denominators for this measure included injuries that were reported on an initial assessment and considered healing surgical wounds to be injuries. These inaccuracies cause it to appear that there were more injuries than there actually were in a given time period.

Recommendation: HSAG recommends that **Region 9 Northeast MI Community Service Agency** work with MDHHS to determine whether healing surgical wounds should be included as part of the measure specifications. Additionally, HSAG recommends that **Region 9 Northeast MI Community Service Agency** 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 9 Northeast MI Community Service Agency** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and address these barriers to improve outcomes. Further, **Region 9 Northeast MI Community Service Agency** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **Region 9 Northeast MI Community Service Agency** 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: **Region 9 Northeast MI Community Service Agency**'s SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: **Region 9 Northeast MI Community Service Agency** calculated its PIP results on a different timing schedule than MDHHS (i.e., **Region 9 Northeast MI Community Service Agency** calculated its results based on the full state fiscal year, and MDHHS calculated the results only on the first half of the state fiscal year for baseline and remeasurement).

Recommendation: HSAG continues to recommend that **Region 9 Northeast MI Community Service Agency** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Region 9 Northeast MI Community Service Agency** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Region 9 Northeast MI Community Service Agency**'s PIPs did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Region 9 Northeast MI Community Service Agency** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Region 9 Northeast MI**

Community Service Agency when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The QAPI Northeast Michigan Community Service Agency Region 9 Area Agency on Aging demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Region 9 Northeast MI Community Service Agency**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.
Recommendation: HSAG recommends that **Region 9 Northeast MI Community Service Agency** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Region 9 Northeast MI Community Service Agency** in a methodologically sound manner. HSAG further recommends that **Region 9 Northeast MI Community Service Agency**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Region 9 Northeast MI Community Service Agency** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Region 9 Northeast MI Community Service Agency** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Region 9 Northeast MI Community Service Agency** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-84 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-84 also provides the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **Region 9 Northeast MI Community Service Agency**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-84, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-84—Waiver Agency Impact to Statewide Performance Measure Rates

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	100%	93.33% ↓	86.65%
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	97.76%	98.69%	93.72%
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	100%	100%	98.95%
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	100%	100%	100%
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	100%	100%	100%
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	100%	100%	94.76%
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	100%	83.33% ↓	93.19%
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	96.15%	90.00% ↓	82.72%
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	94.94%	92.82%	91.10%
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	100%	95.00% ↓	88.74%

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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%**	**94.44%**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**100%**	**100%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**60.00%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Region 9 Northeast MI Community Service Agency**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Region 9 Northeast MI Community Service Agency received a 100 percent performance rating for Performance Measures 4, 7, 8, 15, 21, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; PCSPs included services and supports that aligned with members' assessed needs; 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**]

Weaknesses and Recommendations

Weakness #1: Region 9 Northeast MI Community Service Agency 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 9.86 percentage points below the statewide rate and a decrease of 16.67 percentage points from **Region 9 Northeast MI Community Service Agency**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three of the 15 applicable records did not demonstrate evidence that the member/guardian made informed choices; and two 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. **Region 9 Northeast MI Community Service Agency** reported that not all staff were following the waiver agency policy or standards.

Recommendation: While **Region 9 Northeast MI Community Service Agency**'s CAP included staff education and the development of job aids, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-85 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 interviews. Table 3-85 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-85—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	93.33%		**4.00**	1.00
Focus 3	Release of Information	80.00%		**3.00**	4.00
Focus 4	Status	100%		**4.00**	4.00
Focus 5	Pre-Planning	98.53%	100%	**4.00**	4.00
Focus 6	Assessment	98.52%	100%	**4.00**	4.00
Focus 7	Medication Record	90.91%	100%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	84.62%	100%	**3.35**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 9	MI Choice Services	100%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	93.75%	100%	**4.00**	4.00
Focus 11	Follow-Up and Monitoring	90.91%	100%	**4.00**	4.00
Focus 12	Service Provider	90.91%		**4.00**	4.00
Focus 13	Contingency Plan	75.61%	100%	**3.35**	4.00
Focus 14	Critical Incidents	87.50%	95.00%	**3.35**	NA
Focus 15	Adverse Benefit Determination	100%		**4.00**	4.00
Focus 16	Complaints and Grievances	NA		**NA**	NA
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**92.62%**	**99.76%**	**3.83**	3.98

Indicates the standard was not reviewed as part of the record review or home visit.
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 9 Northeast MI Community Service Agency achieved a substantial compliance rating in 15 of the applicable 16 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to 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 Northeast MI Community Service Agency did not receive any compliance determinations that were in the *Not Full or Substantial* compliance level or *Not Demonstrated* compliance level; therefore, no substantial weaknesses were identified.

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. MDHHS required a CAP for the noted areas of deficiency; however, HSAG recommends **Region 9 Northeast MI Community Service Agency** continue to identify any deficiencies and implement interventions as needed.

Encounter Data Validation

Performance Results

Representatives from **Region 9 Northeast MI Community Service Agency** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Region 9 Northeast MI Community Service Agency**'s original questionnaire responses, and **Region 9 Northeast MI Community Service Agency** responded to these specific questions. To support its questionnaire responses, **Region 9 Northeast MI Community Service Agency** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Region 9 Northeast MI Community Service Agency** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-86 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-86—EDV Results for Region 9 Northeast MI Community Service Agency

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Region 9 Northeast MI Community Service Agency** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Region 9 Northeast MI Community Service Agency** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Region 9 Northeast MI Community Service Agency** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Region 9 Northeast MI Community Service Agency** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Region 9 Northeast MI Community Service Agency** utilizes line-by-line method for its claim payment strategies. • **Region 9 Northeast MI Community Service Agency**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Region 9 Northeast MI Community Service Agency** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Region 9 Northeast MI Community Service Agency** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Region 9 Northeast MI Community Service Agency**'s encounters, **Region 9 Northeast MI Community Service Agency** indicated that it did not store data sent to MDHHS. • **Region 9 Northeast MI Community Service Agency** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.

Analysis	Key Findings
Administrative Profile	
Encounter Data Completeness	• **Region 9 Northeast MI Community Service Agency** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Region 9 Northeast MI Community Service Agency** displayed consistent payment amounts per member per month until April 2022; however, between April 2022 and September 2022, **Region 9 Northeast MI Community Service Agency** exhibited a reduction in payment amounts. • **Region 9 Northeast MI Community Service Agency** had a low volume of duplicate encounters, with 0.7 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Region 9 Northeast MI Community Service Agency** demonstrated timely submission for professional encounters. Within 60 days, **Region 9 Northeast MI Community Service Agency** submitted greater than 99.9 percent of professional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **Region 9 Northeast MI Community Service Agency**'s submitted professional encounters, the billing provider NPI was populated 11.9 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Region 9 Northeast MI Community Service Agency**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Region 9 Northeast MI Community Service Agency**'s submitted data, 98.7 percent were identified in the enrollment data. • Of all identified provider NPIs in **Region 9 Northeast MI Community Service Agency**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Region 9 Northeast MI Community Service Agency**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Region 9 Northeast MI Community Service Agency demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Region 9 Northeast MI Community Service Agency submitted professional encounters in a timely manner from the payment date, with greater than 99.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Region 9 Northeast MI Community Service Agency** were populated at high rates, and most data elements were greater than 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region 9 Northeast MI Community Service Agency indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Region 9 Northeast MI Community Service Agency**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Region 9 Northeast MI Community Service Agency**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Region 9 Northeast MI Community Service Agency reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Region 9 Northeast MI Community Service Agency appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Region 9 Northeast MI Community Service Agency should consider enhancing its data management practices. HSAG recommends that **Region 9 Northeast MI Community Service Agency** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 11.9 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Region 9 Northeast MI Community Service Agency should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-87 presents **Region 9 Northeast MI Community Service Agency**'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 3-87 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-87—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	90.4%	91.8%	91.8%
Recommendation Measures	87.4%	90.7%	92.1%
Staff are Reliable and Helpful	93.4%	93.7%	92.1%

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Staff Listen and Communicate Well	97.0%	91.6% ↓	94.6%
Case Manager is Helpful	81.4%	**85.8%**	95.8%
Choosing the Services that Matter to You	90.6%	88.5%	90.8%
Transportation to Medical Appointments	96.1%	92.8%	92.4%
Personal Safety and Respect	97.5%	96.0%	97.4%
Planning Your Time and Activities	76.1%	76.9%	78.5%
Met Need	95.0%	94.2%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 Northeast MI Community Service Agency achieved scores higher than the statewide results in the following domains: *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, and *Met Need*, indicating that **Region 9 Northeast MI Community Service Agency** provides services in a manner that meets or exceeds members' expectations in several domains. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Region 9 Northeast MI Community Service Agency scored more than 5 percentage points below the statewide average on the *Case Manager is Helpful* domain at 85.8 percent compared with the statewide average of 95.8 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, **Region 9 Northeast MI Community Service Agency** scored below the statewide average for the remaining two questions, *Able to contact this case manager when needed* and *Case manager helped when asked for help with getting or fixing equipment*.

Recommendation: HSAG recommends that **Region 9 Northeast MI Community Service Agency** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores significantly contributed to the low satisfaction score within the *Case Manager is Helpful* domain, specifically the statements related to contacting the case manager and the case manager helping when needed; develop interventions to improve the *Case Manager is Helpful* domain; and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #2: Although **Region 9 Northeast MI Community Service Agency** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. [**Quality**]

Why the weakness exists: This section is not applicable as this domain was not identified as a substantial weakness for **Region 9 Northeast MI Community Service Agency**.

Recommendation: HSAG recommends that **Region 9 Northeast MI Community Service Agency** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores contributed to the low satisfaction score within the *Planning Your Time and Activities* domain; develop interventions to improve the *Planning Your Time and Activities* domain; and evaluate the results of the interventions regularly, making changes as necessary.

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

HSAG performed a comprehensive assessment of **Region 9 Northeast MI Community Service Agency**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Region 9 Northeast MI Community Service Agency** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Region 9 Northeast MI Community Service Agency**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-88 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Region 9 Northeast MI Community Service Agency**'s MI Choice members.

Table 3-88—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Region 9 Northeast MI Community Service Agency** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information on critical incidents. Additionally, through the CQAR activity, **Region 9 Northeast MI Community Service Agency** received a *Substantial* compliance level in the Critical Incidents focus area. Further, through the CAHPS HCBS survey, **Region 9 Northeast MI Community Service Agency** showed a strong focus on member health and safety through a high rating in the *Physical Safety Measure* domain. Lastly, through the PIP activity, **Region 9 Northeast MI Community Service Agency**'s *Prevalence of Falls* rate met the statewide goal and decreased from the prior year's rate, indicating the interventions implemented were effective in decreasing falls. However, through the PIP activity, **Region 9 Northeast MI Community Service Agency**'s *Prevalence of Any Injuries* rate did not meet its goal, indicating the interventions implemented were not effective in decreasing the prevalence of injuries. Additionally, through the PMV activity, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. Further, through the CAHPS HCBS activity, **Region 9 Northeast MI Community Service Agency** scored below the statewide average on the *Personal Safety and Respect* domain, and the rate decreased from the prior year. These findings could imply that while **Region 9 Northeast MI Community Service Agency** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments and does not consistently identify safety risks for the member. HSAG recommends that

Performance Area	Overall Performance Impact
	Region 9 Northeast MI Community Service Agency review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Region 9 Northeast MI Community Service Agency** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, scored above the statewide average, although the rates decreased from the prior year. Further, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager* domain scored above the statewide average. However, the *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored below the statewide averages, and the *Choosing the Services that Matter to You* domain also decreased from the prior year's rate. These findings suggest that although **Region 9 Northeast MI Community Service Agency** conducts care coordination according to policies and procedures, and links the members to services appropriately, members are not consistently satisfied with their case managers. **Region 9 Northeast MI Community Service Agency** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Region 9 Northeast MI Community Service Agency** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, Follow-Up and Monitoring, Contingency Plan, and Adverse Benefit Determination focus areas. Additionally, through the PMV activity, three performance measures scored above the statewide averages: Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver*. Performance Measure 20 also increased over the prior year's rate. Further, through the CAHPS HCBS survey, **Region 9 Northeast MI Community Service Agency**'s rates for the *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, and *Met Need* domains scored above the statewide averages. These findings suggest that services are generally available for **Region 9 Northeast MI Community Service Agency** members, and members feel they are receiving the services and supports they need.

Reliance Community Care Partners

Validation of Performance Improvement Projects

Performance Results

Table 3-89 displays the PIPs in place during SFY 2022. Table 3-89 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Reliance Community Care Partners** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Reliance Community Care Partners** did not meet the statewide goal or the *New Goal*. Any interventions described within **Reliance Community Care Partners**' QMP reports are also provided in Table 3-89. The results in Table 3-89 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-89—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 30.5% SFY 2022 = 36.50% ☒
Interventions: • **Reliance Community Care Partners** studied data on a monthly basis after assessments were completed by the case managers. Additional training was provided at least quarterly and the month following training resulted in the highest percentage of falls being recorded within assessments.		
PIP Validation Feedback: MDHHS provided the following feedback to **Reliance Community Care Partners**: • The Statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the waiver agency's participants. Your falls goal would not meet this goal. It is also not clear what you are going to do to address Prevalence of Falls or Prevalence of Injuries.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 5.1% SFY 2022 = 2.40% ☑
Interventions: • **Reliance Community Care Partners** studied the data on a monthly basis after assessments were completed by the case managers. Additional training was provided at least quarterly and the month following training resulted in the lowest percentage of injuries being recorded within assessments.		

PIP Topic	Goal*	Measurement and Outcome±
PIP Validation Feedback: MDHHS provided the following feedback to **Reliance Community Care Partners**: • The Statewide goal for falls is 23% or lower and Prevalence of any Injuries is below 3.0% of the waiver agency's participants. Your falls goal would not meet this goal. It is also not clear what you are going to do to address Prevalence of Falls or Prevalence of Injuries.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-90 displays the two PIPs **Reliance Community Care Partners** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-90 is displayed as reported by **Reliance Community Care Partners** and was not validated by HSAG.

Table 3-90—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the risk of falls with injury when falls occur to 10% or less annually.	Baseline: Not reported[1] SFY 2023: Not yet reported
Interventions: • In depth root-cause analysis • Focus groups to discuss falls with injury • Quality Council discussion to obtain participant perspective on falls with injury • Chart audits to evaluate all falls with injury • Best practice and literature search for evidence-based practices • Development of clinical protocols as deemed necessary • Development of quarterly metrics to report to quality committees internally and within MHCSN Association • Adoption or development of teaching tools for program participants and their informal supports • Staff training on falls with injury • Development of a metric that focuses on falls with injury		
PIP Validation Feedback: MDHHS did not provide any feedback to **Reliance Community Care Partners**.		

PIP Topic	Goal	Measurement and Outcome
Timeliness of Monitoring Contacts	Increase Monitoring Contacts and Assessments timeliness by supports coordinators to 100% compliance.	Waiver Agency Reporting Baseline: 96.2%[2] SFY 2023: Not yet reported CQAR Baseline: 70.82%[3] SFY 2023: Not yet reported
Interventions: • In depth root-cause analysis • Focus groups to discuss reasons for not complying with requirement • Quality Council discussion to obtain participant perspective on follow-up and timeliness • Chart audits to evaluate follow-up and monitoring timeliness • Best practice definition developed • Development of quarterly metrics to report to quality committees internally and within MHCSN Association • Development of improvement options to implement • Deployment of improvement options		
PIP Validation Feedback: MDHHS did not provide any feedback to **Reliance Community Care Partners**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.
[1] The waiver agency included an estimated baseline only; however, as it was not a true baseline measurement of the waiver agency's performance, HSAG did not include the estimated baseline in this EQR technical report.
[2] The waiver agency's internal reporting showed a baseline of 96.2 percent for *Timeliness of Monitoring Contacts*.
[3] The CQAR measure for *Timeliness of Monitoring Contacts* demonstrated a 70.82 percent baseline.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 the MDHHS-established goal for the *Prevalence of Any Injuries* PIP. **Reliance Community Care Partners** cited quarterly training as the main driver of improvement. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Reliance Community Care Partners** did not appear to be effective in improving outcomes for the *Prevalence of Falls* PIP as the prevalence rate increased, and **Reliance Community Care Partners** did not reach the MDHHS-established goal

(i.e., statewide goal). **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 PIP. [**Quality**]

Why the weakness exists: **Reliance Community Care Partners** cited the question-response options not being set for annual assessments, staff anxiety regarding failure to report a fall, and the limited time frame of the quality indicator report (i.e., only six months of data) as the primary barriers to meeting the goal for this PIP.

Recommendation: Although **Reliance Community Care Partners** conducted a barrier analysis, interventions implemented did not appear to address those barriers. 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 also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and address these barriers to improve outcomes. Further, **Reliance Community Care Partners** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **Reliance Community Care Partners** 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: **Reliance Community Care Partners**' SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: **Reliance Community Care Partners** calculated its PIP results on a different timing schedule than MDHHS (i.e., **Reliance Community Care Partners** calculated its results based on the full state fiscal year, and MDHHS calculated the results only on the first half of the state fiscal year for baseline and remeasurement).

Recommendation: HSAG continues to recommend that **Reliance Community Care Partners** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Reliance Community Care Partners** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Reliance Community Care Partners**' PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Reliance Community Care Partners** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Reliance Community Care Partners** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Reliance Community Care Partners QAPI FY2023-2024 demonstrated some improvement in the

design of the new SFY 2023 PIPs. However, **Reliance Community Care Partners**' PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets. **Recommendation:** HSAG recommends that **Reliance Community Care Partners** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Reliance Community Care Partners** in a methodologically sound manner. HSAG further recommends that **Reliance Community Care Partners**' documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Reliance Community Care Partners** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Reliance Community Care Partners** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Reliance Community Care Partners** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-91 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-91 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-91, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-91—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**79.17%**	**95.83% ↑**	**86.65%**
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	**94.68%**	**88.26% ↓**	**93.72%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**97.94%**	**100%**	**94.76%**
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	**100%**	**87.50% ↓**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**93.75%**	**85.42% ↓**	**82.72%**
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	**95.49%**	**91.64%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**83.87%**	**94.12% ↑**	**88.74%**
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	**86.84%**	**96.88% ↑**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.83%**	**91.67%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**100%**	**100%**
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	**—**	**20.83%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Reliance Community Care Partners**' overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Reliance Community Care Partners received a 100 percent performance rating for Performance Measures 4, 7, 8, 15, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; PCSPs included services and supports that aligned with members' assessed needs; 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**]

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners 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 5.46 percentage points below the statewide rate and a decrease of 6.42 percentage points from **Reliance Community Care Partners**' SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 23 of the 24 applicable records did not demonstrate evidence that there was a valid FOC form in the record; one of the 24 applicable records did not demonstrate that the correct program eligibility status was used; one of the nine applicable records did not demonstrate that the enrollment/dis-enrollment dates were consistent with CHAMPS; two of the 24 applicable records did not demonstrate that the waiver agent completed the initial assessment or reassessment in accordance with MDHHS policy and contract requirements; one of the 24 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; and one of the four applicable records did not demonstrate that if the member/guardian needed assistance with the Medicaid application or redetermination process, the waiver agency provided assistance. **Reliance Community Care**

Partners reported that staff were not documenting attempts to obtain FOC signatures. **Reliance Community Care Partners** reported that other CAP areas only affected one chart from the file review.

Recommendation: While **Reliance Community Care Partners**' CAP included staff education and a return to in-person visits, HSAG recommends that **Reliance Community Care Partners** consider developing a checklist or other reminder system for supports coordinators to use. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: **Reliance Community Care Partners** 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 5.69 percentage points below the statewide rate and a decrease of 12.5 percentage points from **Reliance Community Care Partners**' SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that six of the 24 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. **Reliance Community Care Partners** reported that the waiver agency moved to a new PCSP module and there was a learning curve for how to complete the fields accurately.

Recommendation: While **Reliance Community Care Partners**' CAP included staff education and ongoing chart reviews, HSAG recommends that **Reliance Community Care Partners** consider developing a checklist or other reminder system for supports coordinators to use. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #3: **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 21.84 percentage points below the statewide rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 19 of the 24 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan. **Reliance Community Care Partners** reported that staff were not always mailing the contingency plan as required.

Recommendation: While **Reliance Community Care Partners**' CAP included staff education and ongoing chart reviews, HSAG recommends that **Reliance Community Care Partners** consider developing a checklist or other reminder system for supports coordinators to use and ensuring that chart reviews include this requirement. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-92 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 interviews. Table 3-92 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-92—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	4.17%		**1.00**	1.00
Focus 3	Release of Information	0.00%		**1.00**	1.00
Focus 4	Status	97.01%		**4.00**	4.00
Focus 5	Pre-Planning	96.73%	100%	**4.00**	4.00
Focus 6	Assessment	95.85%	100%	**4.00**	4.00
Focus 7	Medication Record	91.74%	100%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	87.64%	100%	**4.00**	4.00
Focus 9	MI Choice Services	97.69%	98.81%	**4.00**	4.00
Focus 10	Linking and Coordinating	83.61%	92.50%	**2.67**	4.00
Focus 11	Follow-Up and Monitoring	85.71%	100%	**4.00**	2.00
Focus 12	Service Provider	75.00%		**4.00**	4.00
Focus 13	Contingency Plan	36.36%	100%	**2.00**	4.00
Focus 14	Critical Incidents	43.75%	87.10%	**2.00**	3.33

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	66.67%		**1.00**	4.00
Focus 16	Complaints and Grievances	66.67%		**1.00**	4.00
Focus 17	Home and Community Based		92.00%	**4.00**	4.00
	Totals	**86.21%**	**98.10%**	**3.62**	3.84

Indicates the standard was not reviewed as part of the record review or home visit.
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: Reliance Community Care Partners achieved a substantial compliance rating in 10 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were 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 23 out of 24 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **Reliance Community Care Partners** reported that staff were not documenting attempts to obtain FOC signatures.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. However, this deficiency has been noted as noncompliant for the past two years; therefore, **Reliance Community Care Partners**' interventions have not led to performance improvement. HSAG recommends that **Reliance Community Care Partners** update its CAP to include interventions other than implementation of in-person visits, staff education, and ongoing chart audits. For example, **Reliance Community Care Partners** could implement system prompts or another similar workflow that reminds supports coordinators to obtain FOC signatures.

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 all 24 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record. **Reliance Community Care Partners** reported that staff were not documenting attempts to obtain the ROI form/consent signatures.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. However, the deficiency has been noted as noncompliant for the past two years; therefore, **Reliance Community Care Partners**' interventions have not led to performance improvement. HSAG recommends that **Reliance Community Care Partners** update its CAP to include interventions other than implementation of in-person visits, staff education, and ongoing chart audits. For example, **Reliance Community Care Partners** could implement system prompts or another similar workflow that reminds supports coordinators to obtain ROI form/consent signatures.

Weakness #3: Reliance Community Care Partners did not consistently follow all Contingency Plan requirements; specifically, ensuring there is a complete and up-to-date contingency plan, ensuring that the member/guardian received a copy of the contingency plan, and ensuring that other allies received a copy of the contingency plan. Contingency plans are important to ensure that if the member's PCSP services are unavailable, the member will still have services in place until planned services can resume. **Reliance Community Care Partners** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 19 out of 24 applicable records did not demonstrate evidence that the record contained a complete and up-to-date contingency plan, 20 out of 24 applicable records did not demonstrate evidence that the member/guardian received a copy of the contingency plan, and three out of 14 applicable records did

not demonstrate evidence that other allies included in the plan received a copy of the contingency plan as preferred by the member/guardian. **Reliance Community Care Partners** reported that staff were not always mailing a contingency plan to the member/guardian or others as required.

Recommendation: MDHHS required **Reliance Community Care Partners** to submit a CAP to remediate the deficiencies. However, two of the three deficiencies have been noted as noncompliant for the past two years; therefore, **Reliance Community Care Partners**' interventions have not led to performance improvement. HSAG recommends that **Reliance Community Care Partners** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Reliance Community Care Partners** could implement system prompts to remind supports coordinators when and to whom the contingency plan should be mailed.

Weakness #4: Reliance Community Care Partners did not consistently follow all Critical Incident 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. **Reliance Community Care Partners** also received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of four applicable records did not demonstrate evidence that the supports coordinator addressed the incident with the member/guardian; three out of 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; all 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; one of the applicable 12 home visits did not indicate that the member felt safe in his or her home and comfortable with the people that provided care for him/her; one of the applicable three home visits did not indicate that the member thought the supports coordinator took appropriate action to address a reported critical incident with the member; one of the applicable three home visits did not indicate that the supports coordinator talked to the member about ways to prevent further critical incident occurrences; and the one applicable home visit did not indicate that the reviewer followed up by notifying the supports coordinator and contacting the appropriate authorities as warranted. **Reliance Community Care Partners** reported that there was inconsistency related to entering incidents into the critical incident system. Additionally, **Reliance Community Care Partners** reported that the home visit issues were all related to one critical incident, and the supports coordinator responsible had resigned prior to the CQAR.

Recommendation: One of the seven deficiencies was not identified as a citation by MPHI; however, the remaining six deficiencies were documented as citations, and one citation has been noted as noncompliant for the past three years. Therefore, **Reliance Community Care Partners**' interventions have not led to performance improvement in this program area. HSAG recommends that **Reliance Community Care Partners** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **Reliance Community Care Partners** could

develop a critical incident template that must be completed by the supports coordinator for every incident. This template should include all required tasks that must be completed when a critical incident occurs. Management could review the templates as they are completed to immediately address any gaps with the supports coordinator in real time. Additionally, HSAG recommends that **Reliance Community Care Partners** ensure that remediation efforts are put in place for the deficiencies not requiring a CAP.

Weakness #5: Reliance Community Care Partners 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 NABDs are important to ensure members understand their appeal rights and the process to request an appeal. **Reliance Community Care Partners** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one out of four applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and one out of two applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate. **Reliance Community Care Partners** reported that one NABD was not sent.

Recommendation: As these were new citations, HSAG recommends that **Reliance Community Care Partners** continue to implement its CAP of conducting staff education and ongoing chart audits. However, if improvement is not realized, **Reliance Community Care Partners** should modify its CAP and implement alternative interventions.

Weakness #6: Reliance Community Care Partners did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. **Reliance Community Care Partners** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one out of three applicable records did not demonstrate evidence that the member/guardian was made aware of the resolution of complaints or grievances as warranted. **Reliance Community Care Partners** reported that one grievance was not resolved.

Recommendation: As this was a new citation, HSAG recommends that **Reliance Community Care Partners** continue to implement its CAP of conducting staff education and ongoing chart audits. However, if improvement is not realized, **Reliance Community Care Partners** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Reliance Community Care Partners** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Reliance Community Care Partners**' original questionnaire responses, and **Reliance Community Care Partners** responded to these specific questions. To support its questionnaire responses, **Reliance Community Care Partners** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Reliance Community Care Partners** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-93 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-93—EDV Results for Reliance Community Care Partners

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Reliance Community Care Partners** uses MemberCore as its primary software for claim adjudication and encounter preparation. • **Reliance Community Care Partners**' MemberCore software ensures one claim date of service according to the maintained authorization by the case manager. The system has adjudication rules for auto-processing, and the authorization guides the adjudication logic. All processed claims, except for those with ineligible dates submitted by providers, are sent to MDHHS. **Reliance Community Care Partners** indicated that adjustments, if needed, are accomplished through the 837-return file and submitted to MDHHS in the subsequent encounter file. Details of historical and current changes are stored in the MemberCore system. • **Reliance Community Care Partners** collects and processes provider data, as well as handles the enrollment data.

Analysis	Key Findings
Payment Structures	• **Reliance Community Care Partners** utilizes both line-by-line and percent billed (i.e., for durable medical equipment) methods for its claim payment strategies. • For TPL information, **Reliance Community Care Partners** coordinates with other insurers when MI Choice is secondary, prioritizing primary coverage. The waiver agency addresses balances, covering its portion after primary insurance. Legal action is pursued if needed for recovery. TPL details are not submitted on encounters; the waiver agency stores data in its electronic health record system. Outstanding amounts are only considered after providers submit the Explanation of Payment.
Encounter Data Quality Monitoring	• **Reliance Community Care Partners** indicated it edited or made modifications to some of the subcontractor data. • **Reliance Community Care Partners** has a unique practice of submitting full claims with all line items, in contrast to Compass users who submit each claim line separately. As a result, **Reliance Community Care Partners**' claim volume may appear lower than that of Compass users. • Although it is possible that **Reliance Community Care Partners** has an encounter data monitoring process, it was not explicitly mentioned in its response to the questionnaire.
Administrative Profile	
Encounter Data Completeness	• **Reliance Community Care Partners** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Reliance Community Care Partners** had a low volume of duplicate encounters, with 0.1 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Reliance Community Care Partners** did not demonstrate timely submission for professional encounters. Within 60 days, **Reliance Community Care Partners** submitted 70.4 percent of professional encounters to MDHHS after the payment date. Within 180 days, **Reliance Community Care Partners** submitted 97.6 percent of professional encounters to MDHHS after the payment date. **Reliance Community Care Partners** did not reach greater than 99 percent of encounters submitted until after 360 days of payment. • **Reliance Community Care Partners**' submitted data contained a missing paid or submission date for 0.5 percent of encounters.

Analysis	Key Findings
Field-Level Completeness and Accuracy	• In **Reliance Community Care Partners**' submitted professional encounters, the billing provider NPI was populated more than 99.9 percent of the time, and the rendering provider NPI was populated 0.7 percent of the time. • All other data elements in **Reliance Community Care Partners**' submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Reliance Community Care Partners**' submitted data, 99.2 percent were identified in the enrollment data. • Of all identified provider NPIs in **Reliance Community Care Partners**' submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Reliance Community Care Partners**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Reliance Community Care Partners demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Across all professional encounters, most key data elements for **Reliance Community Care Partners** were populated at high rates, and most data elements were over 99 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners performed modifications on encounters before sending them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the providers' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: Reliance Community Care Partners should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the providers.

Weakness #2: Reliance Community Care Partners did not outline any encounter data monitoring process in its questionnaire response. [**Quality**]

Why the weakness exists: Establishing a robust encounter data monitoring process is essential for ensuring the accuracy, completeness, and timeliness of encounters submitted to MDHHS. The absence of a reported process raises concerns about potential gaps in monitoring practices.

Recommendation: While it is possible that **Reliance Community Care Partners** has an encounter data monitoring process that was not explicitly mentioned, it is recommended that the waiver agency ensures clarity in reporting such processes. Additionally, enhancing and formalizing encounter data monitoring practices would contribute to maintaining high data quality standards.

Weakness #3: Reliance Community Care Partners has a distinctive approach compared to Compass users, submitting the entire encounter with all line items instead of individual lines as separate encounters. This has led to a seemingly lower encounter volume for **Reliance Community Care Partners** in comparison to Compass users. [**Quality**]

Why the weakness exists: The difference in reporting formats results in a perception of lower encounter volume for **Reliance Community Care Partners**. This variation could impact data interpretation and comparative analyses.

Recommendation: While not necessarily a weakness, it is recommended that **Reliance Community Care Partners** collaborate with MDHHS to determine the preferred reporting format for encounters. This ensures alignment with State standards and facilitates accurate interpretation and comparison of encounter volumes across different agencies.

Weakness #4: Reliance Community Care Partners did not demonstrate timely submission of professional encounters, where 70.4 percent of professional encounters were submitted within 60 days of payment, not reaching greater than 99 percent of encounters submitted until after 360 days of payment. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Reliance Community Care Partners should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-94 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 3-94 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-94—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	93.2%	96.0%	91.8%
Recommendation Measures	92.3%	96.4%	92.1%
Staff are Reliable and Helpful	91.5%	**97.3%** ↑	92.1%
Staff Listen and Communicate Well	95.5%	98.0%	94.6%
Case Manager is Helpful	100%	100%	95.8%
Choosing the Services that Matter to You	88.8%	87.7%	90.8%
Transportation to Medical Appointments	92.5%	94.1%	92.4%
Personal Safety and Respect	92.1%	100% ↑	97.4%
Planning Your Time and Activities	74.7%	**86.8%** ↑	78.5%
Met Need	97.2%	96.6%	93.0%
Physical Safety Measure	97.5%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, *Case Manager is Helpful*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need*, indicating that **Reliance Community Care Partners** provides services in a manner that meets or exceeds members' expectations in many domains. **Reliance Community Care Partners** also demonstrated improvement in rates across several measures, with three measure rates (i.e., *Staff are Reliable and Helpful*, *Personal Safety and Respect*, and *Planning Your Time and Activities*) increasing by 5 percentage points or more. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Reliance Community Care Partners 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.

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, **Reliance Community Care Partners** scored below the statewide average on the *Choosing the Services that Matter to You* domain; therefore, HSAG recommends that **Reliance Community Care Partners** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within this domain, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **Reliance Community Care Partners** scored above the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Reliance Community Care Partners** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Reliance Community Care Partners**' aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Reliance Community Care Partners** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Reliance Community Care Partners**' overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-95 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Reliance Community Care Partners**' MI Choice members.

Table 3-95—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Reliance Community Care Partners** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information on critical incidents. Additionally, through the CAHPS HCBS survey, **Reliance Community Care Partners** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. Further, through the PIP activity, **Reliance Community Care Partners**' *Prevalence of Any Injuries* rate met the statewide goal and decreased from the prior year's rate, indicating the interventions implemented were effective in decreasing falls. However, through the PIP activity, **Reliance Community Care Partners**' *Prevalence of Falls* rate did not meet its goal and increased from the prior year, indicating the interventions implemented were not effective in decreasing the prevalence of falls. Additionally, through the PMV activity, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. Further, through the CQAR activity, **Reliance Community Care Partners** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. These findings could imply that while **Reliance Community Care Partners** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments; does not consistently identify safety risks for the member; and does not consistently identify, report, and follow up on critical incidents. HSAG recommends that **Reliance Community Care Partners** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.

Performance Area	Overall Performance Impact
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Reliance Community Care Partners** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, scored above the statewide average, although the rates decreased from the prior year. Further, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager* and *Case Manager is Helpful* domains scored above the statewide average. However, the *Recommendation Measures—Recommendation of Case Manager* and *Choosing the Services that Matter to You* domains scored below the statewide averages, and the *Choosing the Services that Matter to You* domain also decreased from the prior year's rate. These findings suggest that although **Reliance Community Care Partners** conducts care coordination according to policies and procedures, and links the members to services appropriately, members are not consistently satisfied with their case managers. **Reliance Community Care Partners** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Reliance Community Care Partners** demonstrated a *Substantial* compliance level in the MI Choice Services and Follow-Up and Monitoring focus areas. Additionally, through the PMV activity, the rates for Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored above the statewide average, and both measure rates increased over the prior year's rates. Further, through the CAHPS HCBS survey, **Reliance Community Care Partners**' rates for the *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, and *Met Need* domains scored above the statewide averages, and the *Staff are Reliable and Helpful* and *Transportation to Medical Appointments* domains increased over the prior year. However, through the CQAR, the Linking and Coordinating focus area scored a *Some Compliance, Needs Improvement* compliance level, and the Contingency Plan focus area scored a *Not Full or Substantial* compliance level. Additionally, through the PMV activity, Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored below the statewide average. These findings suggest that services are generally available for **Reliance Community Care Partners**' members, and members feel they are receiving the services and supports they need; however, supports coordinators do not

Performance Area	Overall Performance Impact
	consistently ensure contingency plans are in place for members when services are not available. **Reliance Community Care Partners** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Senior Resources

Validation of Performance Improvement Projects

Performance Results

Table 3-96 displays the PIPs in place during SFY 2022. Table 3-96 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Senior Resources** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Senior Resources** did not meet the statewide goal or the *New Goal*. Any interventions described within **Senior Resources**' QMP reports are also provided in Table 3-96. The results in Table 3-96 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-96—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
• *Prevalence of Falls*	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 26.4% SFY 2022 = 23.10% ☒
Interventions: • Increased literature distributed. • Increased referrals to physical therapy/occupational therapy or other physical activities to reduce prevalence of falls. • Quality Collaborative discussions. • Fall checklist for use by supports coordinators (developed using information from the Physical Therapy PowerPoint developed by Atrio)		
PIP Validation Feedback: MDHHS did not provide any feedback to **Senior Resources**.		
• *Prevalence of Any Injuries*	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 5.6% SFY 2022 = 4.80% ☒
Interventions: • Supports coordinators provided information annually and as needed to participants on how to prevent injury. • Referrals to physical therapy/ occupational therapy if warranted. • Supports coordinators reported incidents of injuries to PCPs if participant had not already done so. • Consumer Quality Council topic during FY 22.		

PIP Topic	Goal*	Measurement and Outcome±
PIP Validation Feedback: MDHHS did not provide any feedback to **Senior Resources**.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-97 displays the two PIPs **Senior Resources** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-97 is displayed as reported by **Senior Resources** and was not validated by HSAG.

Table 3-97—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the prevalence of falls with injury to meet or exceed the goal of 8.0% by 9/30/2023.	Baseline: 8.3% SFY 2023: Not yet reported
Interventions: • RN Supervisor will provide training on STEDI program to all supports coordinators by April 2023. Scheduled by the Quality Improvement Committee. • Fall Protocol will be reviewed with all waiver staff no later than February 15, 2023. The quality improvement coordinator will provide the review. • The Fall Protocol will be followed for any participant that has a fall recorded.		
PIP Validation Feedback: MDHHS provided the following feedback to **Senior Resources**: • Clinical PIP should be Falls with Injury. Current work plan using for Clinical PIP is using prevalence of falls % for goal and baseline.		
Advance Directives	Increase the percentage of MI Choice Waiver participants who have Advance Directives to greater than 42.8%.	Baseline: 42.8% SFY 2023: Not yet reported

PIP Topic	Goal	Measurement and Outcome
Interventions: • Supports coordinators will review at every assessment Advance Directives with participants who do not have any in place. • Participants will have a choice to not follow up, receive written information on how to complete an Advance Directive or receive a referral to a trained Advance Care Planning staff member.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Senior Resources**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for **Senior Resources**' PIPs did not meet the MDHHS-established goals, suggesting that the implemented interventions did not significantly impact member outcomes. Therefore, no strengths were identified for **Senior Resources**. [**Quality**]

Weaknesses and Recommendations

Weakness #1: While the interventions implemented by **Senior Resources** improved the rates slightly for both PIPs, **Senior Resources** did not reach the MDHHS-established goals for either PIP. **Senior Resources**' 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 PIPs. [**Quality**]

Why the weakness exists: **Senior Resources** cited the PHE as a barrier to reaching the goals as staff were not conducting in-person visits during this time.

Recommendation: Although **Senior Resources** conducted a limited barrier analysis, interventions implemented did not appear to address those barriers. 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 also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and address these barriers to improve outcomes. Further, **Senior Resources** should analyze and interpret results at

multiple points in time and test for statistical significance. Finally, **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 #2: Senior Resources' SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: Senior Resources calculated its PIP results on a different timing schedule than MDHHS (i.e., **Senior Resources** calculated its results based on the full state fiscal year, and MDHHS calculated the results only on the first half of the state fiscal year for baseline and remeasurement).

Recommendation: HSAG continues to recommend that **Senior Resources** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Senior Resources** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Senior Resources**' PIPs did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Senior Resources** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Senior Resources** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Senior Resources of West Michigan Quality Assurance Performance Improvement Plan FY 2023-2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Senior Resources**' PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Senior Resources** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Senior Resources** in a methodologically sound manner. HSAG further recommends that **Senior Resources**' documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Senior Resources** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Senior Resources** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Senior Resources** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-98 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-98 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-98, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-98—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	100%	76.19% ↓	86.65%
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	93.48%	94.12%	93.72%
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	100%	100%	98.95%
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	100%	100%	100%
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	100%	100%	100%
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	98.81%	96.55%	94.76%

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**95.24%**	**92.86%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**95.24%**	**92.86%**	**82.72%**
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	**96.51%**	**92.88%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**97.22%**	**77.78% ↓**	**88.74%**
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	**96.00%**	**84.00% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**95.24%**	**90.48%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**76.19%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**99.48%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Senior Resources**' overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Senior Resources received a 100 percent performance rating for Performance Measures 4, 7, 8, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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**]

Weaknesses and Recommendations

Weakness #1: Senior Resources 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 10.46 percentage points below the statewide rate and a decrease of 23.81 percentage points from **Senior Resources**' SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that five of the 21 applicable records did not demonstrate that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements. **Senior Resources** reported that the supports coordinators were not adhering to the guidelines for the Significant Change Reassessment and Return Assessment Protocol.

Recommendation: While **Senior Resources**' CAP included staff education, HSAG recommends that this education include clear instructions on the protocols supports coordinators are required to follow. **Senior Resources** could also consider ensuring its policies and procedures include clear definitions for when a significant change reassessment is required. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Senior Resources 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 10.96 percentage points below the statewide rate and a decrease of 19.44 percentage points from **Senior Resources**' SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that five of the 21 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and three of the 15 applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements. **Senior Resources** reported that the supports coordinators were not adhering to the guidelines for the Significant Change Reassessment and Return Assessment Protocol. **Senior Resources** also reported the supports coordinators did not have processes in place to assist them in following up on issues identified through monitoring contacts, assessments, and person-centered planning meetings.

Recommendation: While **Senior Resources**' CAP included staff education, HSAG recommends that this education include clear instructions on the protocols supports coordinators are required to follow. **Senior Resources** could also consider ensuring its policies and procedures include clear definitions for when a significant change reassessment is required and developing a process for assisting supports coordinators following up on issues identified through monitoring contacts, assessments, and person-centered planning meetings. Additionally, HSAG recommends that the

waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #3: Senior Resources 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 6.31 percentage points below the statewide rate and a decrease of 12 percentage points from **Senior Resources**' SFY 2021 rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the three 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 three of the applicable 15 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. **Senior Resources** reported that one individual supports coordinator was not adhering to the guidelines for requiring 14-day follow-up on services for a newly enrolled participant.

Recommendation: While **Senior Resources**' CAP included individual staff education, HSAG recommends that **Senior Resources** ensure adherence to the time frames is included in its ongoing record reviews. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-99 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 interviews. Table 3-99 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-99—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	85.71%		**3.00**	3.00
Focus 3	Release of Information	85.71%		**4.00**	4.00
Focus 4	Status	92.65%		**4.00**	4.00
Focus 5	Pre-Planning	98.43%	100%	**4.00**	4.00
Focus 6	Assessment	94.74%	98.48%	**4.00**	4.00
Focus 7	Medication Record	92.92%	96.36%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	88.96%	98.84%	**4.00**	4.00
Focus 9	MI Choice Services	93.33%	98.67%	**4.00**	4.00
Focus 10	Linking and Coordinating	82.22%	96.67%	**2.69**	4.00
Focus 11	Follow-Up and Monitoring	71.74%	100%	**2.03**	4.00
Focus 12	Service Provider	100%		**4.00**	4.00
Focus 13	Contingency Plan	92.06%	100%	**4.00**	4.00
Focus 14	Critical Incidents	81.25%	93.55%	**2.69**	3.34
Focus 15	Adverse Benefit Determination	80.65%		**4.00**	4.00
Focus 16	Complaints and Grievances	75.00%		**2.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**91.37%**	**98.53%**	**3.76**	3.96

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

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: Senior Resources achieved a substantial compliance rating in 12 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Senior Resources did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting newly enrolled 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 MDHHS policy and contract requirements, including the use of the member's backup plan or an 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. **Senior Resources** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that one out of three applicable records did not include evidence that the waiver agency contacted the newly enrolled members/guardians to ensure service delivery in accordance with MDHHS policy and contract requirements; nine out of 21 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP; and three out of 15 applicable records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with MDHHS policy and contract requirements, including the use of the member's backup plan or out-of-network provider. **Senior Resources** reported that an individual supports coordinator did not follow guidelines requiring 14-day follow up on services for a newly enrolled participant, an individual supports coordinator did not follow up on services for an existing participant to ensure receipt and satisfaction with the services, and supports coordinators were not following guidelines for approved contacts for monitoring. **Senior Resources** also reported that the

guidelines did not give the correct instruction to supports coordinators regarding late entries or an amendment to the assessment record.

Recommendation: MDHHS required **Senior Resources** to submit a CAP to remediate the deficiencies. However, one of the three deficiencies have been noted as noncompliant for the past three years; therefore, **Senior Resources**' interventions have not led to performance improvement. HSAG recommends that **Senior Resources** update its CAP to include interventions other than an updated workflow, staff education, and ongoing chart audits. For example, **Senior Resources** could implement system prompts or another similar workflow that reminds supports coordinators when follow-up is due.

Weakness #2: Senior Resources did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. **Senior Resources** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of eight applicable records did not demonstrate evidence that the member/guardian was made aware of the resolution of complaints or grievances as warranted. **Senior Resources** reported that two individual supports coordinators did not communicate to participants/representatives that resolution of their complaints had occurred in a timely manner.

Recommendation: As this was a new citation, HSAG recommends that **Senior Resources** continue to implement its CAP of conducting staff education. However, if improvement is not realized, **Senior Resources** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Senior Resources** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Senior Resources**' original questionnaire responses, and **Senior Resources** responded to these specific questions. To support its questionnaire responses, **Senior Resources** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Senior Resources** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-100 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-100—EDV Results for Senior Resources

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Senior Resources** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Senior Resources** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Senior Resources** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Senior Resources** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Senior Resources** utilizes line-by-line method for its claim payment strategies. • **Senior Resources**, with CIM as its subcontractor, collects TPL data during financial eligibility

Analysis	Key Findings
	assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Senior Resources** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Senior Resources** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Senior Resources**' encounters, **Senior Resources** indicated that it did not store data sent to MDHHS. • **Senior Resources** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Senior Resources** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Senior Resources** had a low volume of duplicate encounters, with 0.3 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Senior Resources** demonstrated timely submission for professional encounters. Within 60 days, **Senior Resources** submitted 96.9 percent of professional encounters to MDHHS after the payment date. Within 90 days, **Senior Resources** submitted 100 percent of professional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **Senior Resources**' submitted professional encounters, the billing provider NPI was populated 19.2 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Senior Resources**' submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Senior Resources**' submitted data, 98.8 percent were identified in the enrollment data. • Of all identified provider NPIs in **Senior Resources**' submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Senior Resources**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Senior Resources demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Senior Resources submitted professional encounters in a timely manner from the payment date, with 100 percent of encounters submitted within 90 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Senior Resources** were populated at high rates, and most data elements were greater than 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Senior Resources indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Senior Resources**' claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Senior Resources**' overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Senior Resources reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Senior Resources appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Senior Resources should consider enhancing its data management practices. HSAG recommends that **Senior Resources** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality

checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 19.2 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: **Senior Resources** should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-101 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 3-101 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-101—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	91.3%	88.9%	91.8%
Recommendation Measures	92.4%	88.4%	92.1%
Staff are Reliable and Helpful	86.9%	**85.7%**	92.1%
Staff Listen and Communicate Well	93.9%	94.3%	94.6%
Case Manager is Helpful	98.1%	93.9%	95.8%
Choosing the Services that Matter to You	94.0%	88.7% ↓	90.8%
Transportation to Medical Appointments	94.7%	95.3%	92.4%

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Personal Safety and Respect	98.3%	97.5%	97.4%
Planning Your Time and Activities	74.3%	77.8%	78.5%
Met Need	94.5%	93.9%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *Transportation to Medical Appointments*, *Personal Safety and Respect*, and *Met Need*, indicating that **Senior Resources** provides services in a manner that meets or exceeds members' expectations in several domains. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Senior Resources scored more than 5 percentage points below the statewide average on the *Staff are Reliable and Helpful* domain at 85.7 percent compared with the statewide average of 92.1 percent. [**Quality**]

Why the weakness exists: Of the six questions within the *Staff are Reliable and Helpful* domain, **Senior Resources** scored below the statewide average for all six questions: *Staff come to work on time*; *Staff work as long as they are supposed to*; *Someone tells you if staff cannot come*; *Staff make sure you have enough privacy for dressing, showering, and bathing*; *Homemakers come to work on time*; and *Homemakers work as long as they are supposed to*.

Recommendation: HSAG recommends that **Senior Resources** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores significantly contributed to the low satisfaction score within the *Staff are Reliable and Helpful* domain; develop interventions to improve the *Staff are Reliable and Helpful* domain; and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #2: Although **Senior Resources** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. [**Quality**]

Why the weakness exists: This section is not applicable as this domain was not identified as a substantial weakness for **Senior Resources**.

Recommendation: HSAG recommends that **Senior Resources** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores correlate to the *Planning Your Time and Activities* domain; develop interventions to improve the *Planning Your Time and Activities* domain; and evaluate the results of the interventions regularly, making changes as necessary.

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

HSAG performed a comprehensive assessment of **Senior Resources**' aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Senior Resources** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Senior Resources**' overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-102 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Senior Resources**' MI Choice members.

Table 3-102—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Senior Resources** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information on critical incidents. Additionally, through the CAHPS HCBS

Performance Area	Overall Performance Impact
	survey, **Senior Resources** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. However, through the PIP activity, **Senior Resources**' *Prevalence of Falls* and *Prevalence of Any Injuries* rates did not meet the statewide goals, indicating the interventions implemented were not significantly effective at decreasing the prevalence of falls and injuries, although both rates decreased slightly. Additionally, through the PMV activity, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. Further, through the CQAR activity, **Senior Resources** received a *Some Compliance, Needs Improvement* compliance level in the Critical Incidents focus area. These findings could imply that while **Senior Resources** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments; does not consistently identify safety risks for the member; and does not consistently identify, report, and follow up on critical incidents. HSAG recommends that **Senior Resources** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Senior Resources** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, scored above the statewide average, although the rates decreased from the prior year. However, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored below the statewide averages, and the *Case Manager is Helpful* and *Choosing the Services that Matter to You* domains also decreased from the prior year's rates. These findings suggest that although **Senior Resources** conducts care coordination according to policies and procedures, and links the members to services appropriately, members are not consistently satisfied with their case managers. **Senior Resources** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.

Performance Area	Overall Performance Impact
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Senior Resources** demonstrated a *Substantial* compliance level in the MI Choice Services and Contingency Plan focus areas. Additionally, through the PMV activity, the rates for Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored above the statewide average, although the Performance Measure 15 measure rate decreased from the prior year's rate. Further, through the CAHPS HCBS survey, **Senior Resources**' rates for the *Transportation to Medical Appointments* and *Met Need* domains scored above the statewide averages. However, through the CQAR, the Linking and Coordinating focus area scored a *Some Compliance, Needs Improvement* compliance level, and the Follow-Up and Monitoring focus area scored a *Not Full or Substantial* compliance level. Additionally, through the PMV activity, Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored below the statewide average. Further, through the CAHPS HCBS survey, the *Staff are Reliable and Helpful* domain scored below the statewide average. These findings suggest that services are generally available for **Senior Resources**' members, and members usually have a contingency plan for when services are not available; however, supports coordinators do not consistently follow up to ensure services are being received as ordered. **Senior Resources** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

The Information Center

Validation of Performance Improvement Projects

Performance Results

Table 3-103 displays the PIPs in place during SFY 2022. Table 3-103 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **The Information Center** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **The Information Center** did not meet the statewide goal or the *New Goal*. Any interventions described within **The Information Center**'s QMP reports are also provided in Table 3-103. The results in Table 3-103 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-103—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less. *New Goal*: 22.5% or lower	SFY 2021 = 22.5% SFY 2022 = 23.0% ☒
Interventions: • Supports coordinators educated participants on fall risks/how to avoid falls on an ongoing basis. • Fall prevention was discussed at Consumer Advisory Council meetings quarterly. • Staff was trained annually on fall prevention. • Service providers were educated on fall prevention and identification of issues within the home that can create a fall risk. • Quality Specialist followed up with participants who had falls monthly based on the Quality Indicator Report to collect data.		
PIP Validation Feedback: MDHHS provided the following feedback to **The Information Center**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to your description, quality control methods, monitoring, evaluating, and corrective action plans? • The waiver agency's performance in meeting quality improvement goals as specified in the Quality Management Plan for the quality indicators of "Prevalence of Falls". ○ The statewide quality improvement goal for "Prevalence of Falls" is below 23.0% of the waiver agency's participants. If the waiver agency was already below 23.0% for this quality indicator at the start of fiscal year 2022, the waiver agency must maintain or decrease its percentage for this quality indicator.		

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less. *New Goal*: 2.7% or lower	SFY 2021 = 2.7% SFY 2022 = 3.70% ☒
Interventions: • Supports coordinators educated participants on how to reduce injuries on an ongoing basis. • Injury prevention was discussed at Consumer Advisory Council meetings. • Service providers were educated on the type and scope of injury to assist supports coordinators with providing additional information and interventions strategies to prevent injuries. • Quality Specialist followed up with participants who had documented injuries based on the Quality Indicator Report monthly to collect data.		
PIP Validation Feedback: MDHHS provided the following feedback to **The Information Center**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to your description, quality control methods, monitoring, evaluating, and corrective action plans? • The waiver agency's performance in meeting quality improvement goals as specified in the Quality Management Plan for the quality indicators of "Prevalence of any Injuries". ○ The statewide quality improvement goal for "Prevalence of any Injuries" is below 3.0% of the waiver agency's participants. If the waiver agency was already below 3.0% for this quality indicator at the start of fiscal year 2022, the waiver agency must maintain or decrease its percentage for this quality indicator.		

*The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-104 displays the two PIPs **The Information Center** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-104 is displayed as reported by **The Information Center** and was not validated by HSAG.

Table 3-104—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the risk of falls with injury when falls occur 6% or less annually.	Baseline: Not reported[1] SFY 2023: Not yet reported
Interventions: • In depth root-cause analysis • Consumer Advisory Council discussion to obtain participant perspective on falls with injury • Chart audits to evaluate all falls with injury • Best practice and literature search for evidence-based practices • Development of clinical protocols as deemed necessary • Development of quarterly metrics to report to Internal Quality Workgroup and within MHCSN Association • Adoption or development of teaching tools for program participants and their informal supports • Staff training on Falls with Injury • Development of metric that focuses on falls with injury		
PIP Validation Feedback: MDHHS provided the following feedback to **The Information Center**: • Can you provide a goal/target?		
Timeliness of Monitoring Contacts	Increase Monitoring Contacts and Assessments to 100% Compliance.	Waiver Agency Reporting Baseline: 91.30%[2] SFY 2023: Not yet reported CQAR Baseline: 50%[3] SFY 2023: Not yet reported
Interventions: • In depth root-cause analysis • Consumer Advisory Council discussion to obtain participant perspective on follow-up and timeliness • Chart audits to evaluate all follow-up and monitoring timeliness • Best practice definition developed • Development of quarterly metrics to report to the Internal Quality Workgroup and within MHCSN Association • Development of improvement options to implement • Deployment of improvement options		
PIP Validation Feedback: MDHHS did not provide any feedback to **The Information Center**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

[1] The waiver agency included an estimated baseline only; however, as it was not a true baseline measurement of the waiver agency's performance, HSAG did not include the estimated baseline in this EQR technical report.
[2] The waiver agency's internal reporting showed a baseline of 96.2 percent for *Timeliness of Monitoring Contacts*.
[3] The CQAR measure for *Timeliness of Monitoring Contacts* demonstrated a 70.82 percent baseline.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for **The Information Center**'s PIPs increased from the baseline measurement, suggesting that the implemented interventions did not positively impact member outcomes. Therefore, no strengths were identified for **The Information Center**. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **The Information Center** did not appear to be effective in improving outcomes as the prevalence rates increased for both SFY 2022 PIPs, and **The Information Center** did not reach the MDHHS-established goals. **The Information Center**'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 PIPs. [**Quality**]

Why the weakness exists: **The Information Center** cited a lack of staff to assist with quality indicators; a lack of education among staff, providers, members, and informal supports regarding measures of safety and prevention; and that some members/informal supports choose not to use the interventions or equipment provided as major barriers to meeting the PIP goals.

Recommendation: HSAG recommends that **The Information Center** implement comprehensive training to all staff, providers, members, and information supports regarding measures of safety and prevention, and an auditing and monitoring process to ensure all falls and injuries are being documented appropriately (i.e., timely, detailed, etc.) to improve the consistency with which these incidents are documented across all staff members. Additionally, although **The Information Center** conducted a barrier analysis, interventions implemented did not appear to address those barriers. 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 also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **The Information Center** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **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 #2: The Information Center's SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: The Information Center did not document its methodology in its QMP documentation (e.g., the time frames for measurement). As such, it is unclear if **The Information Center** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **The Information Center** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **The Information Center** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **The Information Center**'s PIPs did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **The Information Center** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **The Information Center** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Quality Assurance and Performance Improvement Plan Fiscal Years 2023-2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **The Information Center**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **The Information Center** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **The Information Center** in a methodologically sound manner. HSAG further recommends that **The Information Center**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **The Information Center** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **The Information Center** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **The Information Center** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-105 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-105 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-105, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-105—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**90.00%**	**80.00% ↓**	**86.65%**
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	**100%**	**96.12%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**100%**	**92.68% ↓**	**94.76%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**95.00% ↓**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**90.00%**	**85.00% ↓**	**82.72%**
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	**93.00%**	**87.64% ↓**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**82.35%**	**81.25%**	**88.74%**
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	**92.31%**	**100% ↑**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**80.00%**	**70.00% ↓**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**40.00%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**90.00% ↓**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **The Information Center**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: The Information Center received a 100 percent performance rating for Performance Measures 4, 7, 8, 20, 22, and 24, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; members received all services and supports identified in their PCSPs; 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** 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 6.65 percentage points below the statewide rate and a decrease of 10 percentage points from **The Information Center**'s SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the 10 applicable records did not demonstrate that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements. **The Information Center** reported that supports coordinators did not follow up and evaluate or complete the PCSP according to the requirement.

Recommendation: While **The Information Center**'s CAP included staff education and monthly chart audits, HSAG recommends that the education include specific definitions for when the PCSP is required to be updated. **The Information Center** could also consider system prompts or other workflows that trigger the supports coordinator to update the PCSP. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

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 7.49 percentage points below the statewide rate and a decrease of 1.1 percentage points from **The Information Center**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, 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 six applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements. **The Information Center** reported that supports coordinators did not follow up and complete or evaluate the PCSP according to the requirement and did not follow the process for requesting an increase in services.

Recommendation: While **The Information Center**'s CAP included staff education and monthly chart audits, HSAG recommends that the education include specific definitions for when the PCSP is required to be updated and the process for requesting an increase in services. **The Information Center** could also consider system prompts or other workflows that trigger the supports coordinator to update the PCSP. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

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 19.27 percentage points below the statewide rate and a decrease of 10 percentage points from **The Information Center**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three 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. **The Information Center** reported that supports coordinators did not request services that were requested by the member's durable power of attorney, did not understand the requirement related to the handwritten initial plan of care, or did not offer another service when a contract with the waiver agency was cancelled.

Recommendation: While **The Information Center**'s CAP included staff education and monthly chart audits, HSAG recommends that the education include specific guidance around the issues identified for this review. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #4: The Information Center 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 9.48 percentage points below the statewide rate and a decrease of 10 percentage points from **The Information Center**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the 10 applicable records did not demonstrate evidence the member received at least one MI Choice Waiver Program service on a continual basis or that the supports coordinator made an effort to secure the services.

Recommendation: Although MDHHS did not require **The Information Center** to submit a CAP for these deficiencies, HSAG recommends that **The Information Center** continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-106 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 interviews. Table 3-106 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-106—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	90.00%		**4.00**	4.00
Focus 3	Release of Information	100%		**4.00**	4.00
Focus 4	Status	100%		**4.00**	4.00
Focus 5	Pre-Planning	95.51%	100%	**4.00**	4.00
Focus 6	Assessment	94.44%	100%	**4.00**	4.00
Focus 7	Medication Record	85.19%	100%	**4.00**	3.33
Focus 8	Person-Centered Service Planning	85.52%	100%	**4.00**	4.00
Focus 9	MI Choice Services	87.50%	97.14%	**3.33**	4.00
Focus 10	Linking and Coordinating	84.00%	100%	**2.67**	4.00
Focus 11	Follow-Up and Monitoring	77.27%	100%	**2.67**	4.00
Focus 12	Service Provider	75.00%		**4.00**	4.00
Focus 13	Contingency Plan	79.31%	100%	**3.33**	4.00
Focus 14	Critical Incidents	100%	100%	**4.00**	3.33

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	50.00%		**1.00**	4.00
Focus 16	Complaints and Grievances	100%		**4.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**88.87%**	**99.59%**	**3.75**	3.92

Indicates the standard was not reviewed as part of the record review or home visit.
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 14 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: The Information Center 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 NABDs are important to ensure members understand their appeal rights and the process to request an appeal. **The Information Center** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that three out of six applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and three out of six applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate. **The Information Center** reported that NABDs were not being sent out as directed by MDHHS; however, the root cause is unknown to HSAG.

Recommendation: As these were new citations, HSAG recommends that **The Information Center** continue to implement its CAP of conducting staff education and ongoing chart audits. However, if improvement is not realized, **The Information Center** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **The Information Center** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **The Information Center**'s original questionnaire responses, and **The Information Center** responded to these specific questions. To support its questionnaire responses, **The Information Center** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **The Information Center** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-107 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-107—EDV Results for The Information Center

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **The Information Center** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **The Information Center** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **The Information Center** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **The Information Center** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **The Information Center** utilizes line-by-line method for its claim payment strategies. • **The Information Center**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **The Information Center** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **The Information Center** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **The Information Center**'s encounters, **The Information Center** indicated that it did not store data sent to MDHHS. • **The Information Center** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **The Information Center** displayed consistent encounter volume for professional encounters throughout the measurement year. • **The Information Center** had a low volume of duplicate encounters, with 0.5 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **The Information Center** demonstrated timely submission for professional encounters. Within

Analysis	Key Findings
	30 days, **The Information Center** submitted 95.5 percent of professional encounters to MDHHS after the payment date, and within 60 days, **The Information Center** submitted 100 percent of encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **The Information Center**'s submitted professional encounters, the billing provider NPI was populated 20.2 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **The Information Center**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **The Information Center**'s submitted data, 99.4 percent were identified in the enrollment data. • Of all identified provider NPIs in **The Information Center**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **The Information Center**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: The Information Center demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: The Information Center submitted professional encounters in a timely manner from the payment date, with 100 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **The Information Center** were populated at high rates, and most data elements were greater than 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The Information Center indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **The Information Center**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **The Information Center**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: The Information Center reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: The Information Center appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: The Information Center should consider enhancing its data management practices. HSAG recommends that **The Information Center** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 20.2 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: The Information Center should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-108 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 3-108 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-108—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	92.3%	**83.2% ↓**	91.8%
Recommendation Measures	91.7%	**85.5% ↓**	92.1%
Staff are Reliable and Helpful	90.2%	**85.8%**	92.1%
Staff Listen and Communicate Well	96.3%	92.0%	94.6%
Case Manager is Helpful	90.7%	98.7% ↑	95.8%
Choosing the Services that Matter to You	89.0%	93.8%	90.8%
Transportation to Medical Appointments	92.9%	90.5%	92.4%
Personal Safety and Respect	99.1%	97.8%	97.4%
Planning Your Time and Activities	74.9%	79.4%	78.5%
Met Need	94.9%	93.4%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need*, indicating that **The Information Center** provides services in a manner that meets or exceeds members' expectations in several domains. **The Information Center** also demonstrated improvement in rates across three measures, with one measure rate, *Case Manager is Helpful*, increasing by 5 percentage points or more. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The Information Center scored more than 5 percentage points below the statewide average on the *Global Ratings Measures* domain at 83.2 percent compared with the statewide average of 91.8 percent. Additionally, **The Information Center**'s rate decreased 9.1 percentage points below its SFY 2021 rate. [**Quality**]

Why the weakness exists: The *Global Ratings Measures* domain included the *Global Rating of Personal Assistance and Behavioral Health Staff*, *Global Rating of Homemakers*, and *Global Rating of Case Manager* questions. While **The Information Center** scored above the statewide average for *Global Rating of Case Manager*, the *Global Rating of Personal Assistance and Behavioral Health Staff* rate was below the statewide average, and the denominator was too small to calculate for the *Global Rating of Homemakers* question.

Recommendation: HSAG recommends that **The Information Center** review the results of all consumer satisfaction survey questions to determine if any questions significantly contributed to the low satisfaction score within the *Global Ratings Measures* domain, develop interventions to improve the *Global Ratings Measures* domain, and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #2: The Information Center scored more than 5 percentage points below the statewide average on the *Recommendation Measures* domain at 85.5 percent compared with the statewide

average of 92.1 percent. Additionally, **The Information Center**'s rate decreased 6.2 percentage points below its SFY 2021 rate. [**Quality**]

Why the weakness exists: The *Recommendation Measures* domain included the *Recommendation of Personal Assistance and Behavioral Health Staff*, *Recommendation of Homemakers*, and *Recommendation of Case Manager* questions. While **The Information Center** scored above the statewide average for *Recommendation of Case Manager*, the *Recommendation of Personal Assistance and Behavioral Health Staff* rate was below the statewide average, and the denominator was too small to calculate for the *Recommendation of Homemakers* question.

Recommendation: HSAG recommends that **The Information Center** review the results of all consumer satisfaction survey questions to determine if any questions significantly contributed to the low satisfaction score within the *Recommendation Measures* domain, develop interventions to improve the *Recommendation Measures* domain, and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #3: The Information Center scored more than 5 percentage points below the statewide average on the *Staff are Reliable and Helpful* domain at 85.8 percent compared with the statewide average of 92.1 percent. Additionally, **The Information Center**'s rate decreased 4.4 percentage points below its SFY 2021 rate. [**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. Additionally, **The Information Center** scored below the statewide average for one question, *Someone tells you if staff cannot come*.

Recommendation: HSAG recommends that **The Information Center** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores significantly contributed to the low satisfaction score within the *Staff are Reliable and Helpful* domain, specifically the statement related to whether someone notifies the member if staff cannot come; develop interventions to improve the *Staff are Reliable and Helpful* domain; and evaluate the results of the interventions on a regular basis, making changes as necessary.

Weakness #4: Although **The Information Center** did not score below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. [**Quality**]

Why the weakness exists: This section is not applicable as this domain was not identified as a substantial weakness for **The Information Center**.

Recommendation: HSAG recommends that **The Information Center** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores contributed to the low satisfaction score within the *Planning Your Time and Activities* domain; develop interventions to improve the *Planning Your Time and Activities* domain; and evaluate the results of the interventions regularly, making changes as necessary.

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

HSAG performed a comprehensive assessment of **The Information Center**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **The Information Center** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **The Information Center**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-109 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **The Information Center**'s MI Choice members.

Table 3-109—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **The Information Center** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members by identifying and mitigating risk for members and providing information on critical incidents. Additionally, through the CQAR activity, **The Information Center** received a *Substantial* compliance level in the Critical Incidents focus area. Further, through the CAHPS HCBS survey, **The Information Center** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. However, through the PIP activity, **The Information Center**'s *Prevalence of Falls* and *Prevalence of Any Injuries* rates did not meet the waiver agency's goals, and both rates increased over the prior year's rates, indicating the interventions implemented were not effective in maintaining **The Information Center**'s previous performance. These findings could imply that while **The Information Center** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments. HSAG recommends that **The Information Center** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **The Information Center** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, the rate for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, scored above the

Performance Area	Overall Performance Impact
	statewide average, although the rate decreased from the prior year. Further, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored above the statewide averages, and the *Case Manager is Helpful* and *Choosing the Services that Matter to You* domains also increased from the prior year's rates. However, through the PMV activity, the rate for 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*, fell below the statewide average and decreased from the prior year's rate. These findings suggest that although **The Information Center** links the members to services appropriately and members are satisfied with their case managers, **The Information Center** does not consistently conduct care coordination according to policies and procedures. **The Information Center** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **The Information Center** demonstrated a *Substantial* compliance level in the MI Choice Services and Contingency Plan focus areas. Additionally, through the PMV activity, the rate for Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored above the statewide average and increased from the prior year's rate. Further, through the CAHPS HCBS survey, **The Information Center**'s rate for the *Met Need* domain scored above the statewide average, although the rate decreased from the prior year. However, through the CQAR, the Linking and Coordinating and Follow-Up and Monitoring focus areas scored a *Some Compliance, Needs Improvement* compliance level. Additionally, through the PMV activity, Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored below the statewide average. Further, through the CAHPS HCBS survey, the *Staff are Reliable and Helpful* and *Transportation to Medical Appointments* domains scored below the statewide averages. These findings suggest that while services are generally available for **The Information Center** members, supports coordinators do not consistently ensure the appropriate services are in place for members or follow up to ensure services are being received as ordered. **The Information Center** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

The Senior Alliance

Validation of Performance Improvement Projects

Performance Results

Table 3-110 displays the PIPs in place during SFY 2022. Table 3-110 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **The Senior Alliance** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **The Senior Alliance** did not meet the statewide goal or the *New Goal*. Any interventions described within **The Senior Alliance**'s QMP reports are also provided in Table 3-110. The results in Table 3-110 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-110—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 25.2% SFY 2022 = 27.10% ☒
Interventions: • Quality and training managers sent out quarterly Quality Indicator reports to supports coordinators to review participants that had reported falls and ensure adequate interventions were in place. • The agency scheduled a presentation/training from an occupational therapist on fall prevention. • Quality and training managers created and rolled out a fall prevention checklist for supports coordinators to use in the event a participant reports a fall. This checklist included follow up questions to ask and interventions to implement.		
PIP Validation Feedback: MDHHS provided the following feedback to **The Senior Alliance**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to your quality control methods, monitoring, evaluating, and corrective action plans.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less. *New Goal*: 1.5% or lower	SFY 2021 = 1.5% SFY 2022 = 2.20% ☒

PIP Topic	Goal*	Measurement and Outcome±
Interventions: • Quality and training managers sent out quarterly quality indicator reports to supports coordinators to review participants that had reported injuries and ensure adequate interventions were in place. • Quality and training managers included a reminder in waiver newsletters to report any falls or injuries to their supports coordinator.		
PIP Validation Feedback: MDHHS provided the following feedback to **The Senior Alliance**: • The information provided for your PIPs was vague. Can you please provide clarifying details related to your quality control methods, monitoring, evaluating, and corrective action plans? • The statewide quality improvement goal for "Prevalence of any Injuries" is below 3.0% of the waiver agency's participants. If the waiver agency was already below 3.0% for this quality indicator at the start of fiscal year 2022, the waiver agency must maintain or decrease its percentage for this quality indicator. Senior Alliance QI 1.5%		

* The statewide overall goal for Prevalence of Falls was 23 percent and Prevalence of Any Injuries was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-111 displays the two PIPs **The Senior Alliance** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-111 is displayed as reported by **The Senior Alliance** and was not validated by HSAG.

Table 3-111—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the prevalence of falls with injury.	Baseline: Not reported SFY 2023: Not yet reported
Interventions: • To achieve this goal **The Senior Alliance** has identified that to be able to implement effective interventions to reduce falls, **The Senior Alliance** must first develop a system to gather data on the most common reasons for falls as this data is not readily available via reporting from Compass. • **The Senior Alliance** must develop a way to gather data to report falls that result in injury and determine a baseline percentage to work from.		

PIP Topic	Goal	Measurement and Outcome
• Quality and training manager(s) with work with the New Quality Focus Group to share ideas and decide on a reporting mechanism that will provide accurate data on falls with injury and to also ensure that all agencies are reporting with the same data as to provide consistency across all agencies. • Quality and training manager(s) will develop a spreadsheet to log and drill down on the most common reasons for falls. • Quality and training manager(s) will update this spreadsheet monthly for a minimum of 3 months to gather sufficient data for analysis. • Quality and training manager(s) will then analyze the data and develop and implement appropriate interventions to accomplish reducing falls. • Quality and training manager(s) will report these interventions in the FY2023 Outcomes and Activities Report. • Quality and training manager(s) will report on data collection mechanism and baseline percentage obtained in the FY2023 Outcomes and Activities Report.		
PIP Validation Feedback: MDHHS provided the following feedback to **The Senior Alliance**: • Clinical PIP should be Falls with Injury. Current QAPI Clinical PIP is using prevalence of falls % for goal and baseline.		
Medical Record Completeness and Accuracy	Improve completeness and accuracy of participant Medication Record in the Compass Assessment by achieving a 90% or higher evident percentage on standards 7.1 and 7.2 during chart reviews by 09/30/2023.	**Standard 7.1.** Baseline: 75% SFY 2023: Not yet reported **Standard 7.2.** Baseline: 68.75% SFY 2023: Not yet reported
Interventions: • Quality and training manager(s) will conduct a training exercise with waiver staff to include requirements for the medication record in the Compass Assessment. Topics will cover all medication requirements including all prescribed medications, including the name, prescribing physician name, purpose, strength/dose, frequency, and route for all medications. Training will also cover common oversights such as failing to include the number of puffs for inhalers, location for topical medications and how many drops for eye drops. • Quality and training manager(s) will conduct at least 10 chart reviews per month to assess compliance. • Quality and training manager(s) will include this in the CAP reporting to CQAR for the FY2022 Record Audit and report results to CQAR until compliance is met. • Quality and training manager(s) will continue to conduct chart reviews to assess ongoing compliance after compliance is met with CQAR reporting. • Results will be reviewed monthly by quality and training manager(s).		
PIP Validation Feedback: MDHHS did not provide any feedback to **The Senior Alliance**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for **The Senior Alliance**'s PIPs increased from the baseline measurement, suggesting that the implemented interventions did not positively impact member outcomes. Therefore, no strengths were identified for **The Senior Alliance**. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **The Senior Alliance** did not appear to be effective at improving outcomes as the prevalence rates increased for both PIPs, and **The Senior Alliance** did not reach the MDHHS-established goal. **The Senior Alliance**'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 PIPs. [**Quality**]

Why the weakness exists: **The Senior Alliance** did not conduct a barrier or root cause analysis to determine why the prevalence rates increased for these PIPs.

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 also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and address these barriers to improve outcomes. Further, **The Senior Alliance** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **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 #2: **The Senior Alliance**'s SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: **The Senior Alliance** calculated its PIP results on a different timing schedule than MDHHS (i.e., **The Senior Alliance** calculated its results based on the full state fiscal year, and MDHHS calculated the results only on the first half of the state fiscal year for baseline and remeasurement).

Recommendation: HSAG continues to recommend that **The Senior Alliance** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **The Senior Alliance** and MDHHS use the full state fiscal year to calculate

results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **The Senior Alliance**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **The Senior Alliance** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.
Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **The Senior Alliance** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The FY2023-24 QAPI: The Senior Alliance – Area Agency on Aging 1-C demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **The Senior Alliance**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.
Recommendation: HSAG recommends that **The Senior Alliance** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **The Senior Alliance** in a methodologically sound manner. HSAG further recommends that **The Senior Alliance**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **The Senior Alliance** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **The Senior Alliance** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **The Senior Alliance** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-112 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-112 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-112, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-112—Waiver Agency Impact to Statewide Performance Measure Rates

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	87.50%	100% ↑	86.65%
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	96.61%	88.89% ↓	93.72%
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	93.75%	100% ↑	98.95%
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	100%	100%	100%
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	100%	100%	100%
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	96.97%	93.85%	94.76%
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	100%	90.63% ↓	93.19%
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	84.38%	75.00% ↓	82.72%
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	95.18%	89.93% ↓	91.10%
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	92.00%	96.43%	88.74%

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**94.74%**	**86.36% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**93.75%**	**56.25% ↓**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**56.25%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **The Senior Alliance**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: The Senior Alliance received a 100 percent performance rating for Performance Measures 1, 4, 7, 8, 22, 24, and 38, indicating that service plans were completed timely; LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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**]

Weaknesses and Recommendations

Weakness #1: 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 7.72 percentage points below the statewide rate and a decrease of 9.38 percentage points from **The Senior Alliance**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that seven of the 16 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **The Senior Alliance** reported that supports coordinators did not comply with the requirements.

Recommendation: While **The Senior Alliance**'s CAP included staff education, HSAG recommends that **The Senior Alliance** ensure its ongoing record reviews include the specific requirements that supports coordinators did not include. Additionally, **The Senior Alliance** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: The Senior Alliance 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 33.02 percentage points below the statewide rate and a decrease of 37.5 percentage points from **The Senior Alliance**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that seven of the 16 applicable records did not demonstrate evidence that the supports coordinator offered the member/guardian a choice of appropriate MI Choice Waiver Program services. **The Senior Alliance** reported that supports coordinators did not comply with the requirements.

Recommendation: While **The Senior Alliance**'s CAP included staff education, HSAG recommends that **The Senior Alliance** ensure its ongoing record reviews include the specific requirements that supports coordinators did not include. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-113 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 interviews. Table 3-113 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-113—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	12.50%		**1.00**	3.00
Focus 3	Release of Information	12.50%		**1.00**	4.00
Focus 4	Status	94.44%		**4.00**	4.00
Focus 5	Pre-Planning	95.86%	100%	**4.00**	4.00
Focus 6	Assessment	91.72%	100%	**4.00**	4.00
Focus 7	Medication Record	87.64%	100%	**4.00**	4.00
Focus 8	Person-Centered Service Planning	90.21%	100%	**4.00**	4.00
Focus 9	MI Choice Services	88.04%	98.21%	**3.33**	4.00
Focus 10	Linking and Coordinating	80.43%	100%	**2.67**	4.00
Focus 11	Follow-Up and Monitoring	71.05%	100%	**2.00**	3.33
Focus 12	Service Provider	87.50%		**4.00**	4.00
Focus 13	Contingency Plan	85.42%	100%	**4.00**	4.00
Focus 14	Critical Incidents	100%	100%	**4.00**	2.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	85.00%		**4.00**	4.00
Focus 16	Complaints and Grievances	50.00%		**1.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**87.23%**	**99.75%**	**3.73**	3.88

Indicates the standard was not reviewed as part of the record review or home visit.
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 Senior Alliance achieved a substantial compliance rating in 12 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were 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 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. **The Senior Alliance** also

demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Some Compliance, Needs Improvement* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 14 out of 16 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **The Senior Alliance** reported that there was an internal process issue.

Recommendation: MDHHS required **The Senior Alliance** to submit a CAP to remediate the deficiencies. However, this deficiency has been noted as noncompliant for the past two years; therefore, **The Senior Alliance**'s interventions have not led to performance improvement. HSAG recommends that **The Senior Alliance** update its CAP to include interventions other than returning to in-person visits. For example, **The Senior Alliance** could implement system prompts or another similar workflow that reminds supports coordinators to obtain an FOC form.

Weakness #2: The Senior Alliance 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. **The Senior Alliance** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 14 out of 16 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record. **The Senior Alliance** reported that there was an internal process issue.

Recommendation: As this was a new citation, HSAG recommends that **The Senior Alliance** continue to implement its CAP of implementing in-person visits. However, if improvement is not realized, **The Senior Alliance** should modify its CAP and implement alternative interventions.

Weakness #3: The Senior Alliance 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 and ensuring service delivery in accordance with MDHHS policy and contract requirements, including the use of the member's backup plan or an 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. **The Senior Alliance** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that eight out of 16 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP; and three out of 13 applicable records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with

MDHHS policy and contract requirements, including the use of the member's backup plan or out-of-network provider. **The Senior Alliance** reported that supports coordinators were not always compliant with the requirements; however, the root cause of the noncompliance is unclear to HSAG.

Recommendation: MDHHS required **The Senior Alliance** to submit a CAP to remediate the deficiencies. However, one of the two deficiencies has been noted as noncompliant for the past six years; therefore, **The Senior Alliance**'s interventions have not led to performance improvement. HSAG recommends that **The Senior Alliance** update its CAP to include interventions other than staff education. For example, **The Senior Alliance** could implement system prompts or another similar workflow that reminds supports coordinators when follow-up is due.

Weakness #4: The Senior Alliance did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. **The Senior Alliance** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three out of six applicable records did not demonstrate evidence that the member/guardian was made aware of the resolution of complaints or grievances as warranted. **The Senior Alliance** reported that supports coordinators were not always compliant with the requirements; however, the root cause of the noncompliance is unclear to HSAG.

Recommendation: As this was a new citation, HSAG recommends that **The Senior Alliance** continue to implement its CAP of conducting staff training. However, if improvement is not realized, **The Senior Alliance** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **The Senior Alliance** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **The Senior Alliance**'s original questionnaire responses, and **The Senior Alliance** responded to these specific questions. To support its questionnaire responses, **The Senior Alliance** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **The Senior Alliance** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-114 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-114—EDV Results for The Senior Alliance

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **The Senior Alliance** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **The Senior Alliance** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **The Senior Alliance** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **The Senior Alliance** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **The Senior Alliance** utilizes line-by-line method for its claim payment strategies. • **The Senior Alliance**, with CIM as its subcontractor, collects TPL data during financial eligibility

Analysis	Key Findings
	assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **The Senior Alliance** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **The Senior Alliance** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **The Senior Alliance**'s encounters, **The Senior Alliance** indicated that it did not store data sent to MDHHS. • **The Senior Alliance** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **The Senior Alliance** displayed consistent encounter volume for professional encounters throughout the measurement year. • **The Senior Alliance** had a low volume of duplicate encounters, with 0.7 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **The Senior Alliance** demonstrated timely submission for professional encounters. Within 30 days, **The Senior Alliance** submitted 94.3 percent of professional encounters to MDHHS after the payment date. Within 90 days, **The Senior Alliance** submitted 99.1 percent of professional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **The Senior Alliance**'s submitted professional encounters, the billing provider NPI was populated 21.8 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **The Senior Alliance**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **The Senior Alliance**'s submitted data, 99.3 percent were identified in the enrollment data. • Of all identified provider NPIs in **The Senior Alliance**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **The Senior Alliance**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: The Senior Alliance demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: The Senior Alliance submitted professional encounters in a timely manner from the payment date, with 99.1 percent of encounters submitted within 90 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **The Senior Alliance** were populated at high rates, and most data elements were greater than 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The Senior Alliance indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **The Senior Alliance**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **The Senior Alliance**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: The Senior Alliance reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: The Senior Alliance appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: The Senior Alliance should consider enhancing its data management practices. HSAG recommends that **The Senior Alliance** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of

quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 21.8 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: The Senior Alliance should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-115 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 3-115 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-115—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	90.4%	93.9%	91.8%
Recommendation Measures	89.8%	92.1%	92.1%
Staff are Reliable and Helpful	87.2%	91.8%	92.1%
Staff Listen and Communicate Well	94.5%	97.4%	94.6%
Case Manager is Helpful	95.8%	94.7%	95.8%
Choosing the Services that Matter to You	90.2%	90.3%	90.8%
Transportation to Medical Appointments	94.9%	**85.8% ↓**	92.4%

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Personal Safety and Respect	98.3%	97.5%	97.4%
Planning Your Time and Activities	72.0%	75.1%	78.5%
Met Need	91.1%	94.5%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *Global Ratings Measures*, *Staff Listen and Communicate Well*, *Personal Safety and Respect*, and *Met Need*, indicating that **The Senior Alliance** provides services in a manner that meets or exceeds members' expectations in several domains. **The Senior Alliance** also demonstrated improvement in rates across several measures. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The Senior Alliance scored more than 5 percentage points below the statewide average on the *Transportation to Medical Appointments* domain at 85.8 percent compared with the

statewide average of 92.4 percent. Additionally, **The Senior Alliance**'s rate decreased 9.1 percentage points below its SFY 2021 rate. [**Quality** and **Access**]

Why the weakness exists: Of the three questions within the *Transportation to Medical Appointments* domain, **The Senior Alliance** scored below the statewide average for all three questions: *Have a way to get to your medical appointments*, *Able to get in and out of this ride easily*, and *Ride arrives on time to pick you up*.

Recommendation: HSAG recommends that **The Senior Alliance** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores significantly contributed to the low satisfaction score within the *Transportation to Medical Appointments* domain; develop interventions to improve the *Transportation to Medical Appointments* domain; and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #2: Although **The Senior Alliance** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. [**Quality**]

Why the weakness exists: This section is not applicable as this domain was not identified as a substantial weakness for **The Senior Alliance**.

Recommendation: HSAG recommends that **The Senior Alliance** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores correlate to the *Planning Your Time and Activities* domain; develop interventions to improve the *Planning Your Time and Activities* domain; and evaluate the results of the interventions regularly, making changes as necessary.

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

HSAG performed a comprehensive assessment of **The Senior Alliance**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **The Senior Alliance** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **The Senior Alliance**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-116 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **The Senior Alliance**'s MI Choice members.

Table 3-116—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **The Senior Alliance** demonstrated through Performance Measure 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*

Performance Area	Overall Performance Impact
	incidents, that it ensured the health and safety of members by providing information on critical incidents. Additionally, through the CQAR activity, **The Senior Alliance** received a *Substantial* compliance level in the Critical Incidents focus area. Further, through the CAHPS HCBS survey, **The Senior Alliance** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. However, through the PIP activity, **The Senior Alliance**'s *Prevalence of Falls* and *Prevalence of Any Injuries* rates did not meet the waiver agency's goals, and both rates increased over the prior year's rates, indicating the interventions implemented were not effective in maintaining **The Senior Alliance**'s previous performance. Additionally, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. These findings could imply that while **The Senior Alliance** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments and does not consistently mitigate health and safety risks for members. HSAG recommends that **The Senior Alliance** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **The Senior Alliance** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager* domain scored above the statewide average. However, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, fell below the statewide average and decreased from the prior year's rates. Additionally, through the CAHPS HCBS survey, the *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains fell below the statewide averages, and the *Case Manager is Helpful* domain decreased from the prior year. These findings suggest that although **The Senior Alliance** conducts assessments timely, it does not consistently conduct care coordination according to policies and procedures, and members are not generally satisfied with their case managers. **The Senior Alliance** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.

Performance Area	Overall Performance Impact
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **The Senior Alliance** demonstrated a *Substantial* compliance level in the MI Choice Services, Contingency Plan, and Adverse Benefit Determination focus areas. Additionally, through the PMV activity, the rate for Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored above the statewide average. Further, through the CAHPS HCBS survey, **The Senior Alliance**'s rate for the *Met Need* domain scored above the statewide average and increased from the prior year. However, through the CQAR, the Linking and Coordinating focus area scored a *Some Compliance, Needs Improvement* compliance level, and the Follow-Up and Monitoring focus area scored a *Not Full or Substantial* compliance level. Additionally, through the PMV activity, the rates for Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored below the statewide averages and decreased from the prior year's rates. Further, through the CAHPS HCBS survey, the *Staff are Reliable and Helpful* and *Transportation to Medical Appointments* domains scored below the statewide averages, and the *Transportation to Medical Appointments* domain decreased from the prior year's rate. These findings suggest that while **The Senior Alliance** ensured members had a contingency plan in place and members generally felt their needs were met, services were not always provided according to member needs, and supports coordinators did not always follow up to ensure services are being received as ordered. **The Senior Alliance** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers. As several performance measures related to access to waiver services were below statewide averages, **The Senior Alliance** should review its network and ensure it has enough contracted providers to provide timely waiver services to its membership.

Tri-County Office on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-117 displays the PIPs in place during SFY 2022. Table 3-117 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Tri-County Office on Aging** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Tri-County Office on Aging** did not meet the statewide goal or the *New Goal*. Any interventions described within **Tri-County Office on Aging**'s QMP reports are also provided in Table 3-117. The results in Table 3-117 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-117—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 24.9% SFY 2022 = 29.90% ☒
Interventions: • Updates to the COMPASS system occurred in October 2022 which eliminated data related to falls from cloning to upcoming assessments. • Conducted training related to accurately assessing for and documenting falls.		
PIP Validation Feedback: MDHHS provided the following feedback to **Tri-County Office on Aging**: • MDHHS requires waiver agencies to develop clear and quantifiable goals for improvement. The statewide quality improvement goal for "Prevalence of Falls" is below 23.0% of the waiver agency's participants.		
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 6.3% SFY 2022 = 5.60% ☒
Interventions: • Updates to the COMPASS system occurred in October 2022 which eliminated data related to injuries from cloning to upcoming assessments. • Conducted training related to accurately assessing for and documenting injuries.		
PIP Validation Feedback: MDHHS provided the following feedback to **Tri-County Office on Aging**:		

PIP Topic	Goal*	Measurement and Outcome±
• MDHHS requires waiver agencies to develop clear and quantifiable goals for improvement. The statewide quality improvement goal for "Prevalence of any Injuries" is below 3.0% of the waiver agency's participants.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-118 displays the two PIPs **Tri-County Office on Aging** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-118 is displayed as reported by **Tri-County Office on Aging** and was not validated by HSAG.

Table 3-118—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the percentage of MI Choice participants who reported a fall with injury to below .08%.	Baseline: .084% SFY 2023: Not yet reported
Interventions: • All current clinical staff to receive training and education related to the CAPABLE model. • The quality collaborative recommended that a representative from the quality collaborative be present at local Advisory Council meetings to provide training and education on a broader scale. • Brochure and self-assessment tool from STEDI provided to all clinicians for use with participants to assess for fall risk and potential interventions.		
PIP Validation Feedback: MDHHS provided the following feedback to **Tri-County Office on Aging**: • Clinical PIP should be Falls with Injury. The current clinical PIP is listed as "Reduce the percentage of MI Choice participants who reported a fall on a follow-up assessment to below 23%."		
Follow-Up After Hospital Discharge	Contact participants who have had a hospital discharge within 7-days 95% of the time by September of 2023.	Baseline: 84.15% SFY 2023: Not yet reported

PIP Topic	Goal	Measurement and Outcome
Interventions: • Quality Assurance Director provided education about the requirement to follow-up with participants within 7-days of a hospitalization at a mandatory staff meeting in Dec 2022. • The QMT recommended that the internal protocols and procedures related to this topic be added to the QA Orientation Checklist, a tool used by the QA Director to guide the orientation and training of new clinical staff.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Tri-County Office on Aging**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for **Tri-County Office on Aging**'s PIPs did not meet the MDHHS-established goals, and the percentage rate for the *Prevalence of Falls* PIP increased from the baseline, suggesting that the implemented interventions did not positively impact member outcomes. Therefore, no strengths were identified for **Tri-County Office on Aging**. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Tri-County Office on Aging** did not appear to be effective in improving outcomes as the prevalence rates increased for the *Prevalence of Falls* PIP, and **Tri-County Office on Aging** did not reach the MDHHS-established goals for either SFY 2022 PIP. **Tri-County Office 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 PIPs. [**Quality**]

Why the weakness exists: **Tri-County Office on Aging** indicated its most significant barrier was its software program cloning documentation from one assessment to the next, which resulted in **Tri-County Office on Aging** inaccurately reporting the volume of falls and injuries.

Recommendation: HSAG recommends that **Tri-County Office on Aging** implement an auditing and monitoring process to ensure all falls and injuries are being documented appropriately (i.e., timely, detailed, etc.) to improve the consistency with which falls and injuries are documented across

all staff members. Additionally, although **Tri-County Office on Aging** conducted a barrier analysis, only one specific barrier was identified, and that barrier was addressed. However, HSAG recommends that **Tri-County Office on Aging** consider additional barriers and interventions. 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 also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. Further, **Tri-County Office on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **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: Tri-County Office on Aging's SFY 2022 PIP results appeared to only include six months of data. [**Quality**]

Why the weakness exists: Although **Tri-County Office on Aging** did not document the measurement period in its Outcomes & Activities Report, the numerators and denominators provided were calculated in alignment with MDHHS' results, which only used the first six months of the state fiscal year.

Recommendation: HSAG continues to recommend that both **Tri-County Office on Aging** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Tri-County Office on Aging**'s PIPs did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Tri-County Office on Aging** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Tri-County Office on Aging** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Tri-County Office on Aging Quality Assurance & Performance Improvement (QAPI) Plan demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Tri-County Office on Aging**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Tri-County Office on Aging** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Tri-County Office on Aging** in a methodologically sound manner. HSAG further recommends that **Tri-County Office on Aging**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through

Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Tri-County Office on Aging** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Tri-County Office on Aging** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Tri-County Office on Aging** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-119 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-119 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-119, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-119—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**84.00%**	**83.33%**	**86.65%**
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	**97.18%**	**91.90% ↓**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**91.67% ↓**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**92.31%**	**100% ↑**	**100%**
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	**97.12%**	**90.20% ↓**	**94.76%**
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	**100%**	**89.58% ↓**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**90.00%**	**70.83% ↓**	**82.72%**
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	**93.21%**	**86.84% ↓**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**86.05%**	**77.78% ↓**	**88.74%**
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	**94.50%**	**86.67% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**92.00%**	**95.83%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	—	**16.67%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Tri-County Office on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Tri-County Office on Aging received a 100 percent performance rating for Performance Measures 7, 8, 22, 24, and 38, indicating that LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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**]

Weaknesses and Recommendations

Weakness #1: Tri-County Office on Aging performed substantially worse than other waiver agencies on Performance Measure 4, *number and percent of appropriate LOCDs found after MDHHS review*, as indicated by a performance rate of 7.28 percentage points below the statewide rate and a decrease of 8.33 percentage points from **Tri-County Office on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two of the 24 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. **Tri-County Office on Aging** reported that in some instances, member issues were documented in progress notes and assessments but were not carried over and addressed in the PCSP.

Recommendation: MDHHS did not require **Tri-County Office on Aging** to submit a CAP to remediate the two deficiencies associated with Performance Measure 4. However, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Tri-County Office on Aging 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 11.89 percentage points below the statewide rate and a decrease of 19.17 percentage points from **Tri-County Office on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 14 of the 24 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **Tri-County Office on Aging** reported that internal written protocols contained the incorrect time frames for completing an updated assessment. **Tri-County Office on Aging** also reported that there was lack of follow up on non-waiver items in some PCSPs.

Recommendation: While **Tri-County Office on Aging**'s CAP included staff education, HSAG recommends that **Tri-County Office on Aging** consider system prompts or other workflows that trigger the supports coordinator to update the PCSP. Additionally, **Tri-County Office on Aging** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #3: Tri-County Office 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 10.96 percentage points below the statewide rate and a decrease of 8.27 percentage points from **Tri-County Office on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that four of the 24 applicable records did not demonstrate evidence that the PCSP was appropriately developed, evaluated, and updated; and 15 of the 21 applicable records did not demonstrate that the supports coordinator authorized a change in services in accordance with MDHHS policy and contract requirements. **Tri-County Office on Aging** reported that there was a gap in written process and training regarding the circumstances under which a significant change assessment would be indicated. **Tri-County Office on Aging** also reported that there was a lack of or untimely follow up for service implementation.

Recommendation: While **Tri-County Office on Aging**'s CAP included staff education, HSAG recommends that the education include the circumstances under which a significant change assessment would be indicated. HSAG also recommends that **Tri-County Office on Aging** consider system prompts or another option to automatically remind supports coordinators when follow-up is due. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #4: Tri-County Office 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 26 percentage points below the statewide rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 20 of the 24 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan. **Tri-County Office on Aging** reported that the issue was related to including acronyms in the PCSP.

Recommendation: While **Tri-County Office on Aging**'s CAP included staff education, HSAG recommends that **Tri-County Office on Aging** consider developing a checklist or other reminder system for supports coordinators to use and ensuring that chart reviews include this requirement. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-120 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 interviews. Table 3-120 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-120—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	96.36%	91.67%	**4.00**	4.00
Focus 2	Freedom of Choice	70.83%		**1.00**	4.00
Focus 3	Release of Information	75.00%		**2.00**	4.00
Focus 4	Status	93.06%		**4.00**	4.00
Focus 5	Pre-Planning	96.31%	100%	**4.00**	4.00
Focus 6	Assessment	90.74%	98.61%	**4.00**	4.00
Focus 7	Medication Record	80.29%	98.33%	**3.33**	2.03
Focus 8	Person-Centered Service Planning	82.44%	100%	**3.33**	4.00
Focus 9	MI Choice Services	87.94%	98.81%	**3.33**	4.00
Focus 10	Linking and Coordinating	85.45%	100%	**3.33**	4.00
Focus 11	Follow-Up and Monitoring	66.67%	100%	**2.00**	3.34
Focus 12	Service Provider	90.91%		**4.00**	4.00
Focus 13	Contingency Plan	51.67%	100%	**2.00**	4.00
Focus 14	Critical Incidents	78.57%	100%	**2.00**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	73.33%		**2.00**	4.00
Focus 16	Complaints and Grievances	100%		**4.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	4.00
	Totals	**84.88%**	**99.30%**	**3.43**	3.82

Indicates the standard was not reviewed as part of the record review or home visit.
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: A review of 12 home visits was conducted; all reviews achieved full compliance except for four deficiencies, and no focus areas received a citation requiring a CAP. 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 were receiving services in accordance with their service plans and preferences and were satisfied with those services. It should be noted that while the home visit reviews achieved nearly full compliance, the record review identified conflicting results in the areas of Follow-Up and Monitoring, Contingency Plan, and Critical Incidents. [**Quality**]

Strength #2: Tri-County Office on Aging achieved a substantial compliance rating in 11 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were being implemented in accordance with several State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Tri-County Office 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. **Tri-County Office on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that seven out of 24 applicable records did not include evidence that the waiver agency ensured a valid FOC form was included in the member record. **Tri-County Office on Aging** reported that there was a training gap for staff regarding acceptable practice for signing and obtaining signatures on documents electronically.

Recommendation: As this was a new citation, HSAG recommends that **Tri-County Office on Aging** continue to implement its CAP of conducting staff education and an updated workflow. However, if improvement is not realized, **Tri-County Office on Aging** should modify its CAP and implement alternative interventions.

Weakness #2: Tri-County Office on Aging 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. **Tri-County Office on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that six out of 24 applicable records did not include evidence that the waiver agency ensured a valid ROI form was included in the member record. **Tri-County Office on Aging** reported that there was a training gap for staff regarding acceptable practice for signing and obtaining signatures on documents electronically.

Recommendation: As this was a new citation, HSAG recommends that **Tri-County Office on Aging** continue to implement its CAP of conducting staff education and an updated workflow. However, if improvement is not realized, **Tri-County Office on Aging** should modify its CAP and implement alternative interventions.

Weakness #3: Tri-County Office on Aging did not consistently follow all Follow-Up and Monitoring requirements; specifically, contacting newly enrolled 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

MDHHS policy and contract requirements, including the use of the member's backup plan or an 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. **Tri-County Office on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that three out of six applicable records did not include evidence that the waiver agency contacted the newly enrolled members/guardians to ensure service delivery in accordance with MDHHS policy and contract requirements; 14 out of 24 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP; and one out of 21 applicable records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with MDHHS policy and contract requirements, including the use of the member's backup plan or out-of-network provider. **Tri-County Office on Aging** reported that there was an incongruency between **Tri-County Office on Aging** internal written protocols and the MI Choice Contract. Internal written protocol indicated that supports coordinators must complete an updated assessment of the member's home environment within 14 days of becoming aware of the move, which is incongruent with contract requirements stating the environmental assessment must be completed within seven days. **Tri-County Office on Aging** also reported that there was a training gap for newer staff. Further, there was a lack of clear definitions differentiating a late entry and a record amendment.

Recommendation: One of the three deficiencies was not identified as a citation by MPHI; however, the other two deficiencies were documented as citations. One of the two citations has been noted as noncompliant for the past two years, and the other citation has been noted as noncompliant for the past 10 years. Based on these findings, **Tri-County Office on Aging**'s previously implemented interventions have not led to performance improvement in this program area. HSAG recommends that **Tri-County Office on Aging** update its CAP to include interventions other than staff education. For example, **Tri-County Office on Aging** could implement system prompts or another similar workflow that reminds supports coordinators when follow-up is due. Additionally, HSAG recommends that **Tri-County Office on Aging** ensure that remediation efforts are put in place for the deficiency not requiring a CAP.

Weakness #4: Tri-County Office on Aging did not consistently follow all Contingency Plan requirements; specifically, ensuring there is a complete and up-to-date contingency plan, ensuring that the member/guardian received a copy of the contingency plan, and ensuring that other allies received a copy of the contingency plan. Contingency plans are important to ensure that if the member's PCSP services are unavailable, the member will still have services in place until planned services can resume. **Tri-County Office on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial*

compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 20 out of 24 applicable records did not demonstrate evidence that the record contained a complete and up-to-date contingency plan; seven out of 24 applicable records did not demonstrate evidence that the member/guardian received a copy of the contingency plan; and two out of five applicable records did not demonstrate evidence that other allies included in the plan received a copy of the contingency plan as preferred by the member/guardian. **Tri-County Office on Aging** reported issues with acronyms continuing to appear on backup plans instead of being removed when the backup plan was updated. **Tri-County Office on Aging** also reported that there was a process issue that was corrected in April 2022.

Recommendation: MDHHS required **Tri-County Office on Aging** to submit a CAP to remediate the deficiencies. However, one of the three deficiencies has been noted as noncompliant for the past two years; Therefore, HSAG recommends that **Tri-County Office on Aging** continue to implement its CAP of conducting staff education. However, if improvement is not realized, **Tri-County Office on Aging** should modify its CAP and implement alternative interventions.

Weakness #5: Tri-County Office on Aging did not consistently follow all Critical Incident 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. **Tri-County Office on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of seven applicable records did not demonstrate evidence that the supports coordinator addressed the incident with the member/guardian; two out of seven 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 out of seven 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. **Tri-County Office on Aging** reported that the deficiencies were a result of a need for additional training for supports coordinators regarding under which circumstances critical incidents are required and what follow-up steps are necessary.

Recommendation: MDHHS required **Tri-County Office on Aging** to submit a CAP to remediate the deficiencies. However, one of the three deficiencies has been noted as noncompliant for the past four years; therefore, **Tri-County Office on Aging**'s interventions have not led to performance improvement. HSAG recommends that **Tri-County Office on Aging** update its CAP to include interventions other than staff education and development of a decision guide. For example, **Tri-County Office on Aging** could develop a critical incident template that must be completed by the supports coordinator for every incident. This template should include all required tasks that must be

completed when a critical incident occurs. Management could review the templates as they are completed to immediately address any gaps with the supports coordinator in real time.

Weakness #6: Tri-County Office 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 NABDs are important to ensure members understand their appeal rights and the process to request an appeal. **Tri-County Office on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that six out of 17 applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and two out of 12 applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate. **Tri-County Office on Aging** reported that the root cause for this deficiency was the result of breakdowns and staff misunderstanding/misinterpretation of processes due to a lack of written processes; breakdowns were found to be most prevalent during times where staff were out of the office or covering for each other's piece of processes.

Recommendation: One of the deficiencies was not identified as a citation by MPHI; however, the other deficiency was documented as a new citation. Therefore, HSAG recommends that **Tri-County Office on Aging** continue to implement its CAP to conduct staff education. Additionally, HSAG recommends that **Tri-County Office on Aging** ensure that remediation efforts are put in place for the deficiency not requiring a CAP. If improvement is not realized, **Tri-County Office on Aging** should modify its CAP and/or implement additional remediation plans and alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Tri-County Office on Aging** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Tri-County Office on Aging**'s original questionnaire responses, and **Tri-County Office on Aging** responded to these specific questions. To support its questionnaire responses, **Tri-County Office on Aging** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Tri-County Office on Aging** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-121 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-121—EDV Results for Tri-County Office on Aging

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Tri-County Office on Aging** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Tri-County Office on Aging** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Tri-County Office on Aging** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Tri-County Office on Aging** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Tri-County Office on Aging** utilizes line-by-line method for its claim payment strategies. • **Tri-County Office on Aging**, with CIM as its subcontractor, collects TPL data during financial

Analysis	Key Findings
	eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Tri-County Office on Aging** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Tri-County Office on Aging** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Tri-County Office on Aging**'s encounters, **Tri-County Office on Aging** indicated that it did not store data sent to MDHHS. • **Tri-County Office on Aging** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Tri-County Office on Aging** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Tri-County Office on Aging** had a low volume of duplicate encounters, with 0.7 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Tri-County Office on Aging** demonstrated timely submission for professional encounters. Within 60 days, **Tri-County Office on Aging** submitted greater than 99.9 percent of professional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **Tri-County Office on Aging**'s submitted professional encounters, the billing provider NPI was populated 1.1 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Tri-County Office on Aging**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Tri-County Office on Aging**'s submitted data, 99.4 percent were identified in the enrollment data. • Of all identified provider NPIs in **Tri-County Office on Aging**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Tri-County Office on Aging**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Tri-County Office on Aging demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Tri-County Office on Aging submitted professional encounters in a timely manner from the payment date, with greater than 99.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Tri-County Office on Aging** were populated at high rates, and most data elements were over 99 percent valid.

Weaknesses and Recommendations

Weakness #1: Tri-County Office on Aging indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Tri-County Office on Aging**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Tri-County Office on Aging**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Tri-County Office on Aging reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Tri-County Office on Aging appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Tri-County Office on Aging should consider enhancing its data management practices. HSAG recommends that **Tri-County Office on Aging** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a

comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 1.1 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Tri-County Office on Aging should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-122 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 3-122 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-122—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	96.7%	93.8%	91.8%
Recommendation Measures	97.7%	94.0%	92.1%
Staff are Reliable and Helpful	96.1%	93.7%	92.1%
Staff Listen and Communicate Well	95.8%	95.7%	94.6%
Case Manager is Helpful	100%	100%	95.8%
Choosing the Services that Matter to You	93.1%	**96.3%**	90.8%
Transportation to Medical Appointments	92.7%	91.1%	92.4%

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Personal Safety and Respect	94.1%	99.2% ↑	97.4%
Planning Your Time and Activities	73.3%	81.3% ↑	78.5%
Met Need	92.4%	96.4%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *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*, and *Met Need*, indicating that **Tri-County Office on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. **Tri-County Office on Aging** also demonstrated improvement in rates across four measures, with two measure rates, *Personal Safety and Respect* and *Planning Your Time and Activities*, increasing by 5 percentage points or more. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

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.

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 *Transportation to Medical Appointments* domain; therefore, HSAG recommends that **Tri-County Office on Aging** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within this domain, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **Tri-County Office on Aging** scored above the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Tri-County Office on Aging** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Tri-County Office on Aging**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Tri-County Office on Aging** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Tri-County Office on Aging**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-123 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Tri-County Office on Aging**'s MI Choice members.

Table 3-123—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Tri-County Office on Aging** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information on critical incidents. Additionally, through the CAHPS HCBS survey, **Tri-County Office on Aging** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. However, through the PIP activity, **Tri-County Office on Aging**'s *Prevalence of Falls* and *Prevalence of Any Injuries* rates did not meet the waiver agency's goals, and the *Prevalence of Falls* rate

Performance Area	Overall Performance Impact
	increased over the prior year's rates, indicating the interventions implemented were not effective in decreasing the prevalence of falls and injuries. Additionally, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. Further, through the CQAR activity, **Tri-County Office on Aging** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. These findings could imply that while **Tri-County Office on Aging** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments and does not consistently mitigate health and safety risks for members. HSAG recommends that **Tri-County Office on Aging** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Tri-County Office on Aging** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored above the statewide average. However, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, fell below the statewide average and decreased from the prior year's rates. These findings suggest that although **Tri-County Office on Aging** conducts assessments timely and members are generally satisfied with their case managers, it does not consistently conduct care coordination according to policies and procedures. **Tri-County Office on Aging** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Tri-County Office on Aging** demonstrated a *Substantial* compliance level in the MI Choice Services and Linking and Coordinating focus areas. Additionally, through the CAHPS HCBS survey, **Tri-County Office on Aging**'s rates for the *Staff are Reliable and Helpful* and *Met Need* domains scored above the statewide average, and the rate for the *Met Need* domain increased from the prior year. However, through the CQAR, the Follow-Up and Monitoring, Contingency Plan, and Adverse Benefit Determination focus areas scored a *Not Full or Substantial* compliance level. Additionally, through the PMV activity, three performance measures scored below the statewide averages: Performance Measure 15, *number and percent of participants whose person-centered service plan includes*

Performance Area	Overall Performance Impact
	services and supports that align with their assessed needs, Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*. Performance Measures 15 and 20 decreased from the prior year's rates. Further, through the CAHPS HCBS survey, the *Transportation to Medical Appointments* domain scored below the statewide average and decreased from the prior year's rate. These findings suggest that while members felt their needs were met and had a contingency plan in place, **Tri-County Office on Aging** did not consistently ensure services were provided according to member needs, and supports coordinators did not always follow up to ensure services are being received as ordered. **Tri-County Office on Aging** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers. As several performance measures related to access to waiver services were below statewide averages, **Tri-County Office on Aging** should review its network and ensure it has enough contracted providers to provide timely waiver services to its membership.

UPCAP Care Management, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 3-124 displays the PIPs in place during SFY 2022. Table 3-124 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **UPCAP Care Management, Inc.** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **UPCAP Care Management, Inc.** did not meet the statewide goal or the *New Goal*. Any interventions described within **UPCAP Care Management, Inc.**'s QMP reports are also provided in Table 3-124. The results in Table 3-124 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-124—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 31.1% SFY 2022 = 33.70% ☒
Interventions: • A Matter of Balance – a program designed to reduce the fear of falling and increasing activity levels. • CAPABLE Program – a model of care delivered by nurses and/or social workers, who work with participants to remove fall hazards (rugs, clutter, etc.) from the home, educate them on the use of assistive devices (purchase if necessary) and provide them with educational materials, checklists and referrals to occupational therapists if necessary.		
PIP Validation Feedback: MDHHS provided the following feedback to **UPCAP Care Management, Inc.**: • MDHHS included the statewide average and **UPCAP Care Management, Inc.** information below. Please include the baseline, goals, and show it is going to be reported as a numerator/denominator (listed in the instructions).		

Agency	Falls	Falls Goal	Injuries	Injuries Goal
Statewide	24.1%	23.0% or lower	4.2%	3.0% or lower
UPCAP Care Management, Inc.	31.1%	23.0% or lower	10.2%	3.0% or lower

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 10.2% SFY 2022 = 6.10% ☒

Interventions:

- CAPABLE Program – a model of care delivered by nurses and/or social workers, who work with participants to remove fall hazards (rugs, clutter, etc.) from the home, educate them on the use of assistive devices (purchase if necessary) and provide them with educational materials, checklists, and referrals to occupational therapists if necessary.

PIP Validation Feedback:

MDHHS provided the following feedback to **UPCAP Care Management, Inc.**:

- MDHHS included the statewide average and **UPCAP Care Management, Inc.** information below. Please include the baseline, goals, and show it is going to be reported as a numerator/denominator (listed in the instructions).

Agency	Falls	Falls Goal	Injuries	Injuries Goal
Statewide	24.1%	23.0% or lower	4.2%	3.0% or lower
UPCAP Care Management, Inc.	31.1%	23.0% or lower	10.2%	3.0% or lower

* The statewide overall goal for Prevalence of Falls was 23 percent and Prevalence of Any Injuries was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-125 displays the two PIPs **UPCAP Care Management, Inc.** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-125 is displayed as reported by **UPCAP Care Management, Inc.** and was not validated by HSAG.

Table 3-125—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Reduce the prevalence of falls with injury to be at or below 6% of the total participants who recorded a fall.	Baseline: 5.5% SFY 2023: Not yet reported
Interventions: • A Matter of Balance, which is a program designed to reduce the fear of falling and increasing activity levels. • UPCAP staff are also trained on the CAPABLE Program, which is a model of care delivered by nurses and/or social workers, who work with participants to remove fall hazards (rugs, clutter, etc.) from the home, educate them on the use of assistive devices (purchase if necessary) and provide them with educational materials, checklists and referrals to occupational therapists if necessary. Supports coordinators will review the use of assistive devices and home modification, that improves function and things that impact function (i.e., balance, pain).		
PIP Validation Feedback: MDHHS provided the following feedback to **UPCAP Care Management, Inc.**: • Clinical PIP should be Falls with Injury. The current the PIP is using Prevalence of fall data not specific to falls with injuries.		
Satisfaction Rate	Survey all current MI Choice participants who have been enrolled no less than 6 months with a 90% satisfaction rate by September 30, 2023	Baseline: 91%* SFY 2023: Not yet reported
Interventions: • Supports coordinators will alert clients of potential for survey after 90 days of being enrolled in program • Design data collection tool for immediate data collection and reporting • Management of data and reporting by the LTC Quality Improvement Manager and/or the Director of LTC Programs • Provide follow up and education/training to supports coordinators on areas that need improvement • For surveys with feedback of "extremely dissatisfied" or "dissatisfied" will require immediate intervention by the supports coordinator, team leader, Regional RN Supervisor or Director of LTC Programs • Submit and review survey results with the Internal Quality Committee and the AAA Advisory Council/Quality Collaborative Committee		
PIP Validation Feedback: MDHHS did not provide any feedback to **UPCAP Care Management, Inc.**		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.
*The waiver agency reported only Quarter 1 of SFY 2023. As the survey was first implemented in SFY 2023, this will serve as the baseline measurement.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 2022 percentage rates for **UPCAP Care Management, Inc.**'s PIPs did not meet the MDHHS-established goals, and the percentage rate for the *Prevalence of Falls* increased, suggesting that the implemented interventions did not positively impact member outcomes. Therefore, no strengths were identified for **UPCAP Care Management, Inc.** [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **UPCAP Care Management, Inc.** did not appear to be effective in significantly improving outcomes as the prevalence rate increased for the *Prevalence of Falls* PIP, and although the prevalence rate for the *Prevalence of Any Injuries* PIP decreased, **UPCAP Care Management, Inc.** did not reach the MDHHS-established goals for either PIP. **UPCAP Care Management, Inc.**'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 PIPs. [**Quality**]

Why the weakness exists: **UPCAP Care Management, Inc.** cited the variation in supports coordinators' interpretations of the questions on the assessment, resulting in inaccurate reporting as the major barrier to meeting the goals for these PIPs.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** implement an auditing and monitoring process to ensure all falls and injuries are being documented appropriately (i.e., timely, detailed, etc.) to improve the consistency with which falls and injuries are documented across all staff members. Additionally, although **UPCAP Care Management, Inc.** conducted a barrier analysis, interventions implemented did not appear to address those 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 also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **UPCAP Care Management, Inc.** should analyze and interpret results at multiple points in time and test for statistical significance. Finally, **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 #2: UPCAP Care Management, Inc.'s SFY 2022 PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: UPCAP Care Management, Inc. calculated its PIP results on a different timing schedule than MDHHS (i.e., **UPCAP Care Management, Inc.** calculated its results based on the full state fiscal year, and MDHHS calculated the results only on the first half of the state fiscal year for baseline and remeasurement).

Recommendation: HSAG continues to recommend that **UPCAP Care Management, Inc.** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **UPCAP Care Management, Inc.** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **UPCAP Care Management, Inc.**'s PIPs did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **UPCAP Care Management, Inc.** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **UPCAP Care Management, Inc.** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Quality Assurance and Performance Improvement FY2023 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **UPCAP Care Management, Inc.**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **UPCAP Care Management, Inc.** in a methodologically sound manner. HSAG further recommends that **UPCAP Care Management, Inc.**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **UPCAP Care Management, Inc.** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **UPCAP Care Management, Inc.** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **UPCAP Care Management, Inc.** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-126 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-126 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-126, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-126—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**69.23%**	**100% ↑**	**86.65%**
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	**94.29%**	**98.52%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**92.31%**	**100% ↑**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**94.34%**	**90.57%**	**94.76%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**100%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**94.62%**	**88.46% ↓**	**82.72%**
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	**88.25%**	**93.20%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**80.00%**	**95.65% ↑**	**88.74%**
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	**100%**	**92.86% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**100%**	**92.31% ↓**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**94.87%**	**100% ↑**	**100%**
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	**—**	**38.46%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **UPCAP Care Management, Inc.**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: UPCAP Care Management, Inc. received a 100 percent performance rating for Performance Measures 1, 4, 7, 8, 16, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; PCSPs had strategies to address their assessed 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**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial trends of weakness. While Performance Measures 15 and 30 did not meet the statewide performance rate, neither performance measure fell below the statewide rate by more than 5 percentage points.

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

Recommendation: Although **UPCAP Care Management, Inc.** did not fall more than 5 percentage points below the statewide performance rate for any performance measures, HSAG recommends that **UPCAP Care Management, Inc.** focus interventions on performance measures that demonstrated a decline of 5 percentage points from the prior year; specifically, Performance Measures 15 and 30.

Compliance Review

Performance Results

Table 3-127 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 interviews. Table 3-127 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-127—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	100%		**4.00**	1.00
Focus 3	Release of Information	92.31%		**4.00**	4.00
Focus 4	Status	97.37%		**4.00**	4.00

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 5	Pre-Planning	99.15%	100%	**4.00**	4.00
Focus 6	Assessment	96.61%	100%	**4.00**	4.00
Focus 7	Medication Record	83.56%	100%	**3.35**	3.34
Focus 8	Person-Centered Service Planning	90.48%	100%	**4.00**	4.00
Focus 9	MI Choice Services	90.67%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	93.55%	100%	**4.00**	4.00
Focus 11	Follow-Up and Monitoring	77.78%	100%	**2.70**	2.05
Focus 12	Service Provider	88.89%		**4.00**	4.00
Focus 13	Contingency Plan	69.70%	100%	**2.05**	2.70
Focus 14	Critical Incidents	75.00%	100%	**2.05**	NA
Focus 15	Adverse Benefit Determination	59.09%		**1.00**	4.00
Focus 16	Complaints and Grievances	100%		**4.00**	4.00
Focus 17	Home and Community Based		NA	**NA**	4.00
	Totals	**90.72%**	**100%**	**3.66**	3.84

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

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: A review of seven home visits was 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 were receiving services in accordance with their service plans and preferences and were 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 Contingency Plan and Critical Incidents. [**Quality**]

Strength #2: UPCAP Care Management, Inc. achieved a substantial compliance rating in 12 of the applicable 16 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were 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 Contingency Plan requirements; specifically, ensuring there is a complete and up-to-date contingency plan and ensuring that the member/guardian received a copy of the contingency plan. Contingency plans are important to ensure that if the member's PCSP services are unavailable, the member will still have services in place until planned services can resume. **UPCAP Care Management, Inc.** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Some Compliance, Needs Improvement* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that eight out of 13 applicable records did not demonstrate evidence that the record contained a complete and up-to-date contingency plan, and two out of 13 applicable records did not demonstrate evidence that the member/guardian received a copy of the contingency plan. However, **UPCAP Care Management, Inc.** did not identify the root cause of these deficiencies but concluded that policy updates and supports coordinator training were required.

Recommendation: One of the two deficiencies was not identified as a citation by MPHI; however, the other deficiency was documented as a citation and has been noted as noncompliant for the past two years. Therefore, HSAG recommends that **UPCAP Care Management, Inc.** update its CAP to include interventions other than staff education and ongoing chart audits. For example, **UPCAP Care Management, Inc.** could implement system prompts to remind supports coordinators when and to whom the contingency plan should be mailed. Additionally, HSAG recommends that **UPCAP Care Management, Inc.** ensure that remediation efforts are put in place for the deficiency not requiring a CAP.

Weakness #2: UPCAP Care Management, Inc. did not consistently follow all Critical Incident 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 one out of two applicable records did not demonstrate evidence that the supports coordinator addressed the incident with the member/guardian; and one out of two 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. However, **UPCAP Care Management, Inc.** did not identify the root cause of these deficiencies but concluded that policy updates and supports coordinator training were required.

Recommendation: As these were new citations, HSAG recommends that **UPCAP Care Management, Inc.** continue to implement its CAP of conducting staff education and ongoing chart audits. However, if improvement is not realized, **UPCAP Care Management, Inc.** should modify its CAP and implement alternative interventions.

Weakness #3: UPCAP Care Management, Inc. 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 NABDs are important to ensure members understand their appeal rights and the process to request an appeal. **UPCAP Care Management, Inc.** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that two out of 11 applicable records did not demonstrate evidence that the member/guardian was provided the AAN/ABD, and seven out of 11 applicable records did not demonstrate evidence that the AAN/ABD was complete and accurate. However, **UPCAP Care Management, Inc.** did not identify the root cause of these deficiencies but concluded that policy updates and supports coordinator training were required.

Recommendation: One of the deficiencies was not identified as a citation and the other was a new citation. As such, HSAG recommends that **UPCAP Care Management, Inc.** continue to implement its CAP to conduct staff education and ongoing chart audits. Additionally, HSAG recommends that

UPCAP Care Management, Inc. ensure that remediation efforts are put in place for the deficiency not requiring a CAP. However, if improvement is not realized, **UPCAP Care Management, Inc.** should modify its CAP and other remediation efforts and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **UPCAP Care Management, Inc.** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **UPCAP Care Management, Inc.**'s original questionnaire responses, and **UPCAP Care Management, Inc.** responded to these specific questions. To support its questionnaire responses, **UPCAP Care Management, Inc.** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **UPCAP Care Management, Inc.** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-128 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-128—EDV Results for UPCAP Care Management, Inc.

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **UPCAP Care Management, Inc.** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **UPCAP Care Management, Inc.** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **UPCAP Care Management, Inc.** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **UPCAP Care Management, Inc.** indicated that its subcontractor, CIM, manages both provider data and

Analysis	Key Findings
	enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **UPCAP Care Management, Inc.** utilizes line-by-line method for its claim payment strategies. • **UPCAP Care Management, Inc.**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **UPCAP Care Management, Inc.** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **UPCAP Care Management, Inc.** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **UPCAP Care Management, Inc.**'s encounters, **UPCAP Care Management, Inc.** indicated that it did not store data sent to MDHHS. • **UPCAP Care Management, Inc.** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **UPCAP Care Management, Inc.** displayed consistent encounter volume for professional encounters throughout the measurement year. • **UPCAP Care Management, Inc.** had a low volume of duplicate encounters, with 0.8 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **UPCAP Care Management, Inc.** demonstrated timely submission for professional encounters. Within 60 days, **UPCAP Care Management, Inc.** submitted 99.9 percent of professional encounters to MDHHS after the payment date. Within 120 days, **UPCAP Care Management, Inc.** submitted 100 percent of professional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **UPCAP Care Management, Inc.**'s submitted professional encounters, the billing provider NPI was populated 30 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **UPCAP Care Management, Inc.**'s submitted data had high rates of population and validity.

Analysis	Key Findings
Encounter Referential Integrity	• Of all identified member IDs in **UPCAP Care Management, Inc.**'s submitted data, 97.7 percent were identified in the enrollment data. • Of all identified provider NPIs in **UPCAP Care Management, Inc.**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **UPCAP Care Management, Inc.**

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: UPCAP Care Management, Inc. demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: UPCAP Care Management, Inc. submitted professional encounters in a timely manner from the payment date, with 99.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **UPCAP Care Management, Inc.** were populated at high rates, and most data elements were over 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: UPCAP Care Management, Inc. indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **UPCAP Care Management, Inc.**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **UPCAP Care Management, Inc.**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: UPCAP Care Management, Inc. reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: UPCAP Care Management, Inc. appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: UPCAP Care Management, Inc. should consider enhancing its data management practices. HSAG recommends that **UPCAP Care Management, Inc.** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 30 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: UPCAP Care Management, Inc. should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-129 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 3-129 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-129—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	95.8%	93.7%	91.8%
Recommendation Measures	98.6%	94.4%	92.1%
Staff are Reliable and Helpful	92.6%	90.6%	92.1%
Staff Listen and Communicate Well	97.6%	97.2%	94.6%
Case Manager is Helpful	96.4%	95.0%	95.8%
Choosing the Services that Matter to You	97.4%	88.7% ↓	90.8%
Transportation to Medical Appointments	91.8%	93.3%	92.4%
Personal Safety and Respect	97.4%	98.1%	97.4%
Planning Your Time and Activities	80.0%	78.2%	78.5%
Met Need	98.3%	**87.0% ↓**	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 following domains: *Global Ratings Measures*, *Recommendation Measures*, *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, and *Personal Safety and Respect*, indicating that **UPCAP Care Management, Inc.** provides services in a manner that meets or exceeds members' expectations in several domains. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: UPCAP Care Management, Inc. scored more than 5 percentage points below the statewide average on the *Met Need* domain at 87.0 percent compared with the statewide average of 93.0 percent. Additionally, **UPCAP Care Management, Inc.**'s rate decreased 11.3 percentage points below its SFY 2021 rate. [**Quality** and **Access**]

Why the weakness exists: Of the five questions within the *Met Need* domain, **UPCAP Care Management, Inc.** scored below the statewide average for all five questions: *Met need in dressing/bathing*, *Met need in meal preparation/eating*, *Met need in medication administration*, *Met need in toileting*, and *Met need in household tasks*.

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores significantly contributed to the low satisfaction score within the *Met Need* domain and evaluate the results of the interventions regularly, making changes as necessary.

Weakness #2: Although **UPCAP Care Management, Inc.** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. [**Quality**]

Why the weakness exists: This section is not applicable as this domain was not identified as a substantial weakness for **UPCAP Care Management, Inc.**

Recommendation: HSAG recommends that **UPCAP Care Management, Inc.** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores

contributed to the low satisfaction score within the *Planning Your Time and Activities* domain; develop interventions to improve the *Planning Your Time and Activities* domain; and evaluate the results of the interventions regularly, making changes as necessary.

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

HSAG performed a comprehensive assessment of **UPCAP Care Management, Inc.**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **UPCAP Care Management, Inc.** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **UPCAP Care Management, Inc.**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-130 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **UPCAP Care Management, Inc.**'s MI Choice members.

Table 3-130—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **UPCAP Care Management, Inc.** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members by mitigating health and safety risks and providing information on critical incidents. Additionally, through the CAHPS HCBS survey, **UPCAP Care Management, Inc.** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. However, through the PIP activity, **UPCAP Care Management, Inc.**'s *Prevalence of Falls* and *Prevalence of Any Injuries* rates did not meet the waiver agency's goals, and the *Prevalence of Falls* rate increased over the prior year's rate, indicating the interventions implemented were not effective at decreasing the prevalence of falls and injuries. Further, through the CQAR activity, **UPCAP Care Management, Inc.** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. These findings could imply that while **UPCAP Care Management, Inc.** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments and does not consistently report, investigate, and follow up on critical incidents. HSAG recommends that **UPCAP Care Management, Inc.** review its barriers for all measures falling below thresholds

Performance Area	Overall Performance Impact
	and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **UPCAP Care Management, Inc.** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, scored above the statewide averages, although the rate for Performance Measure 17 decreased from the prior year's rate. However, through the CAHPS HCBS survey, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored below the statewide averages. These findings suggest that although **UPCAP Care Management, Inc.** conducts assessments timely and consistently conducts care coordination according to policies and procedures, members are not generally happy with their care managers. **UPCAP Care Management, Inc.** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **UPCAP Care Management, Inc.** demonstrated a *Substantial* compliance level in the MI Choice Services and Linking and Coordinating focus areas. Additionally, through the PMV, the rate for Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored above the statewide average, although the rate decreased from the prior year's rate. Further, through the CAHPS HCBS survey, **UPCAP Care Management, Inc.**'s rate for the *Transportation to Medical Appointments* domain scored above the statewide average and increased from the prior year. However, through the CQAR, the Follow-Up and Monitoring focus area scored a *Some Compliance, Needs Improvement* compliance level, the Contingency Plan focus area scored a *Not Full or Substantial* compliance level, and the Adverse Benefit Determination focus area scored a *Not Demonstrated* compliance level. Additionally, through the PMV activity, the rates for Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored below the statewide averages, and Performance Measure 15 decreased from the prior year's rate. Further, through the CAHPS HCBS survey, the *Staff are Reliable and Helpful* and *Met Need* domains scored below the statewide averages and decreased from the prior year's rate. These findings suggest that while **UPCAP**

Performance Area	Overall Performance Impact
	Care Management, Inc. generally linked members to services and ensured members received those services, members were not always getting the services they needed. Additionally, **UPCAP Care Management, Inc.** did not consistently ensure members had a contingency plan in place. **UPCAP Care Management, Inc.** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers. As several performance measures related to access to waiver services were below statewide averages, **UPCAP Care Management, Inc.** should review its network and ensure it has enough contracted providers to provide timely waiver services to its membership.

Valley Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-131 displays the PIPs in place during SFY 2022. Table 3-131 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **Valley Area Agency on Aging** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **Valley Area Agency on Aging** did not meet the statewide goal or the *New Goal*. Any interventions described within **Valley Area Agency on Aging**'s QMP reports are also provided in Table 3-131. The results in Table 3-131 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-131—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Falls	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less. *New Goal*: 14.3% or lower	SFY 2021 = 14.3% SFY 2022 = 20.60% ☒
Interventions: • Developed fall and injury educational materials to decrease fall and injury prevalence occurrences amongst **Valley Area Agency on Aging** participants. • Educated **Valley Area Agency on Aging** support coordinators on comprehensive assessments that included detailed fall and injury identification of participants and medication interaction reviews. • Provided **Valley Area Agency on Aging** support coordinators with a resource list of local skilled care agencies to make skilled care referrals as applicable. • Created additional self-determination (SD) education and distribute it to all program participants. • Mailed a fall and injury prevention guide to all active MI Choice waiver participants. • Delivered a power point presentation to the local Quality Collaborative meeting addressing fall prevention. • Encouraged participants to explore physical therapy as a way to become stronger as well as suggesting occupational therapy as a way for plans to put in place to help make a participant's home safer.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Valley Area Agency on Aging**.		

PIP Topic	Goal*	Measurement and Outcome±
Prevalence of Any Injuries	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 3.9% SFY 2022 = 1.70% ☑
Interventions: • Developed fall and injury educational materials to decrease fall and injury prevalence occurrences amongst **Valley Area Agency on Aging** participants. • Educated **Valley Area Agency on Aging** support coordinators on comprehensive assessments that included detailed fall and injury identification of participants and medication interaction reviews. • Provided **Valley Area Agency on Aging** support coordinators with a resource list of local skilled care agencies to make skilled care referrals as applicable. • Created additional SD education and distribute it to all program participants. • Mailed a fall and injury prevention guide to all active MI Choice waiver participants. • Delivered a power point presentation to the local Quality Collaborative meeting addressing fall prevention. • Encouraged participants to explore physical therapy as a way to become stronger as well as suggesting occupational therapy as a way for plans to put in place to help make a participant's home safer.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Valley Area Agency on Aging**.		

* The statewide overall goal for *Prevalence of Falls* was 23 percent and *Prevalence of Any Injuries* was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-132 displays the two PIPs **Valley Area Agency on Aging** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-132 is displayed as reported by **Valley Area Agency on Aging** and was not validated by HSAG.

Table 3-132—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	[Goal not identified.]	Baseline: 0.47% SFY 2023: Not yet reported
Interventions: • Educate supports coordinators to better identify participants who are at risk of falling. • Mailed a fall prevention guide to all active MI Choice waiver participants. • Delivered a power point presentation to the local Quality Collaborative meeting addressing falls. • Encourage participants to explore physical therapy as a way to become stronger as well as suggesting occupational therapy as a way for plans to be put in place to help make a participant's home safer. • **Valley Area Agency on Aging** will also be implementing some evidence-based interventions to help reduce falls such as using the Morse Fall scale and completing Post Assessment Fall surveys to determine how and why the fall might have occurred. Supports Coordinators will be trained and educated on how to use these tools. • Supports coordinators will also be educated on the importance of completing a comprehensive assessment to ensure the data input is accurate and complete.		
PIP Validation Feedback: MDHHS provided the following feedback to **Valley Area Agency on Aging**: • Performance Improvement Projects – Clinical PIP was falls with Injuries. Current QAPI is related to falls, but does not address falls with injuries.		
Self-Determination Participants	Increase Self-Determination participants by 2% or six people.	Baseline: 18% SFY 2023: Not yet reported
Interventions: • **Valley Area Agency on Aging**'s supports coordinators provided education related to the benefits of being on self-determination such as choosing their own caregivers which helps support autonomy. • Social work techs can assist with posting jobs on free jobsites such as Zip Recruiter. • Social work techs can assist with contacting local job corps and reach out to community colleges with employment opportunities. • **Valley Area Agency on Aging** can provide interviewing techniques when choosing caregivers as well as education on terminating employees.		
PIP Validation Feedback: MDHHS did not provide any feedback to **Valley Area Agency on Aging**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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 MDHHS-established goal for the *Prevalence of Any Injuries* PIP. However, while **Valley Area Agency on Aging** reported on interventions that may have reduced the prevalence of falls with injuries, it did not identify interventions that may have contributed to improvement specific to the prevalence of any injuries. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **Valley Area Agency on Aging** did not appear to be effective in improving outcomes as the prevalence rate increased for the *Prevalence of Falls* PIP, and **Valley Area Agency on Aging** did not reach the MDHHS-established goal. **Valley 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 PIP. [**Quality**]

Why the weakness exists: Valley Area Agency on Aging did not conduct a barrier or root cause analysis to determine why the prevalence rate increased for this PIP.

Recommendation: Although **Valley Area Agency on Aging** conducted a qualitative analysis regarding falls with injuries, the PIP was related to all falls, and **Valley Area Agency on Aging** did not conduct a barrier or root cause analysis to determine why the prevalence rate increased for this PIP. 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 also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **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 #2: Valley Area Agency on Aging's PIP results differed from those reported by MDHHS. [**Quality**]

Why the weakness exists: Valley Area Agency on Aging did not document its methodology in its QMP documentation (e.g., the time frames for measurement). As such, it is unclear if **Valley Area Agency on Aging** used the same methodology as MDHHS.

Recommendation: HSAG continues to recommend that **Valley Area Agency on Aging** calculate its results using the same timing as MDHHS to ensure that the results are equivalent. Additionally, HSAG recommends that both **Valley Area Agency on Aging** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **Valley Area Agency on Aging**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **Valley Area Agency on Aging** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **Valley Area Agency on Aging** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The FY 2023 Quality Assurance and Performance Improvement Valley Area Agency on Aging demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **Valley Area Agency on Aging**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **Valley Area Agency on Aging** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Valley Area Agency on Aging** in a methodologically sound manner. HSAG further recommends that **Valley Area Agency on Aging**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **Valley Area Agency on Aging** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **Valley Area Agency on Aging** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **Valley Area Agency on Aging** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-133 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-133 also provides 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. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-133, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-133—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**100%**	**91.67% ↓**	**86.65%**
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	**97.27%**	**90.91% ↓**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**91.67% ↓**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**NA**	**100%**
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	**100%**	**92.16% ↓**	**94.76%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**86.96% ↓**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**90.91%**	**58.33% ↓**	**82.72%**
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	**96.82%**	**89.35% ↓**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**100%**	**90.91% ↓**	**88.74%**
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	**75.00%**	**91.67% ↑**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**100%**	**91.67% ↓**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**16.67%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **Valley Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: Valley Area Agency on Aging received a 100 percent performance rating for Performance Measures 7, 22, 24, and 38, indicating that LOCDs were made by a qualified evaluator; 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**]

Weaknesses and Recommendations

Weakness #1: Valley Area Agency on Aging 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 5.02 percentage points below the statewide rate and a decrease of 8.33 percentage points from **Valley Area Agency on Aging**'s SFY 2021 rate. [**Quality** and **Timeliness**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the 12 applicable records did not demonstrate that the PCSP was developed, evaluated, and updated in accordance with MDHHS policy and contract requirements.

Recommendation: MDHHS did not require **Valley Area Agency on Aging** to submit a CAP to remediate the one deficiency associated with Performance Measure 1. However, HSAG recommends that **Valley Area Agency on Aging** continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #2: Valley Area Agency on Aging performed substantially worse than other waiver agencies on Performance Measure 4, *number and percent of appropriate LOCDs found after MDHHS review*, as indicated by a performance rate of 7.28 percentage points below the statewide rate and a decrease of 8.33 percentage points from **Valley Area Agency on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one of the 12 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 **Valley Area Agency on Aging** to submit a CAP to remediate the one deficiency associated with Performance Measure 4. However, HSAG recommends that **Valley Area Agency on Aging** continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #3: Valley 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 6.23 percentage points below the statewide rate and a decrease of 13.04 percentage points from **Valley Area Agency on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that three of the 12 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. **Valley Area Agency on Aging** reported that there were new staff, resulting in individual staff deficiencies.

Recommendation: While **Valley Area Agency on Aging**'s CAP included individual staff education and monthly record reviews, HSAG recommends that **Valley Area Agency on Aging** consider developing a checklist or other reminder system for supports coordinators to use. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #4: Valley Area Agency on Aging 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 24.39 percentage points below the statewide rate and a decrease of 32.58 percentage points from **Valley Area Agency on Aging**'s SFY 2021 rate. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 of the 12 applicable records did not demonstrate evidence that the PCSP included a process for minimizing risk factors, planning, and supporting the member. **Valley Area Agency on Aging** reported that there were individual staff deficiencies; however, the root cause of the deficiencies was not provided.

Recommendation: While **Valley Area Agency on Aging**'s CAP included individual staff education and monthly record reviews, HSAG recommends that **Valley Area Agency on Aging** consider system prompts or other workflows that trigger the supports coordinator to update the PCSP. Additionally, **Valley Area Agency on Aging** could consider developing system prompts or mandating a required field to ensure supports coordinators consistently document information within the system related to risk factors, planning, and supporting the member. Further, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Weakness #5: Valley 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 26 percentage points below the statewide rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 of the 12 applicable records did not demonstrate evidence that the member's record contained a complete and up-to-date contingency plan. While **Valley Area Agency on Aging** reported that the waiver agency process was reviewed, no root cause was provided.

Recommendation: While **Valley Area Agency on Aging**'s CAP included individual staff education and monthly record reviews, HSAG recommends that **Valley Area Agency on Aging** consider developing a checklist or other reminder system for supports coordinators to use and ensuring that chart reviews include this requirement. Additionally, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-134 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 interviews. Table 3-134 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-134—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	96.30%	100%	**4.00**	4.00
Focus 2	Freedom of Choice	91.67%		**4.00**	2.00
Focus 3	Release of Information	100%		**4.00**	3.00
Focus 4	Status	87.50%		**3.00**	4.00
Focus 5	Pre-Planning	99.07%	100%	**4.00**	4.00
Focus 6	Assessment	94.44%	97.22%	**4.00**	4.00
Focus 7	Medication Record	79.41%	100%	**2.67**	4.00
Focus 8	Person-Centered Service Planning	83.33%	100%	**3.33**	4.00
Focus 9	MI Choice Services	91.43%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	89.66%	100%	**3.33**	4.00
Focus 11	Follow-Up and Monitoring	62.50%	100%	**2.00**	3.35
Focus 12	Service Provider	100%		**4.00**	4.00
Focus 13	Contingency Plan	62.07%	100%	**2.00**	4.00
Focus 14	Critical Incidents	62.50%	100%	**2.00**	2.71

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	75.00%		**3.00**	4.00
Focus 16	Complaints and Grievances	0.00%		**1.00**	4.00
Focus 17	Home and Community Based		NA	**NA**	4.00
	Totals	**87.24%**	**99.65%**	**3.39**	3.89

Indicates the standard was not reviewed as part of the record review or home visit.
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: Valley Area Agency on Aging achieved a substantial compliance rating in nine of the applicable 16 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were 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 Follow-Up and Monitoring requirements; specifically, contacting members for follow-up and monitoring as specified in the member's PCSP and ensuring service delivery in accordance with MDHHS policy

and contract requirements, including the use of the member's backup plan or an 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. **Valley Area Agency on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that eight out of 12 applicable records did not include evidence that the waiver agency contacted the member/guardian for follow-up and monitoring as specified in the PCSP, and one out of 10 applicable records did not demonstrate evidence that the supports coordinator ensured service delivery in accordance with MDHHS policy and contract requirements, including the use of the member's backup plan or out-of-network provider. **Valley Area Agency on Aging** reported that addendums were entered incorrectly.

Recommendation: One of the deficiencies was not identified as a citation and the other was a new citation. As such, HSAG recommends that **Valley Area Agency on Aging** continue to implement its CAP of conducting staff education and ensure that remediation efforts are put in place for the deficiency not requiring a CAP. However, if improvement is not realized, **Valley Area Agency on Aging** should modify its CAP and remediation efforts and implement alternative interventions.

Weakness #2: Valley Area Agency on Aging did not consistently follow all Contingency Plan requirements; specifically, ensuring there is a complete and up-to-date contingency plan and ensuring that the member/guardian received a copy of the contingency plan. Contingency plans are important to ensure that if the member's PCSP services are unavailable, the member will still have services in place until planned services can resume. **Valley Area Agency on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that 10 out of 12 applicable records did not demonstrate evidence that the record contained a complete and up-to-date contingency plan, and one out of 12 applicable records did not demonstrate evidence that the member/guardian received a copy of the contingency plan. **Valley Area Agency on Aging** reported that this was a waiver agency process issue.

Recommendation: One of the two deficiencies was not identified as a citation by MPHI; however, the other deficiency was documented as a new citation. As such, HSAG recommends that **Valley Area Agency on Aging** continue to implement its CAP to conduct staff education. HSAG also recommends that **Valley Area Agency on Aging** ensure remediation of the deficiency that did not require a CAP. If improvement is not realized, **Valley Area Agency on Aging** should modify its CAP and/or implement additional remediation plans and alternative interventions.

Weakness #3: Valley Area Agency on Aging did not consistently follow all Critical Incident 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. **Valley Area Agency on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Full or Substantial* compliance level compared to a *Some Compliance, Needs Improvement* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that one out of two applicable records did not demonstrate evidence that the supports coordinator addressed the incident with the member/guardian; one out of two 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 one out of two 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. **Valley Area Agency on Aging** reported that an individual supports coordinator failed to recognize and enter a critical incident.

Recommendation: MDHHS required **Valley Area Agency on Aging** to submit a CAP to remediate the deficiencies. However, one of the three deficiencies has been noted as noncompliant for the past three years; therefore, **Valley Area Agency on Aging**'s interventions have not led to performance improvement. HSAG recommends that **Valley Area Agency on Aging** update its CAP to include interventions other than staff education. For example, **Valley Area Agency on Aging** could develop a critical incident template that must be completed by the supports coordinator for every incident. This template should include all required tasks that must be completed when a critical incident occurs. Management could review the templates as they are completed to immediately address any gaps with the supports coordinator in real time.

Weakness #4: Valley Area Agency on Aging did not consistently follow all Complaints and Grievances requirements; specifically, validating the member/guardian was made aware of the resolution of complaints or grievances as warranted. It is important that members/guardians are made aware of any complaints or grievances filed on their behalf to ensure that the member can be advised of the resolution of the complaint/grievance. **Valley Area Agency on Aging** also demonstrated a decline in performance compared to the prior year; specifically, the waiver agency received a *Not Demonstrated* compliance level compared to a *Substantial* compliance level received during the prior year. [**Quality**]

Why the weakness exists: Through the CQAR, MPHI determined that the one applicable record did not demonstrate evidence that the member/guardian was made aware of the resolution of complaints or grievances as warranted. **Valley Area Agency on Aging** reported that an individual supports coordinator failed to document the member's complaint.

Recommendation: As this was a new citation, HSAG recommends that **Valley Area Agency on Aging** continue to implement its CAP of conducting staff education. However, if improvement is not realized, **Valley Area Agency on Aging** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **Valley Area Agency on Aging** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Valley Area Agency on Aging**'s original questionnaire responses, and **Valley Area Agency on Aging** responded to these specific questions. To support its questionnaire responses, **Valley Area Agency on Aging** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Valley Area Agency on Aging** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-135 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-135—EDV Results for Valley Area Agency on Aging

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Valley Area Agency on Aging** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **Valley Area Agency on Aging** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **Valley Area Agency on Aging** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **Valley Area Agency on Aging** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **Valley Area Agency on Aging** utilizes line-by-line method for its claim payment strategies. • **Valley Area Agency on Aging**, with CIM as its subcontractor, collects TPL data during financial

Analysis	Key Findings
	eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **Valley Area Agency on Aging** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **Valley Area Agency on Aging** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **Valley Area Agency on Aging**'s encounters, **Valley Area Agency on Aging** indicated that it did not store data sent to MDHHS. • **Valley Area Agency on Aging** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **Valley Area Agency on Aging** displayed consistent encounter volume for professional encounters throughout the measurement year. • **Valley Area Agency on Aging** had a low volume of duplicate encounters, with 0.4 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **Valley Area Agency on Aging** demonstrated timely submission for professional encounters. Within 30 days, **Valley Area Agency on Aging** submitted 97.0 percent of professional encounters to MDHHS after the payment date, and within 60 days of the payment date, **Valley Area Agency on Aging** submitted 99.7 percent of professional encounters to MDHHS. Within 120 days, **Valley Area Agency on Aging** submitted 99.8 percent of professional encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• In **Valley Area Agency on Aging**'s submitted professional encounters, the billing provider NPI was populated 15.1 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **Valley Area Agency on Aging**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Valley Area Agency on Aging**'s submitted data, 99.6 percent were identified in the enrollment data.

Analysis	Key Findings
	• Of all identified provider NPIs in **Valley Area Agency on Aging**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Valley Area Agency on Aging**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Valley Area Agency on Aging demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Valley Area Agency on Aging submitted professional encounters in a timely manner from the payment date, with 99.7 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **Valley Area Agency on Aging** were populated at high rates, and most data elements were greater than 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Valley Area Agency on Aging indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Valley Area Agency on Aging**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **Valley Area Agency on Aging**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Valley Area Agency on Aging reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: Valley Area Agency on Aging appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: Valley Area Agency on Aging should consider enhancing its data management practices. HSAG recommends that **Valley Area Agency on Aging** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 15.1 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: Valley Area Agency on Aging should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-136 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 3-136 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-136—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	90.9%	89.8%	91.8%
Recommendation Measures	92.3%	88.0%	92.1%
Staff are Reliable and Helpful	91.7%	90.4%	92.1%
Staff Listen and Communicate Well	95.2%	91.1%	94.6%
Case Manager is Helpful	88.4%	100% ↑	95.8%
Choosing the Services that Matter to You	92.0%	86.3% ↓	90.8%
Transportation to Medical Appointments	94.8%	89.1% ↓	92.4%
Personal Safety and Respect	95.8%	95.8%	97.4%
Planning Your Time and Activities	72.9%	77.9% ↑	78.5%
Met Need	94.4%	91.9%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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 a score higher than the statewide result in the *Case Manager is Helpful* domain, indicating that **Valley Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in this domain. **Valley Area Agency on Aging** also demonstrated improvement in rates across two measures, with one measure rate, *Case Manager is Helpful*, increasing by 5 percentage points or more. [**Quality**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Valley 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.

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, **Valley Area Agency on Aging** 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*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains; therefore, HSAG recommends that **Valley Area Agency on Aging** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction scores within these domains, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **Valley Area Agency on Aging** did not score more than 5 percentage points below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **Valley Area Agency on Aging** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **Valley Area Agency on Aging**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **Valley Area Agency on Aging** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Valley Area Agency on Aging**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-137 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Valley Area Agency on Aging**'s MI Choice members.

Table 3-137—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **Valley Area Agency on Aging** demonstrated through Performance Measure 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*, that it ensured the health and safety of members by providing information on critical incidents. Additionally, through the CAHPS HCBS survey, **Valley Area Agency on Aging** showed a strong focus on member health and safety through a high rating in the *Physical Safety Measure* domain. Further, through the PIP activity, **Valley Area Agency on Aging**'s rate for the *Prevalence of Any Injuries* PIP met the statewide goal and decreased from the prior year. However, **Valley Area Agency on Aging**'s *Prevalence of Falls* rate did not meet the waiver agency's goal and increased over the prior year's rate, indicating the interventions implemented were not effective in maintaining the **Valley Area Agency on Aging**'s previous performance. Additionally, through the CQAR activity, **Valley Area Agency on Aging** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. Further, through the PMV activity, the rate for Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, fell below the statewide average and decreased from the prior year's rate. Lastly, through the CAHPS HCBS activity, the rate for the *Personal Safety and Respect* domain fell below the statewide average. These findings could imply that while **Valley Area Agency on Aging** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments and does not consistently report, investigate, and follow up on critical incidents. HSAG recommends that **Valley Area Agency on Aging** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.

Performance Area	Overall Performance Impact
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **Valley Area Agency on Aging** demonstrated high performance in ensuring appropriate and timely person-centered service planning. Additionally, through the CAHPS HCBS survey, the rate for the *Case Manager is Helpful* domain scored above the statewide average and increased over the prior year's rate. However, the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, and *Choosing the Services that Matter to You* domains scored below the statewide averages. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, scored below the statewide averages and decreased from the prior year's rates. These findings suggest that although **Valley Area Agency on Aging** conducts assessments timely and members find case managers to be helpful, members are not generally satisfied with their case managers, and **Valley Area Agency on Aging** does not consistently conduct care coordination according to policies and procedures. **Valley Area Agency on Aging** should review all measures falling below thresholds related to care coordination to identify barriers and develop appropriate interventions to address the barriers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **Valley Area Agency on Aging** demonstrated a *Substantial* compliance level in the MI Choice Services and Linking and Coordinating focus areas. Additionally, through the PMV, the rate for Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored above the statewide average. However, through the CQAR, the Follow-Up and Monitoring and Contingency Plan focus areas scored a *Not Full or Substantial* compliance level. Additionally, through the PMV activity, the rates for Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored below the statewide averages, and Performance Measure 15 decreased from the prior year's rate. Further, through the CAHPS HCBS survey, the *Staff are Reliable and Helpful*, *Transportation to Medical Appointments*, and *Met Need* domains scored below the statewide averages and decreased from the prior year's rates. These findings suggest that while **Valley Area Agency on Aging** generally linked members to services and ensured members received those services, members were not always getting the services they needed. Additionally, **Valley Area Agency on Aging** did not consistently ensure members had a contingency plan in place. **Valley Area Agency on Aging** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers.

Performance Area	Overall Performance Impact
	As several performance measures related to access to waiver services were below statewide averages, **Valley Area Agency on Aging** should review its network and ensure it has enough contracted providers to provide timely waiver services to its membership.

WellWise Services Area Agency on Aging

Validation of Performance Improvement Projects

Performance Results

Table 3-138 displays the PIPs in place during SFY 2022. Table 3-138 includes the SFY 2021 baseline rate and the results for each PIP for SFY 2022. MDHHS calculated the baseline rate based on the first half of SFY 2021 and the results for SFY 2022 based on the first half of SFY 2022. For each PIP, the topic, goal, and measurement and outcome are identified. If a waiver agency met the statewide goal during the baseline measurement period, MDHHS required the waiver agency to meet or exceed its current rate, which is identified in the table as *New Goal*. The outcome for each PIP is designated with a check mark (☑), signifying that **WellWise Services Area Agency on Aging** met the statewide goal or the *New Goal*, or with an x mark (☒), signifying that **WellWise Services Area Agency on Aging** did not meet the statewide goal or the *New Goal*. Any interventions described within **WellWise Services Area Agency on Aging**'s QMP reports are also provided in Table 3-138. The results in Table 3-138 are displayed as reported by MDHHS and were not validated by HSAG.

Table 3-138—2022 PIP Results

PIP Topic	Goal*	Measurement and Outcome±
• *Prevalence of Falls*	Reduce the prevalence of falls to an agency wide percentage of 23% (statewide goal) or less.	SFY 2021 = 27.0% SFY 2022 = 21.90% ☑
Interventions: • Supports coordinators were educated on fall prevention strategies and resources to discuss with participants. • Supports coordinators met with **WellWise Services Area Agency on Aging** team leads to review cases with falls to discuss preventative measures. • Supports coordinators were encouraged to include fall prevention strategies in the PCSP when appropriate and preferred by the participant. • Supports coordinators were also educated on appropriate coding of iHC questions to reduce coding errors.		
PIP Validation Feedback: MDHHS provided the following feedback to **WellWise Services Area Agency on Aging**: • The Statewide goal for falls is 23% or lower Your QI goal would not meet the statewide goals. Current goal in the Quality Management plan was listed as: ○ Goal and objective: MI Choice Waiver participants reporting falls will be reduced by 5% or below during FY 2022 and 2023. For FY 2021, Region 2 participants reported falls on average 34.02% of the time.		
• *Prevalence of Any Injuries*	Reduce the prevalence of any injury to an agency wide percentage of 3% (statewide goal) or less.	SFY 2021 = 5.0% SFY 2022 = 5.60% ☒
Interventions: • Staff were trained on how to answer and document correctly.		

PIP Topic	Goal*	Measurement and Outcome±
• In-home safety evaluations were resumed to assist in decreasing injuries related to falls.		
PIP Validation Feedback: MDHHS provided the following feedback to **WellWise Services Area Agency on Aging**: • The Statewide goal for Prevalence of any Injuries is below 3.0% of the waiver agency's participants. Your QI goal would not meet the statewide goal. Current goal in the Quality Management plan were listed as: ○ Goal and objective: MI Choice Waiver participants reporting injuries will be at or below 4% of all Waiver participants. For FY 2021, Region 2 Waiver participants reported injuries on an average 6.45 % of all Waiver reassessments.		

*The statewide overall goal for Prevalence of Falls was 23 percent and Prevalence of Any Injuries was 3 percent. If the individual waiver agency was already meeting the goal, its *New Goal* was lowered by MDHHS to support further improvement. Note that the goals and outcomes rates displayed in the table may not match what was reported by the waiver agency within the QMP as MDHHS instructed HSAG to use the rates calculated by MDHHS.

±The SFY 2021 and SFY 2022 rates were calculated using only the first six months of each respective state fiscal year.

☑ Waiver agency met the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

☒ Waiver agency did not meet the statewide goal or the *New Goal*, determined if the agency was already meeting the statewide goal.

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.

PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

While the SFY 2022 PIPs continue to be monitored as quality indicators though each waiver agency's QMP, MDHHS elected to retire these PIPs and implement new PIPs for SFY 2023. Table 3-139 displays the two PIPs **WellWise Services Area Agency on Aging** implemented in SFY 2023. MDHHS mandated the use of *Falls with Injury* for the clinical PIP, and waiver agencies chose their own nonclinical PIP topics. As these PIPs are currently in year one of the PIP cycle, only the baseline and planned interventions of the PIPs are included in the table. Future EQR technical reports will include the results of the PIPs. The information in Table 3-139 is displayed as reported by **WellWise Services Area Agency on Aging** and was not validated by HSAG.

Table 3-139—2023 PIP Design

PIP Topic	Goal	Measurement and Outcome
Falls with Injury	Remain at or below 2% for falls with injury.	Baseline: 0.42% SFY 2023: Not yet reported
Interventions: • **WellWise Services Area Agency on Aging** will continue to offer and advertise Matter of Balance workshops, an evidence-based program developed by Boston University and MainHealth to reduce fall incidents in people over 60 years old.		
PIP Validation Feedback: MDHHS provided the following feedback to **WellWise Services Area Agency on Aging**: • Clinical PIP Falls with Injury with clinical PIP currently in QAPI listed as prevalence of falls.		
Residential Care Agreements	Reach 100% compliance regarding having up-to-date Residential Care Agreements by 10/01/2023.	Baseline: 8.20% SFY 2023: Not yet reported

PIP Topic	Goal	Measurement and Outcome
Interventions: • Require supports coordinators to obtain a copy of Residential Care Agreements annually.		
PIP Validation Feedback: MDHHS did not provide any feedback to **WellWise Services Area Agency on Aging**.		

Interventions as written by the waiver agency via the QMP reports with only minor edits made by HSAG.
PIP Validation Feedback as written by MDHHS with only minor edits made by HSAG.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP 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: WellWise Services Area Agency on Aging met the MDHHS-established goal for the *Prevalence of Falls* PIP. The reduction in prevalence rate for this PIP was attributed to the interventions implemented focused on equipping supports coordinators to assess for and address fall risks as reported by the waiver agency. [**Quality**]

Weaknesses and Recommendations

Weakness #1: The interventions implemented by **WellWise Services Area Agency on Aging** did not appear to be effective in improving outcomes as the prevalence rate increased for the *Prevalence of Any Injuries* PIP, and **WellWise Services Area Agency on Aging** did not reach the MDHHS-established goal. **WellWise Services 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 PIP. [**Quality**]

Why the weakness exists: WellWise Services Area Agency on Aging cited limitations of the reporting system as a major barrier to achieving the PIP goal.

Recommendation: HSAG recommends that **WellWise Services Area Agency on Aging** work with MDHHS to identify and mitigate any issues with the software system. HSAG also recommends that **WellWise Services 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). **WellWise Services Area Agency on Aging** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions and should address these barriers to improve outcomes. Further, **WellWise Services Area Agency on Aging** should analyze and interpret results at multiple

points in time and test for statistical significance. Finally, **WellWise Services 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 #2: WellWise Services Area Agency on Aging's SFY 2022 PIP results only included six months of data. [**Quality**]

Why the weakness exists: While **WellWise Services Area Agency on Aging**'s results matched MDHHS' results, MDHHS only used quarters 1 and 2 of the year for the baseline and remeasurement periods. Therefore, **WellWise Services Area Agency on Aging** also only used a six-month remeasurement period and not the entire state fiscal year.

Recommendation: HSAG continues to recommend that both **WellWise Services Area Agency on Aging** and MDHHS use the full state fiscal year to calculate results to ensure interventions can be developed to address falls across different seasons (e.g., a member may need assistive devices during the icy months, but not during warmer weather).

Weakness #3: The documentation pertaining to **WellWise Services Area Agency on Aging**'s PIP did not include all details of the design, implementation, and outcomes stages of each PIP to assure that **WellWise Services Area Agency on Aging** is conducting a comprehensive and formal PIP process that is methodologically sound. These PIP details are necessary for MDHHS to conduct a formal validation of each PIP that meets the requirements of CMS EQR Protocol 1.

Why the weakness exists: The SFY 2022–2023 QMP and SFY 2022 annual report included limited details on the design developed and the methodology followed by **WellWise Services Area Agency on Aging** when implementing its *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs. The Region 2 Area Agency on Aging Quality Assurance Program Improvement FY 2023 and 2024 demonstrated some improvement in the design of the new SFY 2023 PIPs. However, **WellWise Services Area Agency on Aging**'s PIPs did not align with all review elements identified in CMS EQR Protocol 8 and the corresponding worksheets.

Recommendation: HSAG recommends that **WellWise Services Area Agency on Aging** follow the CMS EQR Protocols, specifically CMS EQR Protocol 8 when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **WellWise Services Area Agency on Aging** in a methodologically sound manner. HSAG further recommends that **WellWise Services Area Agency on Aging**'s documentation of each PIP correlates with all elements outlined in Worksheet 1.1 through Worksheet 1.9 referenced in CMS EQR Protocol 1 and CMS EQR Protocol 8. **WellWise Services Area Agency on Aging** should use the worksheets to create a checklist; for example, adding a column to each worksheet for **WellWise Services Area Agency on Aging** to document how its PIP meets the requirement of the review element. This checklist could be used throughout the lifecycle of the PIP and be updated periodically as the PIP progresses. Further, **WellWise Services Area Agency on Aging** could provide the completed checklist to MDHHS annually for its PIP validation process.

Performance Measure Validation

Performance Results

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 16 of the 39 performance measures. Table 3-140 displays the 16 performance measures and CQAR standards that determine the statewide percentage rate. Table 3-140 also provides the statewide percentage rates as calculated by MDHHS for the CMS-372 report, and **WellWise Services Area Agency on Aging**'s percentage rate for each performance area that was calculated by HSAG to provide a comparison to the statewide average. Performance rates shaded in green indicate that performance is equal to or better than the statewide rate, while performance rates shaded in red indicate that performance is worse than the statewide rate. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓. Performance measures calculated from non-CQAR related sources (23 of the 39 performance measures) are not displayed in Table 3-140, as only statewide rates were calculated by MDHHS and made available to HSAG.

Table 3-140—Waiver Agency Impact to Statewide Performance Measure Rates

Performance Measures and Applicable CQAR Standards*		2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % Rate*
1‡	*Number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS.* 8.1	**88.89%**	**88.89%**	**86.65%**
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	**94.20%**	**97.28%**	**93.72%**
4	*Number and percent of appropriate LOCDs found after MDHHS review.* 1.3	**100%**	**100%**	**98.95%**
7	*Number and percent of LOCDs made by a qualified evaluator.* 1.4	**100%**	**100%**	**100%**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* 1.1	**100%**	**100%**	**100%**
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	**94.44%**	**93.24%**	**94.76%**

	Performance Measures and Applicable CQAR Standards*	2021 Waiver Agency % Rate**	2022 Waiver Agency % Rate†	2022 CMS-372 Statewide % 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	**100%**	**97.22%**	**93.19%**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.* 8.2, 8.5	**91.67%**	**83.33% ↓**	**82.72%**
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	**95.44%**	**93.74%**	**91.10%**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.* 8.1, 9.5	**94.29%**	**90.91%**	**88.74%**
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	**95.83%**	**80.00% ↓**	**90.31%**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.* 9.4	**100%**	**100%**	**89.27%**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* 5.11	**100%**	**100%**	**100%**
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	**100%**	**100%**	**100%**
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	**—**	**61.11%**	**42.67%**
38	*Number and percent of service plans that supported paid services.* 9.3	**100%**	**100%**	**99.48%**

* Statewide percentage rates are displayed as reported by MDHHS.

** 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.

† The individual waiver agency performance measure rates calculated by HSAG were derived from the FY 2022 CQAR Record Review Final Agency Results Report, 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.

‡ Performance Measure 1 in the SFY 2021 External Quality Review Technical Report for the MI Choice Waiver Program rates were calculated based on the CQAR results that included the elements that made up the performance measure as indicated in the FY 2021 Performance Measures.01272022 spreadsheet provided by MDHHS. However, based on information later provided by MDHHS, the rates should have been calculated using the CQAR elements identified in the CMS-372 report. As such, HSAG revised the performance measure rates for this 2022–2023 External Quality Review Technical Report for the MI Choice Waiver Program.

— The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, the SFY 2021 rate is not displayed, and HSAG did not compare the SFY 2021 rate to the SFY 2022 rate.

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's rate.

NA Indicates the waiver agency did not have any records that were applicable for the performance measure.

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: Although MDHHS has not established performance measure benchmarks, **WellWise Services Area Agency on Aging**'s overall performance helped MDHHS and the MI Choice Waiver Program achieve a rate of 100 percent in numerous performance measures that demonstrate the waiver program's efforts to support the quality, access, and timeliness of services being provided to the MI Choice Waiver Program members. These included Performance Measures 3, 5, 6, 10, 11, 12, 13, 27, 28, 29, 31, 33, 34, 36, 37, and 39. [**Quality** and **Timeliness**]

Strength #2: WellWise Services Area Agency on Aging received a 100 percent performance rating for Performance Measures 4, 7, 8, 21, 22, 24, and 38, indicating that LOCDs were made appropriately; LOCDs were made by a qualified evaluator; LOC criteria were accurately applied; 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**]

Weaknesses and Recommendations

Weakness #1: WellWise Services 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 10.31 percentage points below the statewide rate and a decrease of 15.83 percentage points from **WellWise Services Area Agency on Aging**'s SFY 2021 rate. [**Quality** and **Access**]

Why the weakness exists: Through the CQAR, MPHI determined that five of the 15 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. **WellWise Services Area Agency on Aging** reported that the root cause of the findings were related to individual supports coordinator errors.

Recommendation: While **WellWise Services Area Agency on Aging**'s CAP included staff education and monthly audits, HSAG recommends that the waiver agency continue to identify root causes of noncompliance, develop interventions to improve performance, and evaluate the effectiveness of interventions on an ongoing basis.

Compliance Review

Performance Results

Table 3-141 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 interviews. Table 3-141 also identifies the 2022 compliance level for each standard assigned by MPHI and included as part of the MI Choice Clinical Quality Assurance Review Final Agency Compliance Determination, and the compliance level assigned to each standard in 2021 to show a comparison of performance over time. The overall level 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 compliance level.

Table 3-141—CQARs and Overall Compliance Level

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 1	Level of Care Determination	100%	100%	**4.00**	3.33
Focus 2	Freedom of Choice	88.89%		**3.00**	1.00
Focus 3	Release of Information	94.44%		**4.00**	4.00
Focus 4	Status	100%		**4.00**	4.00
Focus 5	Pre-Planning	98.73%	100%	**4.00**	4.00
Focus 6	Assessment	95.06%	100%	**4.00**	4.00
Focus 7	Medication Record	83.33%	100%	**3.33**	4.00
Focus 8	Person-Centered Service Planning	93.08%	100%	**4.00**	4.00
Focus 9	MI Choice Services	94.29%	100%	**4.00**	4.00
Focus 10	Linking and Coordinating	95.00%	96.00%	**4.00**	4.00
Focus 11	Follow-Up and Monitoring	83.72%	100%	**3.33**	4.00
Focus 12	Service Provider	90.00%		**4.00**	4.00
Focus 13	Contingency Plan	77.78%	100%	**3.33**	4.00
Focus 14	Critical Incidents	75.00%	100%	**2.00**	NA

Standard		2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Compliance Level	2021 MDHHS Compliance Level
Focus 15	Adverse Benefit Determination	90.48%		**4.00**	4.00
Focus 16	Complaints and Grievances	100%		**4.00**	4.00
Focus 17	Home and Community Based		100%	**4.00**	NA
	Totals	**92.80%**	**99.77%**	**3.80**	3.95

Indicates the standard was not reviewed as part of the record review or home visit.
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: WellWise Services Area Agency on Aging achieved a substantial compliance rating in 15 of the 17 record review standards reviewed as part of the CQAR. The purpose of the record review 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 to each member; therefore, CQAR findings suggested that PCSPs and service delivery were being implemented in accordance with many State and federal requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: WellWise Services Area Agency on Aging did not consistently follow all Critical Incident requirements; specifically, 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 out of three 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 out of three 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. **WellWise Services Area Agency on Aging** reported that its procedure document was outdated.

Recommendation: As these were new citations, HSAG recommends that **WellWise Services Area Agency on Aging** continue to implement its CAP of conducting staff education and updating the procedure. However, if improvement is not realized, **WellWise Services Area Agency on Aging** should modify its CAP and implement alternative interventions.

Encounter Data Validation

Performance Results

Representatives from **WellWise Services Area Agency on Aging** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **WellWise Services Area Agency on Aging**'s original questionnaire responses, and **WellWise Services Area Agency on Aging** responded to these specific questions. To support its questionnaire responses, **WellWise Services Area Agency on Aging** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **WellWise Services Area Agency on Aging** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-142 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-142—EDV Results for WellWise Services Area Agency on Aging

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **WellWise Services Area Agency on Aging** uses Compass as its primary software for claim adjudication and encounter preparation. It uses CIM as its subcontractor for maintaining the database utilized for data input. • **WellWise Services Area Agency on Aging** has established procedures for detecting and identifying duplicate claims. Additionally, it highlighted that denied claims are not submitted to MDHHS. In cases requiring adjustments, **WellWise Services Area Agency on Aging** explained that the system automatically addresses these claims by categorizing them as replacement or void claims. • **WellWise Services Area Agency on Aging** indicated that its subcontractor, CIM, manages both provider data and enrollment data. Additionally, CIM offers software solutions to ensure data quality.
Payment Structures	• **WellWise Services Area Agency on Aging** utilizes line-by-line method for its claim payment strategies. • **WellWise Services Area Agency on Aging**, with CIM as its subcontractor, collects TPL data during financial eligibility assessments. Insurance details are reviewed in CHAMPS, and if another insurance covers waiver services, **WellWise Services Area Agency on Aging** does not bill. Limited TPL data, mostly Medicare information, is entered into the software, but TPL is not reported in **WellWise Services Area Agency on Aging** encounters.
Encounter Data Quality Monitoring	• While CIM facilitated the collection and processing of **WellWise Services Area Agency on Aging**'s encounters, **WellWise Services Area Agency on Aging** indicated that it did not store data sent to MDHHS. • **WellWise Services Area Agency on Aging** and/or its subcontractors conducted the field-level completeness and validity on encounter data collected by the subcontractors.
Administrative Profile	
Encounter Data Completeness	• **WellWise Services Area Agency on Aging** displayed consistent encounter volume for professional encounters throughout the measurement year.

Analysis	Key Findings
	• **WellWise Services Area Agency on Aging** had a low volume of duplicate encounters, with 1.6 percent of professional encounters identified as duplicative.
Encounter Data Timeliness	• **WellWise Services Area Agency on Aging** demonstrated timely submission for professional encounters. Within 60 days, **WellWise Services Area Agency on Aging** submitted greater than 99.9 percent of professional encounters to MDHHS after the payment date. Within 120 days, **WellWise Services Area Agency on Aging** submitted 100 percent of encounters to MDHHS.
Field-Level Completeness and Accuracy	• In **WellWise Services Area Agency on Aging**'s submitted professional encounters, the billing provider NPI was populated 7.2 percent of the time, and the rendering provider NPI was populated 0 percent of the time. • All other data elements in **WellWise Services Area Agency on Aging**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **WellWise Services Area Agency on Aging**'s submitted data, 99.2 percent were identified in the enrollment data. • Of all identified provider NPIs in **WellWise Services Area Agency on Aging**'s submitted data, 100 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **WellWise Services Area Agency on Aging**.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: WellWise Services Area Agency on Aging demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The waiver agency has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: WellWise Services Area Agency on Aging submitted professional encounters in a timely manner from the payment date, with greater than 99.9 percent of encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all professional encounters, most key data elements for **WellWise Services Area Agency on Aging** were populated at high rates, and most data elements were over 99.9 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: WellWise Services Area Agency on Aging indicated that it did not store data managed and sent to MDHHS by CIM. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **WellWise Services Area Agency on Aging**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support **WellWise Services Area Agency on Aging**'s overall capabilities, it should consider storing its subcontractors' encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: WellWise Services Area Agency on Aging reported only conducting the field-level completeness and validity quality checks for its claims and encounters. [**Quality**]

Why the weakness exists: WellWise Services Area Agency on Aging appears to have limited scope of its quality checks, focusing solely on the field-level completeness and validity of claims and encounters.

Recommendation: WellWise Services Area Agency on Aging should consider enhancing its data management practices. HSAG recommends that **WellWise Services Area Agency on Aging** introduce additional checks, particularly monthly claim volume submission checks, to ensure alignment with expected volumes and timeliness checks to verify compliance with State or contractual deadlines. Implementing a comprehensive set of quality checks will contribute to a more robust data validation process, promoting accuracy, completeness, and adherence to submission timelines.

Weakness #3: Although not required to be populated, 7.2 percent of professional encounters contained a billing provider NPI and 0 percent contained a rendering provider NPI. [**Quality**]

Why the weakness exists: Billing and rendering provider information is important for proper provider identification.

Recommendation: WellWise Services Area Agency on Aging should determine the completeness of key provider data elements by implementing quality checks to ensure these fields are populated.

Consumer Assessment of Healthcare Providers and Systems Survey

Performance Results

In 2022, CAHPS HCBS surveys were conducted which asked waiver members to report on and evaluate their experiences with their waiver services and providers. Table 3-143 presents **WellWise Services 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 3-143 also includes the 2021 waiver agency score for each domain to show a comparison of performance over time. Performance rates scoring 5 percentage points or more above the waiver agency's prior year's rate are denoted with a ↑. Performance rates scoring 5 percentage points or more below the waiver agency's prior year's rate are denoted with a ↓.

Table 3-143—CAHPS Domain Scores

Domain	2021 Waiver Agency Score	2022 Waiver Agency Score	2022 Statewide Average Score
Global Ratings Measures	92.3%	94.9%	91.8%
Recommendation Measures	94.3%	96.6%	92.1%
Staff are Reliable and Helpful	92.9%	94.6%	92.1%
Staff Listen and Communicate Well	94.6%	97.1%	94.6%
Case Manager is Helpful	99.1%	97.7%	95.8%
Choosing the Services that Matter to You	95.1%	95.4%	90.8%
Transportation to Medical Appointments	93.7%	93.7%	92.4%
Personal Safety and Respect	98.4%	98.4%	97.4%
Planning Your Time and Activities	79.3%	78.8%	78.5%
Met Need	96.6%	91.8%	93.0%
Physical Safety Measure	100%	100%	100%

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

Indicates the performance measure rate is equal to or higher than the statewide rate.

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

↑ Indicates the performance measure rate is 5 percentage points above the waiver agency's prior year's rate.

↓ Indicates the performance measure rate is 5 percentage points below the waiver agency's prior year's 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: WellWise Services Area Agency on Aging achieved scores higher than the statewide results in the following domains: *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*, and *Planning Your Time and Activities*, indicating that **WellWise Services Area Agency on Aging** provides services in a manner that meets or exceeds members' expectations in many domains. **WellWise Services Area Agency on Aging** also demonstrated improvement in rates across several measures. [**Quality** and **Access**]

Strength #2: The *Physical Safety Measure* domain received the highest statewide rate at 100 percent across all waiver agencies. This demonstrates a strong focus on the physical safety of members when in the care of waiver agency staff. [**Quality**]

Weaknesses and Recommendations

Weakness #1: WellWise Services 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.

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, **WellWise Services Area Agency on Aging** scored below the statewide average on the *Met Need* domain; therefore, HSAG recommends that **WellWise Services Area Agency on Aging** review the results of all consumer satisfaction survey questions to determine if any questions contributed to the low satisfaction score within this domain, develop interventions to improve, and evaluate the results of the interventions regularly, making changes as necessary. Additionally, although **WellWise Services Area Agency on Aging** did not score below the statewide average on the *Planning Your Time and Activities* domain, this domain received the lowest statewide average score compared to all domains. As such, **WellWise Services Area Agency on Aging** should prioritize improvement efforts on questions within this domain that received low scores.

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

HSAG performed a comprehensive assessment of **WellWise Services Area Agency on Aging**'s aggregated performance and its overall strengths and weaknesses related to the provision of waiver services to identify common themes within **WellWise Services Area Agency on Aging** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **WellWise Services Area Agency on Aging**'s overall performance contributed to the MI Choice Waiver Program's progress in achieving the CQS goals and objectives. Table 3-144 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **WellWise Services Area Agency on Aging**'s MI Choice members.

Table 3-144—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health and Safety	**Quality** and **Timeliness**—By collecting performance measure data to support the delivery of the CMS-372 report, MDHHS is able to assess the quality, timeliness, and availability of care and services provided to the MI Choice waiver members across all waiver agencies. **WellWise Services Area Agency on Aging** demonstrated through Performance Measure 16, *number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks*, and Performance Measure 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*, that it ensured the health and safety of members by mitigating risks for members and providing information on critical incidents. Additionally, through the CAHPS HCBS survey, **WellWise Services Area Agency on Aging** showed a strong focus on member health and safety through high ratings in the *Personal Safety and Respect* and *Physical Safety Measure* domains. Further, through the PIP activity, **WellWise Services Area Agency on Aging**'s rate for the *Prevalence of Falls* PIP met the statewide goal and decreased from the prior year. However, **WellWise Services Area Agency on Aging**'s *Prevalence of Any Injuries* rate did not meet the statewide goal and increased over the prior year's rate, indicating the interventions implemented were not effective in decreasing the prevalence of injuries. Additionally, through the CQAR activity, **WellWise Services Area Agency on Aging** received a *Not Full or Substantial* compliance level in the Critical Incidents focus area. These findings could imply that while **WellWise Services Area Agency on Aging** generally ensures the health and safety of members when providing services directly to the member, it lacks the appropriate safety protocols for members in their home/community environments and does not consistently report, investigate, and follow up on critical incidents. HSAG recommends that **WellWise Services Area Agency on Aging** review its barriers for all measures falling below thresholds and implement interventions other than implementing a standard operating procedure to address the barriers.
Care Coordination and Person-Centered Service Planning	**Quality, Timeliness,** and **Access**—Through the CQAR Assessment and Person-Centered Service Planning focus areas, **WellWise Services Area Agency on Aging** demonstrated high performance in ensuring appropriate and timely

Performance Area	Overall Performance Impact
	person-centered service planning. Additionally, through the CAHPS HCBS survey, the rates for the *Global Ratings Measures—Global Rating of Case Manager*, *Recommendation Measures—Recommendation of Case Manager*, *Case Manager is Helpful*, and *Choosing the Services that Matter to You* domains scored above the statewide averages. Additionally, through the PMV activity, the rates for Performance Measure 17, *number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*, and 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*, scored above the statewide averages, although both rates decreased from the prior year's rates. These findings suggest that **WellWise Services Area Agency on Aging** conducts assessments timely and according to policies and procedures, and members generally are satisfied with their case managers.
Access to Waiver Services	**Quality, Timeliness,** and **Access**—Through the CQAR process, **WellWise Services Area Agency on Aging** demonstrated a *Substantial* compliance level in the MI Choice Services, Linking and Coordinating, Follow-Up and Monitoring, and Contingency Plan focus areas. Additionally, through the PMV, the rate for Performance Measure 30, *number and percent of participants with an individualized contingency plan for emergencies (e.g., severe weather or unscheduled absence of a caregiver)*, scored above the statewide average. Further, through the CAHPS HCBS survey, **WellWise Services Area Agency on Aging**'s rates for the *Staff are Reliable and Helpful* and *Transportation to Medical Appointments* domains scored above the statewide averages. However, through the PMV activity, the rates for Performance Measure 15, *number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs*, and Performance Measure 20, *number and percent of participants who received all of the services and supports identified in their person-centered service plan*, scored below the statewide averages and decreased from the prior year's rates. Additionally, through the CAHPS HCBS survey, **WellWise Services Area Agency on Aging**'s rate for the *Met Need* domain fell below the statewide average. These findings suggest that while **WellWise Services Area Agency on Aging** generally linked members to services and ensured members had a contingency plan for when services were not available, members were not always getting the services they needed. **WellWise Services Area Agency on Aging** should review all measures not meeting thresholds, identify barriers, and implement interventions to address the barriers. As several performance measures related to access to waiver services were below statewide averages, **WellWise Services Area Agency on Aging** should review its network and ensure it has enough contracted providers to provide timely waiver services to its membership.

4. Follow-Up on Prior External Quality Review Recommendations for MI Choice Waiver Agencies

From the findings of each waiver agency's performance for the SFY 2021 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the MI Choice Waiver Program. The recommendations provided to each waiver agency for the EQR activities in the *State Fiscal Year 2021 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: • **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 PIPs. 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. 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 PIP 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. • 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* PIP 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 PIP. 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.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
• 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 PIPs were unclear. **A&D Home Health Care**'s PIPs 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. HSAG recommends that **A&D Home Health Care** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP 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)***: Upon review of the prior year recommendations, it is noted that the following activities were continued 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: o QA runs the iHC detail report for the quarter prior. (Example: Quarter 2 review information would be obtained by April 15) o QA then converts the information to a computerized workbook (such as Excel). o QA completes individual reviews on each participant triggering the specific goal with results being kept in the computerized workbook. o The computerized workbook then indicates how many individual participants triggered the goal incorrectly (outlier). o New numerator is then identified on the Corrected Numbers review for the SFY and information is provided in the SFY Activities and Outcomes report. • Current status of goals and percentages are reported quarterly to the Management Team for additional oversight and monitoring. • 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. • QA and Management completed a comprehensive review of the quality of data in this domain. It was determined that certain participants' current value in a clinical domain, was merely carried over from the previous assessment. It was determined that a hard reset would force clinician to assess the field in question, because said field was now blank. By ensuring that supports coordinators evaluate each clinical field and then record current value for the field, the quality of data is improved. New processes and activities implemented following the 2022-2023 fiscal year Quality Management Plan (QMP): a) Goals were updated to reflect 2 areas of improvement rather than the original 5 goals notated in the 2020-2021 QMP and SFY 2021. Which has improved monitoring and allowed for more effective monitoring of the statewide goals.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
b) The updated internal monitoring tools continue to be used for tracking and trending the QMP percentage goal to ensure consistency throughout the monitoring and reporting process. c) In 10/2022 it was noted that the electronic medical records (EMR) system, Compass, several of the qualifying questions were updated to complete a "re-set" of the indicators. This has led to the collection of more accurate information.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): By more accurately assessing and recording current participant status in a given field, QA and management are more accurately able to measure the effectiveness of a given intervention. There has been a performance improvement in agency compliance, as evidenced by scores.
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** partially addressed the prior year's recommendations. Although **A&D Home Health Care** outlined the interventions that were conducted as part of this Follow-Up on Prior External Quality Review Recommendations activity, interventions implemented for improvement in the 2022 PIPs were still unclear in the waiver agency's QMP documentation, and the goals and reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **A&D Home Health Care** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation still did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. Further, **A&D Home Health Care**'s goals did not match the goals set by MDHHS. HSAG continues to recommend that **A&D Home Health Care** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
• **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. 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. • **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. 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.
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) Measure 20: During the SFY 2020-2021 QMP and SFY 2021 the focus on participants who received all of the services and supports identified in their person-centered service plan was not tracked. This has been rectified with the Quality Assurance Program Improvement plan for FY 2023-2024 following further direction and clarification from MDDHS. Full implementation is scheduled for October 1, 2023. 2) Measure 30: It is noted that all participants have an Emergency Back Up plan. This is a generated report from CIM's [Center for Information Management, Inc.] Compass system and is populated drawing from fields completed on each assessment. Verification of receipt of the plan is notated on all Care Plan of Services (#30 A), which is signed at each participant visit. Upon review it was noted that supports coordinators would have "slimmed down" contingency plan which did not present all supports and services the participant receives. **A&D Home Health Care** Leadership will be reviewing and receiving education on the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted,

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
and reported in a methodologically sound manner. Additionally, **A&D Home Health Care** will be collaborating with the Michigan Home and Community Service Network (MHCSN a non-area agency on aging waiver collaborative group) in developing best practice related to Quality Improvement Plans using CMS EQR Protocols. Full implementation is scheduled for October 1, 2023. 3) Measure 38: Following a review of the performance measure it is was determined that when the IAA cases were removed from the sample, **A&D Home Health Care**'s percentage was 100%. Because of how IAAs are structured, participants have to at least two waiver services until the asset assessment is completed by MDHHS and Medicaid is granted. Because of that MDHHS mandated process, services are delayed and outside of support coordination responsiveness and dependent on MDHHS response times. This artificially deflates scores, thereby giving the appearance of substandard performance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): 1) Measure 20: During the SFY 2020–2021 QMP and SFY 2021 the focus on participants who received all of the services and supports identified in their person-centered service plan was not tracked. This has been rectified with the Quality Assurance Program Improvement plan for FY 2023-2024 following further direction and clarification from MDDHS. 2) Measure 30: **A&D Home Health Care** completed updated training with all supports coordinators on the contingency plan. It was noted that during the review, supports coordinators drafted an abbreviated contingency plan which did not present all supports and services the participant receives. Training was provided to all supports coordinators indicated that ALL supports and services are required to be on the contingency plan. The training assisted supports coordinators in identification and documenting all supports and services which according to preliminary reviews has indicated promising results. QA is doing a monthly chart review at least 20 charts to ensure ALL services and supports are entered, so that they will be included on the contingency plan. These chart reviews of these elements will continue until **A&D Home Health Care** receives a compliance rating of 95% or greater. 3) Measure 38: **A&D Home Health Care** received a 100% compliance with Measure 38 (CQAR Standard 9.3) during the FY 2022 audit. If agency is 100% compliant for individualized emergency plan, then no initiative would be necessary at this time.
c. Identify any barriers to implementing initiatives: **A&D Home Health Care** will continue to collaborate with MDHHS and MHCSN to improve service delivery and quality indicators stipulated in the EQR. **A&D Home Health Care** appreciates the feedback provided by HSAG and will integrate the feedback into its processes and initiatives. Ongoing case monitoring can be completed by designated Waiver staff even when indicator thresholds are met. Regarding, HSAG's recommendation "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),

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
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" would be untenable. If **A&D Home Health Care** were to audit charts using the example provided, it would translate into 500 chart reviews per month (10 chart reviews *50 supports coordinators). As 500 reviews per month is not feasible, **A&D Home Health Care** has focused on conducting 3 reviews per supports coordination team (25 teams in total) which would translate into 75 chart reviews per month.
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. Additionally, while the SFY 2022 rate for Performance Measure 20 scored below the statewide average, it increased from the prior year. The SFY 2022 rate for Performance Measure 38 also increased from the prior year and scored above the statewide average. However, **A&D Home Health Care** continued to score more than 5 percentage points below the statewide average for Performance Measure 30 during SFY 2022; therefore, HSAG recommends that **A&D Home Health Care** explore additional/modified interventions to improve performance. However, please note that while **A&D Home Health Care**'s SFY 2022 rate for Performance Measure 30 continued to score 5 percentage points below the statewide average, the review standards for Performance Measure 30 changed from SFY 2021. Therefore, HSAG was unable to assess a year-over-year comparison.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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.
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** 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. It is noted that although the standard shows compliance at 90%, the standard is continually monitored. The noted difference is that the results, following the compliance assertion, are not reported to the MPHI for the CQAR CAP.

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): Since the SFY 2020-2021 QMP and SFY 2021, **A&D Home Health Care** has continued the monitoring activities despite the compliance rating benchmark of 90% being attained. Since **A&D Home Health Care** is maintaining the benchmark endorsed by MPHI during its CQAR and through the period of formal resolution of the CAPs, it did not implement an initiative in this area, therefore there is no performance improvement to result. Regarding HSAG's recommendation "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" would be untenable. If **A&D Home Health Care** were to audit charts using the example provided, it would translate into 500 chart reviews per month (10 chart reviews *50 supports coordinators). As 500 reviews per month is not feasible, **A&D Home Health Care** has focused on conducting 3 reviews per supports coordination team (25 teams in total) which would translate into 75 chart reviews per month.
c. Identify any barriers to implementing initiatives: **A&D Home Health Care** will continue to collaborate with MDHHS and MHCSN to improve service delivery and quality indicators stipulated in the EQR. **A&D Home Health Care** appreciates the feedback provided by HSAG and will integrate the feedback into its processes and initiatives. Ongoing case monitoring can be completed by designated Waiver staff even when indicator thresholds are met. However, regarding HSAG's recommendation "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" would be untenable. If **A&D Home Health Care** were to audit charts using the example provided, it would translate into 500 chart reviews per month (10 chart reviews *50 supports coordinators). As 500 reviews per month is not feasible, **A&D Home Health Care** has focused on conducting 3 reviews per supports coordination team (25 teams in total) which would translate into 75 chart reviews per month.
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. However, while the waiver agency implemented an auditing process to ensure program requirements are being met, **A&D Home Health Care** continued to receive a low score, demonstrated a decline in the compliance level for the Critical Incidents focus area in SFY 2022, and should explore additional interventions to ensure compliance requirements are met for this focus area.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. HSAG recommends that **A&D Home Health Care** review the results of the member satisfaction survey to

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
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. • **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. 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.
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** Waiver Management reviews all participant experience surveys in both an aggregate and at an individual level on an annual basis, after surveys are conducted. Individual concerns noted on the survey, are followed up by a member of management and/or supports coordinator to resolve concern. In addition, aggregate results of the surveys are presented to the supports coordinators and to supervisors to illuminate the areas where **A&D Home Health Care** is performing well in terms of participant experience. If patterns are observed among the population, **A&D Home Health Care** management provides education/training to supports coordinators related to best practices and/or any related policy/process updates that could enhance participant experience. It appears that HSAG is recommending a more formalized process that entails review of *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. **A&D Home Health Care** will utilize Root Cause Analysis on Domains in the survey that are below the stipulated threshold. A PDSA cycle will be utilized for planning and implementation of the solution. (Preliminary Outline located below) • "PLAN": (To understand the essence of the problem and plan a solution). Management Review Findings, Present Findings to Staff and Develop strategies to improve participant experience through Collaboration. Solicit input from Quality Collaborative Meeting members on suggested enhancements to participant experience. • "DO": (To implement the solution devised). Management Review Findings, Present Findings to Staff and Develop strategies to improve participant experience through Collaboration. Solicit input from Quality Collaborative Meeting members on suggested enhancements to participant experience. • "STUDY" & "ACT": (Feedback analysis of the devised health system and to plan changes). Implement suggested changes and then re-measure participant experience.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
This was implemented with the updates to the QAPI Plan in February of 2023.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): N/A. **A&D Home Health Care** has not implemented the initiative listed above at this time, so does not have any performance improvement to report at this time. Future performance improvement can be reported at annual EQRs.
c. Identify any barriers to implementing initiatives: Third party surveyors can provide objectivity, by providing impartial outside entity to gather and collect the data related to participant experience. However, the skill level of the surveyor can in and of itself impact respondent survey responses. Additionally, the participant experience encompasses an extensive range of variables and is highly subjective in nature**.** Their experience and how they report it can be impacted in numerous ways: the participant's mood that day, pain level, current relationship with their caregivers, the chemistry between the surveyor and the respondent, their pain level, situational factors in the participant's life, etc. Their responses can also be impacted by hearing concerns, language barriers, cognitive problems, etc. Ensuring these factors are addressed or the respondents are filtered out by the third-party entity is important. Despite these barriers, **A&D Home Health Care** would implement Root Cause analysis and PDSA cycle and re-measure after implementation to see if experience changes.
HSAG's Assessment: HSAG determined that **A&D Home Health Care** was unable to fully address the prior year's recommendations. It is unclear if **A&D Home Health Care** has implemented its improvement plan. However, it is noted that the waiver agency did not have any substantial weaknesses identified in the SFY 2022 CAHPS results. Additionally, while the *Global Ratings Measures* domain for SFY 2022 scored below the statewide average, the rate increased from the prior year. Further, the SFY 2022 rate for *Staff Listen and Communicate Well* domain scored above the statewide average and increased from the prior year.

Area Agency on Aging 1-B

Table 4-2—Prior Year Recommendations and Responses for Area Agency on Aging 1-B

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **Area Agency on Aging 1-B**'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 1-B** when initiating the PIPs. 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. HSAG recommends that **Area Agency on Aging 1-B** 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 1-B** 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. • The interventions implemented by **Area Agency on Aging 1-B** did not appear to be appropriate, active interventions as **Area Agency on Aging 1-B** did not meet its goals for the *Prevalence of Neglect/Abuse*, *Prevalence of Pain With Inadequate Pain Control*, and *Prevalence of Dehydration* PIPs, and the prevalence rates increased for the *Prevalence of Neglect/Abuse, Prevalence of Pain With Inadequate Pain Control, and Prevalence of Any Injuries* PIPs. **Area Agency on Aging 1-B**'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 PIPs. Additionally, a review of prevalence rates for neglect/abuse for all waiver agencies demonstrated **Area Agency on Aging 1-B** as an outlier with prevalence significantly higher than all other waiver agencies, suggesting that **Area Agency on Aging 1-B**'s members are experiencing more incidents of abuse and neglect or the prevalence rate is not being appropriately calculated by **Area Agency on Aging 1-B**. HSAG recommends that **Area Agency on Aging 1-B** 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 1-B** 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 1-B** should analyze and interpret results at multiple points in time and test for statistical significance. **Area Agency on Aging 1-B** 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. • 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 PIPs were limited. **Area Agency on Aging 1-B**'s PIPs 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. HSAG recommends that **Area Agency on Aging 1-B** follow the CMS EQR

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Area Agency on Aging 1-B** 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)***:

FY22:

- MDHHS Quality Management Collaboration (QMC) selected 2 Quality Indicator (QI) measures for all Waiver Agencies to monitor and address in FY22-23 and 2 Performance Improvement Projects (PIP), selected by **Area Agency on Aging 1-B**.
  - Decrease the percentage of participants that report a fall within the last 90 days, post initial assessment to be at or below 23.00%. Baseline: 21.10%, FY22 Goal: <21.10%
  - Decrease the percentage of participants that report an injury to be at or below the statewide goal of 3%. Baseline: 3.4%, FY22 Goal: <3.0%
  - Improve timely Critical Complaints and Incident Reporting (CCIR), by 1.0%, each year, over the next two years. Baseline: 95.30%, FY22 Goal: 96.30% compliance
  - Decrease the percentage of participants who report being hospitalized or visited an emergency room in the last 90 days by 0.50%, each year, over the next two years. Baseline: 28.03%, FY22 Goal: 27.53% (or less)
- **Area Agency on Aging 1-B** implemented supplemental questions into the iHC assessment to gain additional information regarding a triggered QI; this information will ensure the most appropriate interventions are implemented to improve participant outcomes.
  - **Area Agency on Aging 1-B** focused on obtaining additional information from participants regarding ER/Hospitalizations, Falls, Medication Compliance, and Restraints.
    - **Area Agency on Aging 1-B** continues to conduct 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; **Area Agency on Aging 1-B** has added additional questions to determine the intent of the restraint, the type, ensure appropriate use, provide education, and alternatives.
      - The iHC assessment user's manual states the following regarding coding restraints: *a restraint must be coded regardless of its intent (i.e., seatbelt, bedrail, etc.).*
      - MDHHS instructed Waiver Agencies to code restraints based on intent, this instruction *directly contradicts the iHC user's manual and jeopardizes the validity and reliability of the tool.*
  - Supports coordinators received extensive training on the additional questions added to improve participant specific interventions, participant outcomes, and data collection.
- **Area Agency on Aging 1-B** implemented a new workflow for CCIR entry into the state's portal.
  - One-point person with one backup to enter CCIRs into the portal.
- **Area Agency on Aging 1-B** completed the FY22/23 Quality Management Plan based on the outline and guidance provided by MDHHS.
  - **Area Agency on Aging 1-B**'s FY22 Activities and Outcomes Report identifies the outcomes of our goals, successes, barriers, and recommendations for improvements, providing both a quantitative and qualitative review of our goals.
- A root cause analysis for each goal was completed on a quarterly basis and were monitored every quarter by the QI workgroup and the MI Choice Quality Assurance Team.

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):
FY22:
• After root cause analysis adjustment, 1.60% (21/1317) of our participants had fractures or major skin problems (excluding current pressure or stasis ulcers'), 1.4 percentage points less than the statewide goal: thus, exceeding the statewide goal of 3.0% or less.
  ○ 80% (8/10) of interventions were successfully implemented with no subsequent injury/fall reported 30-90 days after intervention execution.
  ▪ Of the 10 unique participants with avoidable injuries, 2 participants reported subsequent falls after the intervention(s).
• MI Choice Critical Incident Summary Report identifies 98.72% (232/235) of Complaints and Critical Incidents were reported timely; thus, exceeding our goal of 96.30%

c. Identify any barriers to implementing initiatives: • Updating the iHC to include additional probing questions was cumbersome and created some issues with data transmission to the state warehouse; thus, impacting our ability to process our data from the source of truth electronic medical record, COMPASS.
HSAG's Assessment: HSAG determined that **Area Agency on Aging 1-B** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Area Agency on Aging 1-B** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Area Agency on Aging 1-B** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Area Agency on Aging 1-B** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **Area Agency on Aging 1-B** 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. MDHHS required **Area Agency on Aging 1-B** to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **Area Agency on Aging 1-B**'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 1-B**'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 1-B** 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.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
• **Area Agency on Aging 1-B** 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. MDHHS required **Area Agency on Aging 1-B** to submit a CAP to remediate the deficiencies associated with Performance Measure 21. **Area Agency on Aging 1-B**'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 1-B**'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 1-B** 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.
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)***:
• Clinical Trainer and Quality provide annual training on the Clinical Quality Assurance Record Review tool; including Performance Measure 19: CQAR Standard 8.1 and Performance Measure 21: CQAR Standard 9.4. on an annual basis.
  ○ **Area Agency on Aging 1-B** continues to audit a minimum of 10 participant records per month utilizing a targeted CQAR audit tool (provided by MDHHS).
  ○ **Area Agency on Aging 1-B** continues to audit a minimum of 50% of newly enrolled cases per month, using a full or partial audit tool.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Performance Measure 19: CQAR Standard 8.1: • Aggregated data does not show performance improvement; rather the need for additional training and coaching for supports coordinators. Performance Measure 21: CQAR Standard 9.4: • In FY23 we have internally achieve 90% compliance for Performance Measure 21 for two consecutive quarters (Q2:90%, Q3:90%)
c. Identify any barriers to implementing initiatives: • No barriers with implementing a standard auditing practice and schedule. • Staffing changes created additional barriers for Supervisors to provide effective coaching to supports coordinators. • Waiver Agents have not been provided the FY22 Statewide Roll-up for CQAR Record reviews to aid in identifying areas that individual Waiver Agents may be scoring lower than the statewide average.
HSAG's Assessment: HSAG determined that **Area Agency on Aging 1-B** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. Additionally, **Area Agency on Aging 1-B**'s SFY 2022 rate for Performance Measure 21 scored above the statewide average and increased from the prior year. However, **Area Agency on Aging 1-B** continued to score more than 5 percentage points below the statewide average for Performance Measure 19 during SFY 2022, and the rate

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
decreased from the prior year. Therefore, HSAG recommends that **Area Agency on Aging 1-B** explore additional/modified interventions to improve performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **Area Agency on Aging 1-B** 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. Although no substantial weaknesses were identified within any of the program areas under review, **Area Agency on Aging 1-B** 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 1-B**'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 1-B**'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 1-B** 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.
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)***:
• Critical Incident training was provided to all staff on 02/15/2022.
• Ongoing record reviews for standard 14.4 Critical Incidents continues regardless of compliance achieved.
  ○ **Area Agency on Aging 1-B** continues to audit a minimum of 10 participant records per month utilizing a targeted CQAR audit tool (provided by MDHHS).
  ○ **Area Agency on Aging 1-B** continues to audit a minimum of 50% of newly enrolled cases per month, using a full or partial audit tool.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Internal monitoring post-training rendered similar compliance of 50% for FY22. • Aggregated data does not show performance improvement; rather the need for additional training and coaching for supports coordinators.
c. Identify any barriers to implementing initiatives: • No barriers with implementing a standard auditing practice and schedule. • Staffing changes created additional barriers for supervisors to provide effective coaching to supports coordinators.
HSAG's Assessment: HSAG determined that **Area Agency on Aging 1-B** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. Additionally, **Area Agency on Aging 1-B** received a *Substantial* compliance level for the Critical Incident focus area during SFY 2022, which was also an improvement from the prior year.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **Area Agency on Aging 1-B** 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. Although no substantial weaknesses were identified within any of the CAHPS domains, **Area Agency on Aging 1-B** 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 1-B** 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.
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)***: • All waiver agencies requested our members individual CAHPS survey results from the MDHHS in order to conduct a root-cause analysis.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • **Area Agency on Aging 1-B** has not been provided our members individual CAPHS survey results in order to conduct a root-cause analysis. • Michigan State University (MSU) completes all Waiver Agencies CAHPS surveys. The MI Choice Enrollment Satisfaction Report indicates "agency specific results are not intended to meet federal reporting requirements."
HSAG's Assessment: HSAG determined that **Area Agency on Aging 1-B** was unable to fully address the prior year's recommendations. As CAHPS results are anonymous, **Area Agency on Aging 1-B** should proceed with conducting its root cause analysis based on the aggregated results of the questions within each domain. However, **Area Agency on Aging 1-B**'s SFY 2022 results demonstrated that the rate for the *Global Ratings Measures* domain scored below the statewide average but improved from the prior year; the rate for the *Transportation to Medical Appointments* domain scored below the statewide average and decreased from the prior year; and the rate for the *Met Need* domain scored above the statewide average and increased from the prior year. As such, HSAG recommends that **Area Agency on Aging 1-B** explore additional/modified interventions to improve performance for each domain not demonstrating continued improvement.

Area Agency on Aging of Northwest Michigan

Table 4-3—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: • **Area Agency on Aging of Northwest Michigan** did not clearly identify its goal for two PIPs, *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 **Area 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 **Area 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. HSAG recommends that **Area 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, **Area 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. • **Area Agency on Aging of Northwest Michigan**'s PIP performance results reported in the SFY 2021 annual report were not comparable to the prevalence rates reported by other waiver agencies. HSAG recommends that **Area Agency on Aging of Northwest Michigan**'s annual report include an evaluation of the full year's performance results for each PIP quality indicator. • The interventions implemented by **Area Agency on Aging of Northwest Michigan** did not appear to be appropriate, active interventions as prevalence rates for four PIPs did not meet the goals: *Prevalence of Neglect/Abuse*, *Prevalence of Pain With Inadequate Pain Control*, *Prevalence of Falls*, and *Prevalence of Any Injuries*. **Area 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 PIPs. HSAG recommends that **Area 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). **Area 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. **Area Agency on Aging of Northwest Michigan** should analyze and interpret results at multiple points in time and test for statistical significance. **Area 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. • 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 PIPs were unclear. **Area Agency on Aging of Northwest Michigan**'s PIPs 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. HSAG recommends that

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
Area Agency on Aging of Northwest Michigan follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Area 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)***: • *Prevalence of Neglect/Abuse* and *Prevalence of Dehydration:* PIP goal for prevalence of neglect/abuse and Prevalence of dehydration has been removed from MDHHS required PIP focus initiatives for current reporting and improvement projects. **Area Agency on Aging of Northwest Michigan** has included MDHHS PIP projects into current reporting QMP plan, defined and updated by MDHHS, for FY2023. • **Area Agency on Aging of Northwest Michigan**'s current QMP report will include a full year of data for PIP measures defined by MDHHS for FY2023 reporting. • Interventions and details of the PIP design and project have been included in the recent QMP report submitted to MDHHS for FY2023, following reporting requirements defined by MDHHS.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Initiatives implemented in FY2023 reporting, following MDHHS template and requirements for reporting QMP initiatives.
c. Identify any barriers to implementing initiatives: • Reporting requirements and changes to MDHHS required reporting and templates did not go into effect until FY2023 reporting period. Barriers include similar information, per MDHHS defined reporting, for FY2022. Changes have been made and implemented with FY23 reporting.
HSAG's Assessment: HSAG determined that **Area Agency on Aging of Northwest Michigan** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. However, while **Area Agency on Aging of Northwest Michigan** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Area Agency on Aging of Northwest Michigan** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Area Agency on Aging of Northwest Michigan** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **Area 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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
percentage points below the statewide rate. This demonstrated that supports coordinators did not always comply with the service plan completion time frames. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 1. **Area 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, **Area 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 **Area 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.
• **Area 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. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 17. **Area 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, **Area 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 **Area 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.
• **Area 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. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **Area 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, **Area 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 **Area 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.
• **Area 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. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
CAP to remediate the deficiencies associated with Performance Measure 20. **Area 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, **Area 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 **Area 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.
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)***: • Ongoing and routine chart review processes put in place in FY23, following recommendations for continued monitoring of performance measures beyond measurement and reporting of corrective action plans defined by MDHHS. • Policies and procedures updated to reflect and include compliance with performance measures.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase in number of chart reviews reviewed.
c. Identify any barriers to implementing initiatives: • Recommendations received regarding FY21 performance and changes unable to be made/implemented until FY23 due to timing of feedback and result recommendations for improvement. • Performance measure initiatives not included in MDHHS required format/template for QMP reporting. • Barriers identified in improvement initiatives as new/different components of the performance measure were focused on and identified during audit, resulting in deficiencies of same performance measure, with different reasons and focus areas, creating a moving target and barriers to identifying and resolving root causes from one year to another.
HSAG's Assessment: HSAG determined that **Area Agency on Aging of Northwest Michigan** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improved performance on the SFY 2022 performance measures. The rates for Performance Measures 1, 17, 19, and 20 scored above the statewide average and increased from the prior year.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **Area 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. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Area 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, **Area 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 **Area Agency on Aging of Northwest Michigan** continue conducting a specific number of record reviews (e.g., 10 records) per

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
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. • **Area 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. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Area 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, **Area 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 **Area 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. • **Area 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. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Area 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, **Area 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 **Area 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. • **Area 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. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Area 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, **Area 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 **Area 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

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
designated level of compliance is achieved, as it is important to regularly monitor staff members to ensure performance stays consistent and requirements are met. • **Area 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. MDHHS required **Area Agency on Aging of Northwest Michigan** to submit a CAP to remediate the deficiencies. **Area 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, **Area 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 **Area 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 **Area Agency on Aging of Northwest Michigan** ensure mechanisms are in place that verify timely completion of the PCSP 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)***: • Ongoing and routine chart review processes put in place in FY23, following recommendations for continued monitoring of performance measures beyond measurement and reporting of corrective action plans defined by MDHHS. • Policies and procedures updated to reflect and include compliance with performance measures. • Reports created to identify deficiencies and timely completion of records, to assist in monitoring and feedback mechanisms through organizational process changes
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase in number of chart reviews reviewed in FY23. • Chart review tools updated to reflect focus areas for improvement FY23.
c. Identify any barriers to implementing initiatives: • Recommendations received regarding FY21 performance and changes unable to be made/implemented until FY23 due to timing of feedback and result recommendations for improvement. • Performance measure initiatives not included in MDHHS required format/template for QMP reporting. • Barriers identified in improvement initiatives as new/different components of the performance measure were focused on and identified during audit, resulting in deficiencies of same performance measure, with different reasons and focus areas, creating a moving target and barriers to identifying and resolving root causes from one year to another.
HSAG's Assessment: HSAG determined that **Area Agency on Aging of Northwest Michigan** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. However, while **Area Agency on Aging of Northwest Michigan**'s SFY 2022 compliance levels for the Medication Record and Service Provider focus areas improved, the compliance level for the Freedom of Choice

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
focus area continued to demonstrate low performance and declined from the prior year; therefore, the waiver agency should explore additional interventions to ensure compliance requirements are met for this focus area. Further, as the Critical Incidents and Adverse Benefit Determination focus areas were not assigned a compliance level, HSAG was unable to assess **Area Agency on Aging of Northwest Michigan**'s performance.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **Area 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. Although no substantial weaknesses were identified within any of the CAHPS domains, **Area 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 **Area 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.
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)***: • Internal surveys conducted to obtain adequate sample size and actionable data • Initiatives for improvement specific to participant experience of care included in agencies internal Quality Assessment Performance Improvement plan
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Area Agency on Aging of Northwest Michigan** scored above statewide mean for category of "Case Manager is Helpful" on 2022 CAHPS report • **Area Agency on Aging of Northwest Michigan** scored above statewide mean for category of "Planning your time and activities" on 2022 CAHPS report
c. Identify any barriers to implementing initiatives: • State CAHPS survey conducted on small sample size, at agency level, and difficulty obtaining root cause to specific questions • CAHPS survey indicates agency specific results are not intended to meet federal reporting requirements

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
• CAHPS survey results provided to agency indicates Agency-level results are informational only and not intended for federal reporting, barriers to identify root causes with small sample size at agency level
HSAG's Assessment: HSAG determined that **Area Agency on Aging of Northwest Michigan** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. Further, **Area Agency on Aging of Northwest Michigan**'s SFY 2022 rates for the *Case Manager is Helpful* and *Planning Your Time and Activities* domains scored above the statewide average and increased from the prior year.

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: • 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. 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. • 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* PIPs 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 PIPs. 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.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
• 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 PIPs were unclear. **Area Agency on Aging of Western Michigan**'s PIPs 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. HSAG recommends that **Area Agency on Aging of Western Michigan** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Area Agency on Aging of Western Michigan** in a methodologically sound manner. • 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. 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.
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 QMP is now a QAPI as of January 2023 which has clearly defined, objective, measurable quality indicators and goals. We are establishing periodic timeframes within which to review the effectiveness of our interventions and implement changes when appropriate based on the results. We are also reviewing our internal validation processes so that data reported to MDHHS is correct.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): [None identified].
c. Identify any barriers to implementing initiatives: There has been a delay with the monitoring and routine reviewing of our QAPI with a turnover in Compliance Manager staffing.
HSAG's Assessment: HSAG determined that **Area Agency on Aging of Western Michigan** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Area Agency on Aging of Western Michigan** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Area Agency on Aging of Western Michigan** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Area Agency on Aging of Western Michigan** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **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. 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.
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** conducts chart reviews on cited standards even after statistical compliance is met. In addition, **Area Agency on Aging of Western Michigan** has hired an additional Compliance Specialist to conduct ongoing chart reviews. Twenty to thirty charts will be audited monthly and one of the criteria will be to ensure the array of MI Choice services are offered. Supports coordinators were also provided education on the importance of identifying and addressing unmet needs which MI Choice could address.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Performance improvement was evident in the FY 2022 CQAR record review with the standard being met at 90.32% as compared to not being met at 86.21% in FY 2021.
c. Identify any barriers to implementing initiatives: The new Compliance Specialist is close to completion of training and which at that point will begin the monthly chart reviews.
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. Additionally, **Area Agency on Aging of Western Michigan**'s SFY 2022 rate for Performance Measure 21 scored above the statewide average and increased from the prior year.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. MDHHS required **Area Agency on Aging of Western Michigan** to submit a CAP to

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
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.
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** conducts chart reviews on cited standards even after statistical compliance is met. CI [critical incidents] trends are evaluated every quarter. After providing education to Support Coordination staff on what is a CI, prevention of future occurrences and the timeframes for reporting, compliance staff reviewed and improved the oversight of this process. Weekly review of CIs has improved timeliness of follow up. In addition, **Area Agency on Aging of Western Michigan** has hired an additional Compliance Specialist to conduct ongoing chart reviews. Part of the review will focus on ensuring if a CI is present, if it was identified timely and was given the appropriate follow up.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): [None identified.]
c. Identify any barriers to implementing initiatives: The new Compliance Specialist is close to completion of training and which at that point will begin the monthly chart reviews.
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. However, while **Area Agency on Aging of Western Michigan** had an ongoing auditing process to ensure program requirements are being met, the waiver agency continued to receive a low score for the Critical Incidents focus area and should explore additional interventions to ensure compliance requirements are met for this focus area.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
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** conducts its own survey which has a higher response rate of approximately 309 participants. Questions like those on the CAHPS elicited a 95% satisfaction rate with participants supports coordinators. For service providers, the response rate was a little over 90% which is a high level of satisfaction given that Covid [the coronavirus disease] created many restrictions and impacted providers' ability to provide care and influenced participants' willingness to receive care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): The CAHPS 2022 survey showed improvement in all domains. The Recommendation Measures domain score was 3.2% less than the state average. Recommendation of Homemaker item score is 10.8% less than state average.
c. Identify any barriers to implementing initiatives: [None identified.]
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. However, while **Area Agency on Aging of Western Michigan**'s SFY 2022 rate for the *Recommendation Measures* domain increased from the prior year, it continued to score lower than the statewide average; therefore, the waiver agency should explore additional interventions to ensure compliance requirements are met for this domain.

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: • Inconsistencies within the SFY 2020–2021 QMP and SFY 2021 annual report created significant challenges in deciphering the PIP-related goals, interventions, prevalence rates, and outcomes. 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 PIP indicators. Additionally, **Detroit Area Agency on Aging** should ensure that its annual report identifies the PIP 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. • 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 PIP 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* PIPs, suggesting that the interventions implemented by **Detroit Area Agency on Aging** were not effective. As significant and sustained improvement results from developing and implementing

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
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 PIPs. 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. • **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 PIPs. **Detroit Area Agency on Aging**'s PIPs 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. HSAG recommends that **Detroit Area Agency on Aging** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP 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** has been working on educating all stakeholders, staff and constituents on fall prevention, neglect and abuse, the prevalence of pain, and the prevalence of dehydration. In order to do this, a gap analysis has been completed to determine contributing factors that are causing increased rates for dehydration and pain. **Detroit Area Agency on Aging** has promoted a speak up culture during participant advisory groups, and educated on abuse/neglect as well as trained the providers on signs to look for when providing care. • Pain management resources and best practice have been reviewed to determine strategies in pain management. Supports coordinators will provide a list of pain management clinics, will educate on safe and effective pain management strategies as ordered by their physician, will link and coordinate with primary care physician to discuss alternative strategies to help manage pain such as acupuncture, PT/OT [physical therapy/occupational therapy], exercise, yoga, meditation and will continue to research evidence-based ways to manage pain. • **Detroit Area Agency on Aging** provides monthly fall prevention education and has home repair place grab bars as needed into homes for fall prevention. **Detroit Area Agency on Aging** has started to review increased lighting in homes as a strategy for fall prevention. Each fall is reviewed to determine the root cause and to determine what preventative measures if any could have helped prevent the fall. **Detroit Area Agency on Aging** and other area agency on aging have a work group with MDHHS that has requested a fall mini root cause analysis to be placed in the electronic health record so that each fall

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
will have a category of harm and can identify any contributing factors. **Detroit Area Agency on Aging** offers the matter of balance class that is for fall prevention and participants can be referred to this program to learn ways to prevent falls. **Detroit Area Agency on Aging** has falls as a key performance indicator that is reviewed monthly for effectiveness of fall prevention strategies. **Detroit Area Agency on Aging** completes environmental inspection of home to identify any fall risks, trip hazards, unsafe areas in the home and works with home repair and chore services to ensure a safe environment. • **Detroit Area Agency on Aging** has reviewed the assessment questions that are asked of the participant to determine if the participant has adequate water intake. Staff received training on the assessment tool and completed peer review to audit peer charts and identified any gaps in completing the assessment. **Detroit Area Agency on Aging** is going to inquire on if prompts can be added to the assessment to further assess fluid intake. Staff is educating participants on the need for increased hydration and are educating about the importance of hydration during the participant advisory committee meeting.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Prevalence of Neglect/Abuse – Quality indicators revealed that **Detroit Area Agency on Aging** was continuing to fall under the state guidelines for prevalence of neglect and abuse for FY22. • Prevalence of Pain with Inadequate Pain Control – Data will be reviewed for effectiveness of process improvement in the upcoming quarter. **Detroit Area Agency on Aging** did have a decrease in pain reported for the second half of 2021 and into FY22. • Prevalence of Falls – Quality measures revealed that in 2022 **Detroit Area Agency on Aging** fell well below the state fall guidelines and further maintained a decrease in falls, while remaining steady in 2023 for the first six months. • Prevalence of Dehydration – Quality measures show a slight reduction in the prevalence of dehydration over the second half of 2022, however further data needs review for effectiveness.
c. Identify any barriers to implementing initiatives: • Prevalence of Neglect/Abuse - Lack of communication, some participants withhold needed information when abuse is suspected, which can be a barrier to accurate reporting. • Prevalence of Pain with Inadequate Pain Control – Coordination with Primary Care Physician can be difficult at times if the physician does not return attempts to link and coordinate. **Detroit Area Agency on Aging** has worked around this by sending the supports coordinator to the Primary Care Physician location for coordinating purposes. • Prevalence of Falls – No barriers identified to implementation. • Prevalence of Dehydration – The current assessment tool does not have prompts that are filled out if a person reports inadequate fluid intake, which leaves this question broad and for interpretation, which can result in a variety of ways to respond to the question. Improved performance has been minimal.
HSAG's Assessment: HSAG determined that **Detroit Area Agency on Aging** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Detroit Area Agency on Aging** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Detroit Area Agency on Aging** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Detroit Area Agency on Aging** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **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. 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. • **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. 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.
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)***: When reviewing the process for each performance measure, it was determined that staff wasn't utilizing the dashboard or outlook for an organization tool that will help them complete PCSP's in a timely manner. Monthly reports now include timeliness of PCSPs. Performance Measure 19 – PCSP: supports coordinators will utilize the dashboard/outlook calendar to ensure assessments/re-assessments are completed on time and or when there is a change in status, supports

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
coordinators will utilize PCSP checklist that was created in FY22 to ensure all elements of the assessment are included to ensure compliance. Performance Measure 30 – BUP: the backup plan has been added to the assessment checklist that was implemented in FY22. This will be checked for accuracy prior to submission and throughout monthly auditing of each supports coordinator.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance Measure 19 – PCSP: Timeliness of turning in the PCSP has seen an increase over the last six months of 2022. • Performance Measure 30 – BUP: Back up plans are being audited with initial findings showing an improvement, these targets will continue to be monitored and incorporated into normal practice as part of the PCSP process.
c. Identify any barriers to implementing initiatives: • Performance Measure 19 – PCSP: It is a lengthy process in the electronic health record to clean up the supports coordinator's dashboard and relies on staff to consistently update the dashboard to utilize for a good guide to the caseload. • Performance Measure 30 – BUP: Multiple prompts on form are easy to miss, staff will need to take time to ensure full completion of document. Random audits will be completed monthly to help identify any gaps in filling out the forms.
HSAG's Assessment: HSAG determined that **Detroit Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. However, please note that **Detroit Area Agency on Aging** continued to score more than 5 percentage points below the statewide average for Performance Measure 19 during SFY 2022, and the rate decreased from the prior year. Therefore, HSAG recommends that **Detroit Area Agency on Aging** explore additional/modified interventions to improve performance. Additionally, while **Detroit Area Agency on Aging**'s SFY 2022 rate for Performance Measure 30 scored above the statewide average, the review standards for this measure changed from SFY 2021. Therefore, HSAG was unable to assess a year-over-year comparison.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
• **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. 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. • **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. 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. • **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. 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. • **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. 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

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
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.
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)***: ABD – Gaps identified during RCA were that staff were not consistently filling out the form accurately. • **Detroit Area Agency on Aging** has completed a new training with staff to go over the ABD process and has assigned one support staff to be in charge of ensuring the ABD letters are completed on time and completely accurate and sent to the participants per contractual requirements. • **Detroit Area Agency on Aging** has assigned one staff member to the ADT [admission, discharge, transfer] report each day that notifies staff of any hospitalizations and ABD letters needed. • **Detroit Area Agency on Aging** has created a tracking tool for any form that is needed for participants, which includes the ABD form. ROI – • **Detroit Area Agency on Aging** is in the process of implementing DocuSign to complete initial enrollment package and the release of information will be part of this pilot to determine if there will be an increase of accurate completions via docusign and then having them uploaded into the record by medical records. • One staff was assigned as the sole person to upload the ROI to the paperclip and two staff are assigned to audit each ROI for accuracy prior to the upload. Follow-up & Monitoring – New process is set to begin; performance data will be reviewed during quarterly audits. Critical Incidents – • **Detroit Area Agency on Aging** has educated staff on filing critical incidents and the timely follow up needed for critical incidents per the policy and contract requirements. • **Detroit Area Agency on Aging** has added Critical Incidents to the key performance indicators to track effectiveness of strategies implemented for timely completion. • Staff were trained on critical incidents during FY22 • **Detroit Area Agency on Aging** will continue conducting monthly audits of each support's coordinator on an ongoing basis to ensure compliance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
• Initial quarterly review shows improvement in accuracy of critical incidents being completed per MDHHS requirements. Effectiveness will continue to be monitored • FOC – Initial re-audit of the records to determine improvement shows that FOC compliance has improved minimally, and more audits will be completed to determine efficacy. • Follow-up & Monitoring - Improved performance is still being monitored and will continue to be monitored for this next quarter.
c. Identify any barriers to implementing initiatives: • Barriers identified will be that staff will need to make sure each item is filled out with 100% accuracy when completing these documents. Staff will have continuous prompts and training on these documents.
HSAG's Assessment: HSAG determined that **Detroit Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. Additionally, **Detroit Area Agency on Aging** demonstrated a *Substantial* compliance level for the Freedom of Choice and Release of Information focus areas in SFY 2022 and improved both compliance levels from the prior year. However, while **Detroit Area Agency on Aging** implemented interventions to ensure program requirements are being met, **Detroit Area Agency on Aging** continued to receive a low score for the Follow-Up and Monitoring, Critical Incidents, and Adverse Benefit Determination focus areas and should explore additional interventions to ensure compliance requirements are met for these focus areas.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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.
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)***: • Transportation to medical appointments – **Detroit Area Agency on Aging** has evaluated the network adequacy internally to determine if there are enough transportation providers to meet the needs of the participants. While **Detroit Area Agency on Aging** does meet MDHHS requirements for transportation vendors, **Detroit Area Agency on Aging** has started to increase the network in this category to ensure that there is an ability to complete the appointments in a timely manner for the participants. • **Detroit Area Agency on Aging** has a dedicated staff that completes the scheduling for medical appointments and this staff works collaboratively with the participants and the vendors. When identifying the gap in care, it was identified that the vendors being late or missing appointments was causing dissatisfaction with participants.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
• **Detroit Area Agency on Aging** has created a monthly key performance indicator that reports how many canceled appointments, late appointments and no shows are identified and by vendor or by the participant. This report is viewed quarterly and discussed with the vendors as a way to establish an increase in satisfaction. • **Detroit Area Agency on Aging** has started working on a report card for vendors that will be implemented in upcoming fiscal years, this report card will include satisfaction scores, vendor cancellation rates, and any corrective action plans that were needed over the time period. This will further strengthen our provider network and thus increase satisfaction of the participants.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Detroit Area Agency on Aging** has been completing satisfaction surveys with the participants to ensure that participants are satisfied with the transportation provided. We have seen a reduction in the cancellation of appointments since we have been working with our transportation vendors closely, and have a designated staff who helps schedule medical transportation for the participants. • **Detroit Area Agency on Aging** has also implemented a vehicle inspection checklist to ensure safety of the participants while being transported and completes this audit of vehicles, which includes satisfaction survey, timeliness of appointments and is tracking completion rate for each vendor as part of key performance indicators for FY23. • Data is currently being reviewed to determine effectiveness for FY23. Preliminary findings show a decrease in complaints surrounding transportation appointments.
c. Identify any barriers to implementing initiatives: • **Detroit Area Agency on Aging** is still in the process of increasing the providers for transportation so the improvement may show smaller increases in satisfaction at this time while improving our internal provider network.
HSAG's Assessment: HSAG determined that **Detroit Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Detroit Area Agency on Aging**'s SFY 2022 rate continued to score below the statewide average for the *Transportation to Medical Appointments* domain, it increased from the prior year.

Easterseals/MORC

Table 4-6—Prior Year Recommendations and Responses for Easterseals/MORC

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **Easterseals/MORC**'s SFY 2020–2021 QMP and the SFY 2021 annual report did not identify the goal for any of the five state-required PIPs. 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. HSAG recommends that **Easterseals/MORC** 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, **Easterseals/MORC** 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. • The interventions implemented by **Easterseals/MORC** 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. **Easterseals/MORC**'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 PIPs. HSAG recommends that **Easterseals/MORC** 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). **Easterseals/MORC** should identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active interventions should address these barriers to improve outcomes. **Easterseals/MORC** should analyze and interpret results at multiple points in time and test for statistical significance. **Easterseals/MORC** 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. • **Easterseals/MORC**'s PIP performance results reported in the SFY 2021 annual report were not comparable to the prevalence rates reported by other waiver agencies. HSAG recommends that **Easterseals/MORC**'s annual report include the full year's annual performance results for each PIP quality indicator. • **Easterseals/MORC**'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 PIPs. **Easterseals/MORC**'s PIPs 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. HSAG recommends that **Easterseals/MORC** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Easterseals/MORC** in a methodologically sound manner.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
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)***: • **Easterseals/MORC** received HSAG recommendations after FY2021 & implemented quality indicators into the FY22-23 QAPI. The MDHHS implemented quality indicators chosen by the Statewide Quality Collaborated Group: Prevalence of falls & Prevalence of any injuries. **Easterseals/MORC** implemented quality indicators are: Improvement of metrics timeliness of monitoring contacts 94% or greater; assessments/ reassessments 97% or greater; and person-centered service plan (PCSP) monitoring; Reduce unplanned to hospital stays to less than 25%; Increase participant experience satisfaction to 95% or greater; Increase follow-up completion to 90% or greater; Prevalence of falls less than 18.7% or lower; Prevalence of any injuries 3% or lower.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The initiatives have been implemented for FY2023 on June 2, 2022. The results will be calculated for FY2023 at the end of the fiscal year September 30, 2023.
c. Identify any barriers to implementing initiatives: • **Easterseals/MORC** received HSAG recommendations after FY2021 & implemented quality indicators into the FY22-23 QAPI.
HSAG's Assessment: HSAG determined that **Easterseals/MORC** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Easterseals/MORC** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Easterseals/MORC** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Easterseals/MORC** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • HSAG did not identify any substantial trends of weakness. Although **Easterseals/MORC** met or exceeded the statewide performance rate for all performance measures, HSAG recommends that **Easterseals/MORC** 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.
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:
• **Easterseals/MORC** received HSAG recommendations after FY2021 & revised the Quality Management Plan (QMP) to the QAPI. **Easterseals/MORC** implemented the Performance Measures April 2023.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The data experience for performance measures was implemented in April 2023. Currently, **Easterseals/MORC** is unable to identify or verify any trends. **Easterseals/MORC** will continue auditing activities and address findings.
c. Identify any barriers to implementing initiatives: • **Easterseals/MORC** received HSAG recommendations after FY2021 & implemented quality indicators into the FY22-23 QAPI. Internal barrier: **Easterseals/MORC** supports coordinators Staffing issues which affected the capability of implementing this performance measure.
HSAG's Assessment: HSAG determined that **Easterseals/MORC** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and continued high performance on performance measures in SFY 2022.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **Easterseals/MORC** 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. No substantial weaknesses were identified within any of the program areas under review; however, HSAG recommends **Easterseals/MORC** 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.
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 the interim of developing and initiating the QAPI and auditing activities, the Quality Analyst completes monthly supports coordinator Monitoring Reports which include data on timely monitoring contacts, assessments and PCSPs from FY2022 to present. Clinical Supervisor completes monthly one on one targeted case reviews with supports coordinators. Scope of quality review includes hospital mitigation, ascertaining coordination of care/ follow-up completions based on Bamboo Health notifications (communication portal between healthcare provider), and Vendor View messages.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The activities mentioned above are completed by the Quality Analyst have shown improvement and are above the **Easterseals/MORC** goal percentages. The activities mentioned above are completed by the Clinical Supervisor have consistently occurred since FY2022 to present but not formally recorded. As of August 2023, these activities will be formally recorded.
c. Identify any barriers to implementing initiatives: • **Easterseals/MORC** received HSAG recommendations after FY2021 & implemented quality indicators into the FY22-23 QAPI.
HSAG's Assessment: HSAG determined that **Easterseals/MORC** 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:
Easterseals/MORC also demonstrated continued high performance on the compliance review activity with the exception of the Complaints and Grievances focus area.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **Easterseals/MORC** 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. Although no substantial weaknesses were identified within any of the CAHPS domains, **Easterseals/MORC** 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 **Easterseals/MORC** 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.
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)***: Global Ratings Measures, Recommendation Measures, Staff are Reliable and Helpful, Staff Listen & Communicate Well: **Easterseals/MORC** initiated in the performance improvement projects "PIP" found within the Quality Improvement Plan for FY 22- FY23 on January 15th of 2022/revised June 22nd 2022. It has been analyzed that **Easterseals/MORC** continued to have staffing issues for supports coordinators (case manager) from FY2021 through FY2022 due to the lack of available clinicians. This contributed to staffing burnout related carrying high caseloads. New staff require more ongoing training and support. Additional efforts have been implemented to hire supports coordinators to fill vacancies to allow supports coordinators to manage their caseload more effectively. Clinical supervisor continues to meet one on one with support coordination staff one to two times monthly and as needed to address potential follow up and monitoring identified through Vendor View communications. Administration staff works in Vendor View daily and sends all critical notices to clinical supervisor that will require follow up between the participant and the support coordinator and vendor to improve participant satisfaction. **Easterseals/MORC** will continue to send their quarterly "Vendor View Blasts" to remind providers on participants rights and satisfaction of service. Transportation to Medical Appointments: **Easterseals/MORC** identified the need to obtain an additional in network transportation provider to improve transportation availability and secured a contract July 2023.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
Physical Safety Measures: **Easterseals/MORC** sends "Vendor View Blasts" quarterly and as needed to remind vendors of "Health, Safety and Welfare" practices which has been an effective tool to maintain participant safety physical measures.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Global Ratings Measures: **Easterseals/MORC** did not score below the statewide average 91.8% (**Easterseals/MORC** 92.5%) in FY2022. Staff are Reliable and Helpful: **Easterseals/MORC** did not score below the statewide average 92.1% (**Easterseals/MORC** 97.4%) in FY2022. Physical Safety Measures: **Easterseals/MORC** did not score below the statewide average 100% (**Easterseals/MORC** 100%) in FY2022
c. Identify any barriers to implementing initiatives: **Easterseals/MORC** is currently trying to secure clinicians for supports coordinator position to alleviate high caseloads. **Easterseals/MORC** has had difficulty securing new providers willing to contract with the strict guidelines of the Medicaid Waiver Program in southeast MI.
HSAG's Assessment: HSAG determined that **Easterseals/MORC** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. **Easterseals/MORC**'s SFY 2022 rates for the *Global Ratings Measures* and *Staff are Reliable and Helpful* domains also scored above the statewide average, and both rates improved from the prior year. Additionally, while the SFY 2022 rates for the *Staff Listen and Communicate Well* and *Transportation to Medical Appointments* domains scored below the statewide average, both rates showed improvement. However, the rate for the *Recommendation Measures* domain continued to fall below the statewide average and declined from the prior year. As such, HSAG recommends that **Easterseals/MORC** explore additional/modified interventions to improve performance for each domain not demonstrating continued improvement.

Milestone Senior Services

Table 4-7—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: • **Milestone Senior Services** did not identify a goal for any of the five state-required PIPs. Additionally, although **Milestone Senior Services**' SFY 2020–2021 QMP included its first quarter metrics for each of the five PIPs, 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 PIP needs to be identified in **Milestone Senior Services**' QMP reports. 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. • **Milestone Senior Services** did not include PIP interventions in its QMP reports. Additionally, the prevalence rate for the *Prevalence of Dehydration* PIP 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 PIPs. 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. • 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 PIPs were unclear. **Milestone Senior Services**' PIPs 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. HSAG recommends that **Milestone Senior Services** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Milestone Senior Services** in a methodologically sound manner.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
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)***: Per QMP FY 2022-2023 (that should actually be 2021-2022 for FY22) Quality Management Plan, regarding Prevalence of falls, the plan states "MSS has chartered a Falls Prevention CQI Focus Improvement Project Team with a goal of achieving a minimum 53% improvement during the scope of this QMP. The team will utilize STEADI assessment tools during Assessments and Monthly Contacts to collect data and identify trends to PDSA causes for corrective and preventative actions." Regarding Prevalence of any injuries in the same plan, it states "MSS will charter an Injury Prevention CQI Focus Improvement Project with a goal of achieving 50% improvement during the scope of this QMP." Due to staff changes and Quality department restructuring, activities "still underway" include adding 3 of the 5 statewide PIPs (Prevalence of Falls, Prevalence of Any Injury, and Prevalence of Dehydration) to the FY23 QAPI plan as well as to the future FY24 plan assuming improvement projects for these PIPs are necessary continue improving upon.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Due to lack of documentation record of improvements projects being worked on and status of improvements, it is unknown if any performance improvement was achieved.
c. Identify any barriers to implementing initiatives: Due to the change in the Quality department structure and staff, the current Quality Manager was unaware of the HSAG report and expectations, and could not locate any documentation of work completed/accomplished towards initiatives and improvements.
HSAG's Assessment: HSAG determined that **Milestone Senior Services** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Milestone Senior Services** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Milestone Senior Services** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Milestone Senior Services** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report. Further, due to staff turnover, the waiver agency was unable to determine if any initiatives were implemented. As such, HSAG recommends that the waiver agency ensure more than one staff member participate in activities to improve performance and ensure documentation is available to those staff members.

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

HSAG recommended the following:

- **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. 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.
- **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. 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.
- **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. 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.
- **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. MDHHS did not require **Milestone Senior Services** to submit a CAP to remediate the one deficiency associated with

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
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.
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)***: Policies & procedures were developed and implemented to provide clear standards and expectations in order to meet the performance measure goals noted above. Comprehensive team AND one-on-one training with staff was also completed. Waiver leadership required supports coordinators to practice and conduct a personal chart audit and would continuously follow up with supports coordinators on areas needing improvement to ensure staff understand and are implementing the training provided accurately. Conducting consistent and regularly frequent record audits is an ongoing activity and standard the Quality department is working to successfully establish with sustainability.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Internal audit results revealed improvement as well as CQAR record submission and initial CQAR follow-up requests were significantly lower than the year prior.
c. Identify any barriers to implementing initiatives: Time is a reoccurring and frequent barrier to successful audit completion on a monthly basis of the recommended 10 records per supports coordinator. Current Quality Manager was also unaware of the HSAG EQR and recommendation.
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 and improvement in SFY 2022 Performance Measures 2, 4, 18, and 21, as all rates scored above the statewide average, and three of the four rates improved from the prior year.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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. • **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

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
includes a valid ROI form during the review period. 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. • **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. 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. • **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. 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. • **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. 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),

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
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. • **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. 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.
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)***: Policies & procedures were developed and implemented to provide clear standards and expectations in order to meet the performance measure goals noted above. Comprehensive team AND one-on-one training with staff was also completed. Waiver leadership required supports coordinators to practice and conduct a personal chart audit and would continuously follow up with supports coordinators on areas needing improvement to ensure staff understand and are implementing the training provided accurately. Conducting consistent and regularly frequent record audits is an ongoing activity and standard the Quality department is working to successfully establish with sustainability. Focus is also being placed on Follow-Up and Monitoring and Service Provider as it is not clear if improvements were made in those areas and/or improvements made are sustainable. It is also unclear if there is documentation of how to maintain success in these 2 areas.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Internal audit results revealed improvement as well as CQAR record submission and initial CQAR follow-up requests were significantly lower than the year prior.
c. Identify any barriers to implementing initiatives: Time is a reoccurring and frequent barrier to successful audit completion on a monthly basis of the recommended 10 records per supports coordinator. Current Quality Manager was also unaware of the HSAG EQR and recommendation.
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. Additionally, **Milestone Senior Services** received a *Substantial* compliance level for the Follow-Up and Monitoring focus area in SFY 2022, which was also an improvement from the prior year. However, **Milestone Senior Services** continued to receive low compliance levels for the Freedom of Choice, Service Provider, Critical Incidents, and Adverse Benefit Determination focus areas. As such, HSAG recommends that the waiver agency identify additional/modified interventions to improve performance in these focus areas.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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.
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)***: It is unknown if any initiatives were implemented or attempted. The new/current Quality Manager is working on locating results to review and conduct an RCA [root cause analysis] per recommendations to understand what specific questions caused lower scores in the areas noted above. The Quality Manager will also ensure future results are sent to the appropriate individuals within the organization (including themselves) as it is unclear where they were sent to.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Unknown.
c. Identify any barriers to implementing initiatives: New/Current Quality Manager was unaware of CAHPS survey taking place, when, by whom, and where the results are sent to when compiled and reported out. The new/current Quality Manager is unable to locate the results from FY21 to review and move forward with corrective action/improvement implementation.
HSAG's Assessment: HSAG determined that **Milestone Senior Services** was unable to fully address the prior year's recommendations. Due to staff turnover, the waiver agency was unable to determine if any initiatives were implemented. The SFY 2022 results indicate that the *Global Ratings Measures*, *Recommendation Measures*, *Staff are Reliable and Helpful*, and *Planning Your Time and Activities* domains scored above the statewide averages and improved from the prior year. The *Case Manager is Helpful* domain also improved

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
from the prior year but continued to score below the statewide average. The *Met Need* domain also continued to score below the statewide average and declined from the prior year. As such, HSAG recommends that the waiver agency ensure more than one staff member participate in activities to improve performance and ensure documentation is available to those staff members. HSAG further recommends that **Milestone Senior Services** identify additional/modified interventions to improve performance for each domain not demonstrating continued improvement.

Northern Health Care Management

Table 4-8—Prior Year Recommendations and Responses for Northern Health Care Management

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **Northern Health Care 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 Health Care Management** when initiating the PIPs. 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 PIP 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 PIPs, which would allow for year-to-year comparative data. HSAG recommends that **Northern Health Care 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 Health Care 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 Health Care Management** should develop a mechanism to validate PIP performance and present performance rates for the entire state fiscal year. • The interventions implemented by **Northern Health Care 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 Health Care 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 PIPs. HSAG recommends that **Northern Health Care 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 Health Care 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 Health Care Management** should analyze and interpret results at multiple points in time and test for statistical significance. **Northern Health Care 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.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
• **Northern Health Care 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 PIPs. **Northern Health Care Management**'s PIPs 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. HSAG recommends that **Northern Health Care Management** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Northern Health Care 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 Health Care Management** is a participating MI Choice Waiver Agency in the MDHHS sponsored "Quality Focus Group", that is meets to define, objective, and measurable quality indicators. **Northern Health Care Management**'s FY23 initiative is to review and ensure future QAPI reports 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. QAPIs will include goal analysis, success or barriers, and strategies for eliminating identified barriers. • **Northern Health Care Management** has assigned a 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 Health Care Management**'s Administrative Review Committee (ARC) was created in June 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 PIPs to ensure the technical structure of each PIP is designed, conducted, and reported in a methodologically sound manner.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Northern Health Care Management** FY23 QAPI includes clearly defined, objective, and measurable quality indicators and established goals based on report instructions created during the Quality Focus group. The QAPI includes goals, interventions, data, analysis, and barriers. • **Northern Health Care Management** continues to participate in Quality Focus Group with other agencies. • Continued review and changes to agency staff, roles, and responsibilities that contribute to agency improvements to assist with quality focus. Creating QMP to include recommendation regarding the analysis of goals, outcomes, barriers, and strategies for improvement. • Initiative to review continue to learn CMS EQR Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity. Working with MDHHS to establish performance improvement projects.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
c. Identify any barriers to implementing initiatives: • Barrier #1 FY21 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 and followed MDHHS' report outline instructions. • 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 FY.
HSAG's Assessment: HSAG determined that **Northern Health Care Management** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Northern Health Care Management** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals, interventions implemented were still unclear, and the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Northern Health Care Management** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Northern Health Care Management** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **Northern Health Care 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. MDHHS required **Northern Health Care Management** to submit a CAP to remediate the deficiencies associated with Performance Measure 17. **Northern Health Care 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 Health Care Management**'s CAP required internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Northern Health Care 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. • **Northern Health Care 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. MDHHS required **Northern Health Care**

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
Management to submit a CAP to remediate the deficiencies associated with Performance Measure 19. **Northern Health Care 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 Health Care Management**'s CAP required internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Northern Health Care 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. • **Northern Health Care 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. MDHHS did not require **Northern Health Care Management** to submit a CAP to remediate the one deficiency associated with Performance Measure 21. However, HSAG recommends that **Northern Health Care 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.
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 Health Care Management** will review each Performance Measure identified by CQAR in next FY23 audit that require a CAP and will include a plan for continued internal monitoring of a specific number of record reviews on a quarterly basis. • **Northern Health Care Management** conducts record reviews internally that are not reported to CQAR after internal compliance is demonstrated.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Specific citation education was provided in February 2023 regarding the CAPs for person centered services plan and the services that **Northern Health Care Management** provide for MI Choice waiver participants. • Person centered service plan education was provided in person to all supports coordinators on August 3rd, 2023. • Performance measure #17, 19, and 21: Improved performance has yet to be demonstrated. Interventions are being provided to supports coordinators and will be monitored over the next quarter.
c. Identify any barriers to implementing initiatives: • CQAR CAPs occur during part of the next FY timeframe, delaying implementation of new initiatives of including continued agency monitoring to the CAP prior to the next CQAR audit.
HSAG's Assessment: HSAG determined that **Northern Health Care Management** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. However, the rates for Performance Measures 17, 19, and 21 continued to fall below the statewide average rates for

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
SFY 2022, with Performance Measures 17 and 21 demonstrating a significant decline from the prior year. As such, HSAG recommends that **Northern Health Care Management** explore additional/modified interventions to improve performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **Northern Health Care 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. MDHHS required **Northern Health Care Management** to submit a CAP to remediate the deficiencies. **Northern Health Care 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 Health Care Management**'s CAP required internal monitoring until compliance of 85 percent is achieved, HSAG recommends that **Northern Health Care 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. • **Northern Health Care 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. MDHHS required **Northern Health Care Management** to submit a CAP to remediate the deficiencies. **Northern Health Care 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 Health Care Management**'s CAP required internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Northern Health Care 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.
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 Health Care Management** will review each Performance Measure identified by CQAR in next FY23 audit that require a CAP and will include a plan for continued internal monitoring of a specific number of record reviews on a quarterly basis. • Release of Information form was revised by **Northern Health Care Management** and implemented. Electronic health record was modified to include an expiration date on current uploaded documents that triggers to the supports coordinators dashboard for due dates. A new release of information is conducted during each assessment conducted so that the form is due at the same time as the next annual assessment.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
• Participant status and enrollment/disenrollment date information is continually monitored to ensure that the **Northern Health Care Management**'s technology system is consistent with those in CHAMPS.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Performance of ROI: Improved performance has yet to be demonstrated. Interventions are being provided to supports coordinators and will be monitored over the next quarter. • Release of Information still requires ongoing staff education and monitoring for compliance FY22 showed a continued need for CAP. • FY22 improvement was demonstrated with no requirement for creating a CAP for program enrollment and disenrollment dates as dates were supported in the member's record and were consistent with those in CHAMPS.
c. Identify any barriers to implementing initiatives: • CQAR CAPs occur during part of the next FY timeframe, delaying implementation of new initiatives of including continued agency monitoring to the CAP prior to the next CQAR audit.
HSAG's Assessment: HSAG determined that **Northern Health Care Management** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. The results of the SFY 2022 compliance review activity also confirmed that **Northern Health Care Management** received a *Substantial* or *Some, Needs Improvement* compliance level for the Release of Information and Status focus areas, which was an improvement from the prior year.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **Northern Health Care 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. HSAG recommends that **Northern Health Care 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.
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)***:
• Review of case manager is helpful domain. This domain includes three questions. Two of the questions were below statewide average by 5%.
  ○ 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.
• Meeting with supports coordinators took place to ensure follow-up with participants is occurring as scheduled or as changes occur.
• Discussion with supports coordinators took place reviewing MI Choice Waiver practices and policies to ensure consistency amongst the team.
• Discussion took place with supports coordinators to ensure all calls are returned to each participant in a timely manner and documented as a progress note within the medical chart.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
• The importance of community collaboration was discussed. For example, collaborating care with Continued Living Support providers, and other contracted providers (Mom's Meals, Valued Relations Inc) to address any concerns with services. Follow-up with participant must occur as soon as possible to ameliorate any concerns and documented as a progress note within the medical chart.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Calls to participants are returned within 24 hours. • Immediate concerns related to participants are addressed same day and documented in medical chart. • Face to face assessments resumed post COVID. Reminder calls implemented 72 hours beforehand. • Chart reviews to ensure missing documents are obtained for example physician notes, scripts, and signed documents to prevent a lapse in service. • Follow-up resources offered for services MI Choice Waiver is unable to assist or authorize (for example non-Waiver paid items such as a sauna/hot tub, need for Community Mental Health services). • **Northern Health Care Management** will continue to work towards improvement in participant satisfaction.
c. Identify any barriers to implementing initiatives: • Low sample size of 30 surveys completed out of 275. • We are missing specific examples from the survey. For example, what are response options, "yes", "no", "not applicable?" We are unable to remedy an issue without specificity. • How are the participants interpreting the questions asked within the survey? Do they understand the question? • Support coordinator's report and document discussion with participants with little to no follow through on participant end. This could skew how the participant responds in relation to satisfaction of services. For example, as discussed with supports coordinators, "personalities of the participant" play a factor in satisfaction of services. Some participants are requesting unrealistic items claiming "medical necessity" for example a hot tub and sauna. When declined these items, participants and their families become upset with the MI Choice Waiver program. • Participants do not always understand program constraints. What we can and cannot pay for despite being explained and documented. They do not understand Medicaid rules. • Changes in funding. Resources and funding change frequently. It is reported we have participants who have been enrolled for 10 plus years and are noticing a decline in provided services. No fault of MI Choice Waiver rather changes to the Medicaid rules over the years. • Refusal of participants to answer questions or phone calls for follow-up. • In the moment responses. For example, situational stressors could affect mood and how the participant may respond to the survey. For example, is the participant experiencing chronic pain or loneliness/isolation, things outside of Mi Choice Waiver Support's Coordinator control. • Requested services that participant does not qualify for. Example- transportation when participant owns a car but would rather not drive. Additional Community Living Support services but are not eligible. • Limited resources due to lack of staffing. This has been a universal concern when seeking Continued Living Support for participants with limited to no informal supports.
HSAG's Assessment: HSAG determined that **Northern Health Care Management** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. However,

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
Northern Health Care Management's SFY 2022 rate for the *Case Manager is Helpful* domain continued to score below the statewide average and declined in performance from the prior year. As such, **Northern Health Care Management** should identify additional/modified interventions to improve performance in this domain.

Region 3B Area Agency on Aging/Carewell Services

Table 4-9—Prior Year Recommendations and Responses for Region 3B Area Agency on Aging/ Carewell Services

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • The **Region 3B Area Agency on Aging/Carewell Services** 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. HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** ensure its QMP includes clearly defined, objective, and measurable quality indicators and established goals. • **Region 3B Area Agency on Aging/Carewell Services** 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. HSAG recommends **Region 3B Area Agency on Aging/Carewell Services** identify the baseline period and rate for each quality indicator and measure them regularly to determine if interventions implemented are effective. • In the SFY 2021 annual report, **Region 3B Area Agency on Aging/Carewell Services** 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. HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** monitor the percentage results for each quality indicator on an ongoing basis to determine if interventions are successful throughout the time period of the PIP. • The interventions implemented by **Region 3B Area Agency on Aging/Carewell Services** did not appear to be effective as **Region 3B Area Agency on Aging/Carewell Services** did not meet the statewide goals for four of the five PIPs (*Prevalence of Neglect/Abuse*, *Prevalence of Falls*, *Prevalence of Any Injuries*, and *Prevalence of Dehydration*). Additionally, **Region 3B Area Agency on Aging/Carewell Services'** rate for the *Prevalence of Falls* PIP increased significantly (20.63 percentage points) from SFY 2020 to SFY 2021. **Region 3B Area Agency on Aging/Carewell 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 PIPs. HSAG recommends that **Region 3B Area Agency on Aging/Carewell 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) and innovative (e.g., not an activity already included as part of the expected care management processes). **Region 3B Area Agency on Aging/Carewell Services** should also identify and prioritize barriers through causal/barrier analysis and the selection of appropriate, active

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
interventions should address these barriers to improve outcomes. **Region 3B Area Agency on Aging/Carewell Services** should analyze and interpret results at multiple points in time and test for statistical significance. **Region 3B Area Agency on Aging/Carewell 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. • 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 PIPs were unclear. **Region 3B Area Agency on Aging/Carewell Services**' PIPs 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. HSAG recommends that **Region 3B Area Agency on Aging/Carewell Services** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Region 3B Area Agency on Aging/Carewell 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)***: • **Region 3B Area Agency on Aging/Carewell Services** created its QMP based on the requirements specified by MDHHS' QMP outline. • **Region 3B Area Agency on Aging/Carewell Services** created a detailed QAPI that established goals, target dates, and workplans to measure progress or setbacks. • **Region 3B Area Agency on Aging/Carewell Services** created improved auditing tools to help this provider identify any potential issues quickly. • **Region 3B Area Agency on Aging/Carewell Services** implanted a new orientation program that allowed this provider to do more training on care management and quality goals.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • [None identified.]
c. Identify any barriers to implementing initiatives: • Staff changes within the Quality department have created a minor barrier due to the fact that the staff member who wrote the QAPI is no longer with **Region 3B Area Agency on Aging/Carewell Services**. • Staffing issues resulting in high caseloads have caused some barriers in meeting some of the goals outlined in **Region 3B Area Agency on Aging/Carewell Services** QAPI.
HSAG's Assessment: HSAG determined that **Region 3B Area Agency on Aging/Carewell Services** partially addressed the prior year's recommendations. While **Region 3B Area Agency on Aging/Carewell Services** included its goals for each PIP in place during 2022, they did not align with MDHHS-required goals, and the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Region 3B Area Agency on Aging/Carewell Services** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, the PIP documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Region 3B Area Agency on Aging/Carewell Services** ensure its PIP documentation aligns with the nine activities outlined in

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report. Further, **Region 3B Area Agency on Aging/Carewell Services** reported staff turnover as a barrier to implementing initiatives. As such, HSAG recommends that the waiver agency ensure more than one staff member participate in activities to improve performance and ensure documentation is available to those staff members.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **Region 3B Area Agency on Aging/Carewell Services** 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. MDHHS required **Region 3B Area Agency on Aging/Carewell Services** to submit a CAP to remediate the deficiencies associated with Performance Measure 16. **Region 3B Area Agency on Aging/Carewell Services'** 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/Carewell Services** identified it would conduct internal monitoring until compliance of 90 percent is achieved, HSAG recommends that **Region 3B Area Agency on Aging/Carewell 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.
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/Carewell Services** created a detailed training of PCSPs for all new staff as part of their orientation process. • **Region 3B Area Agency on Aging/Carewell Services** created internal monitoring tools that are used on a minimum of 2 PCSPs per support coordinator per month to ensure that this provider is addressing the assessed health and safety risks of our participants.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • [None identified.]
c. Identify any barriers to implementing initiatives: • High caseloads have caused some inconsistencies in hitting the 90 percent compliance rate.
HSAG's Assessment: HSAG determined that **Region 3B Area Agency on Aging/Carewell Services** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improvement in Performance Measure 16, which scored above the SFY 2022 statewide average and improved in performance from the prior year.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **Region 3B Area Agency on Aging/Carewell Services** 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. MDHHS required **Region 3B Area Agency on Aging/Carewell Services** to submit a CAP to remediate the deficiencies. **Region 3B Area Agency on Aging/Carewell Services'** 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/Carewell Services** 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/Carewell 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 **Region 3B Area Agency on Aging/Carewell 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.
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/Carewell Services** developed a workplan to monitor the utilization of services on a quarterly basis. • Monthly audits are conducted to ensure that 2 week follow up calls are made
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • [None identified.]
c. Identify any barriers to implementing initiatives: • High caseloads of 40-50 per supports coordinator. High turnover in supports coordinator staffing.
HSAG's Assessment: HSAG determined that **Region 3B Area Agency on Aging/Carewell Services** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improvement in the SFY 2022 results for the Follow-Up and Monitoring focus area, which received a *Substantial* compliance level and increased in performance from the prior year.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **Region 3B Area Agency on Aging/Carewell 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. Although no substantial weaknesses were identified within any of the CAHPS domains, **Region**

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
3B Area Agency on Aging/Carewell Services 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/Carewell Services** 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.
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)***: • Quality staff no longer works for **Region 3B Area Agency on Aging/Carewell Services** so it is unclear what interventions and processes were implanted in SFY 2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • According to CAHPS report for FY22, **Region 3B Area Agency on Aging/Carewell Services** scored 100% in category Case Manager is Helpful (State 95.8%), 91.8% in category Choosing the Services that Matter to You (State 90.8%), and 79.7% in category Planning Your Time and Activities (State 78.5%).
c. Identify any barriers to implementing initiatives: • [None identified.]
HSAG's Assessment: HSAG determined that **Region 3B Area Agency on Aging/Carewell Services** was unable to fully address the prior year's recommendations. Due to staff turnover, the waiver agency was unable to determine if any initiatives were implemented. As such, HSAG recommends that the waiver agency ensure more than one staff member participate in activities to improve performance and ensure documentation is available to those staff members. Further, the SFY 2022 results demonstrated that the *Case Manager is Helpful* and *Planning Your Time and Activities* domains scored above the statewide average and improved in performance from the prior year. However, while the *Choosing the Services that Matter to You* domain also scored above the statewide average, it declined in performance from the prior year, and the *Met Need* domain declined in performance and continued to score below the statewide average. HSAG further recommends that **Region 3B Area Agency on Aging/Carewell Services** identify additional/modified interventions to improve performance for each domain not demonstrating continued improvement.

Region IV Area Agency on Aging

Table 4-10—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: • **Region IV Area Agency on Aging** did not identify any goals for the PIPs 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. 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. • **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. 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. • **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 PIPs. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly documented. 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. • 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 PIPs were unclear. **Region IV Area Agency on Aging**'s PIPs 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. HSAG recommends that **Region IV Area Agency on Aging** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP 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)***:

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
• **Region IV Area Agency on Aging** updated the QAPI plan as required by MDHHS in FY 23 as well as the FY 22 QMP to include defined, objective, and measurable quality indicators and established goals. These goals are documented within the updated FY 23 QAPI to be evaluated in the annual report. • Included in the FY 23 QAPI plan and FY 22 QMP are baseline periods and rate for each quality indicator to be measured at a minimum quarterly. • FY 21 QMP described **Region IV Area Agency on Aging** use of the STEADI screening for fall prevention, which is evidenced based. Currently, **Region IV Area Agency on Aging** is in collaboration with the "New Quality Focus" group which is comprised of MDHHS and quality departments throughout the state. The measurement of statewide QIs is outdated due to changes within the MI Choice program- annual assessments vs quarterly assessments, measurements of falls and injuries includes those falls and injuries that occur prior to admission into the MI Choice program and exclude the bed bound population. **Region IV Area Agency on Aging** continues to evaluate falls during monitoring contacts and assessments with participants. • **Region IV Area Agency on Aging** FY 22 QMP and FY 23 QAPI follows the follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Region IV Area Agency on Aging** recognizes the compliance of the FY 22 QMP and FY 23 QAPI as a performance improvement to the identified deficiencies in our FY 21 QMP.
c. Identify any barriers to implementing initiatives: • There are no identified barriers to implementing the recommended and required changes to the FY 22 QMP and FY 23 QAPI.
HSAG's Assessment: HSAG determined that **Region IV Area Agency on Aging** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Region IV Area Agency on Aging** included its goals for each PIP in place during SFY 2022 that aligned with MDHHS-required goals, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Region IV Area Agency on Aging** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Region IV Area Agency on Aging** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • 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. 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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
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.
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** continues to monitor all deficiencies identified on MDHHS CQAR audit even after 90% compliance is achieved at a rate of 10 charts a month.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Noted performance improvements have been noted with compliancy of MDHHS standards upon record reviews that is demonstrated in reporting to CQAR monthly for FY 21-22.
c. Identify any barriers to implementing initiatives: • **Region IV Area Agency on Aging** does not have the staffing capacity to conduct record reviews of 10 per month per supports coordinator.
HSAG's Assessment: HSAG determined that **Region IV Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. Additionally, the SFY 2022 results demonstrated that Performance Measures 15, 16, and 19 scored above the statewide average, and two of the measures increased in performance from the prior year. However, **Region IV Area Agency on Aging** received a score that fell more than 5 percentage points below the statewide rate for Performance Measure 17 during SFY 2022. Further, **Region IV Area Agency on Aging**'s SFY 2022 rate for Performance Measure 30 scored below the statewide average; however, the review standards for this measure changed from SFY 2021. Therefore, HSAG was unable to assess a year-over-year comparison. As such, HSAG recommends that **Region IV Area Agency on Aging** explore additional/modified interventions to improve performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
• **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. 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.
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** continues to monitor all deficiencies identified on MDHHS CQAR audit even after 90% compliance is achieved at a rate of 10 charts a month. **Region IV Area Agency on Aging** monitors underutilization of services monthly by reviewing non-services reporting by provider agencies and monitoring contacts with participants to ensure services are received.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Noted performance improvements have been noted with compliancy of MDHHS standards upon record reviews that is demonstrated in reporting to CQAR monthly for FY 21-22.
c. Identify any barriers to implementing initiatives: • **Region IV Area Agency on Aging** does not have the staffing capacity to conduct record reviews of 10 per month per supports coordinator. • The national direct care workforce shortage has impacted **Region IV Area Agency on Aging** provider network.
HSAG's Assessment: HSAG determined that **Region IV Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Region IV Area Agency on Aging** improved its performance on the Follow-Up and Monitoring focus area, its performance remained the same for the Freedom of Choice focus area. HSAG recommends that **Region IV Area Agency on Aging** continue to implement its CAP of conducting staff education and the use of a job aid. However, if improvement is not realized, **Region IV Area Agency on Aging** should modify its CAP and implement alternative interventions.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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.
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)***: • Activities that have been implemented to address the findings identified above were implemented previous to our 04/26/2023 receipt of the FY 22 CAHPS report: Increased transportation network providers, dashboard reminders for supports coordinators for follow up for participant needs, reopening of Adult Day Health centers, use of Grandpads by participants to improve activities and loneliness.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Unable to identify performance improvement until the FY 23 CAHPS survey is completed.
c. Identify any barriers to implementing initiatives: • None.
HSAG's Assessment: HSAG determined that **Region IV Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. However, **Region IV Area Agency on Aging** scored below the SFY 2022 statewide average for the *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Planning Your Time and Activitie*s, and *Met Need* domains. However, the *Planning Your Time and Activities* domain did demonstrate some improvement from the prior year. As such, HSAG recommends that **Region IV Area Agency on Aging** explore additional/modified interventions to improve performance for each domain not demonstrating continued improvement.

Region VII Area Agency on Aging

Table 4-11—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: • 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 PIPs. 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. • The interventions implemented by **Region VII Area Agency on Aging** for the *Prevalence of Neglect/Abuse* PIP 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. 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. • 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 PIPs were unclear. **Region VII Area Agency on Aging**'s PIPs 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. HSAG recommends that **Region VII Area Agency on Aging** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP 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** did not specifically indicate the date by which the goal was to be achieved in the FY2020-2021 QMP. In the future, **Region VII Area Agency on Aging** will establish clearly defined timeframes allowing for measurable quality indicators and goals. This will allow **Region VII Area Agency on Aging** to evaluate the rates against clearly defined goals. • **Region VII Area Agency on Aging** has increased the amount of education provided to the MI Choice Waiver staff in regards to Neglect/Abuse. All MI Choice Waiver staff members are required to attend

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
assigned trainings throughout the year and MI Choice Waiver meetings on a monthly basis. The Quality Department and MI Choice Waiver Department have been working closely together to ensure that staff understand the importance of identifying and reporting Critical Incidents, identifying reasons for hospitalizations, and identifying possible neglect/abuse during in-person visits, assessments, and phone calls. MI Choice Waiver staff members are also required to not only identify, but also educate program participants on elder abuse/neglect during each assessment. Participants are provided with resources and contact information for APS [Adult Protective Services] central intake and Critical Incidents. • The following trainings have been assigned to MI Choice staff no less than annually: Abuse/Neglect and Elder Justice, Critical Incidents, Hospitalizations, and Mandated Reporting. Each training also includes a required test to ensure understanding of information presented.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During FY2019, 61 (6.4%) participants reported neglect or abuse, had poor hygiene, were fearful of a family member, or were restrained. • During FY2020, 37.5 (4.9%) participants reported neglect or abuse, had poor hygiene, were fearful of a family member, or were restrained. **Region VII Area Agency on Aging** participants experienced 0.1% lower than the statewide goal of 5.0% for prevalence of abuse/neglect for FY2022. State Average: 5.2% • During FY2021, 49.5 (5%) participants reported neglect or abuse, had poor hygiene, were fearful of a family member, or were restrained. **Region VII Area Agency on Aging** participants experienced the same as the statewide goal of 5.0% for prevalence of abuse/neglect for FY2022. State Average: 5.3%
c. Identify any barriers to implementing initiatives: • The Public Health Emergency (PHE) related to Covid-19 began in March 2020 did result in barriers to implementing initiatives. The PHE limited face-to-face and in-person visits (and assessments) with participants. As a result of the PHE, finding and ensuing care for participants through community living supports also resulted in participant physical isolation and social isolation. • **Region VII Area Agency on Aging** continued to provide education in regards to neglect/abuse to MI Choice Waiver staff members via email, Zoom, and Paycor to overcome the PHE-related barriers.
HSAG's Assessment: HSAG determined that **Region VII Area Agency on Aging** partially addressed the prior year's recommendations. While **Region VII Area Agency on Aging** included its goals for each PIP in place during 2022, the reported outcome rates differed from the MDHHS-reported rates. Additionally, the goal identified for the *Falls with Injury* PIP beginning in SFY 2023 did not align with MDHHS' expected measurement, and instead restated the goals for the *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs from SFY 2022. HSAG continues to recommend that **Region VII Area Agency on Aging** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, the PIP documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Region VII Area Agency on Aging** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • HSAG did not identify any substantial trends of weakness. 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.
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** continues to provide oversight and monitoring of compliance of each supports coordinator through internal audits completed by the Quality Department, Waiver Department managers, and supports coordinator peer reviews.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Region VII Area Agency on Aging** will continue to provide oversight and monitoring of compliance of each supports coordinator through internal audits completed by the Quality Department, Waiver Department managers, and supports coordinator Peer Reviews. The Quality Department completes chart audits of all supports coordinators no less than quarterly. All newly enrolled participant charts are audited following enrollment into the MI Choice Waiver program. supports coordinator peer reviews are completed bi-annually by all supports coordinators, which includes 3 charts per supports coordinator. Information obtained through internal audits is utilized to determine needed staff trainings.
c. Identify any barriers to implementing initiatives: • No barriers.
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 and continued high performance on most SFY 2022 performance measures.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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.

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)***: • **Region VII Area Agency on Aging** completed the CAP and continues to provide internal monitoring of chart compliance through internal audits completed by the Quality Department, Waiver Department Managers, and supports coordinator peer reviews. The Quality Department completes chart audits of all supports coordinators no less than quarterly. All newly enrolled participant charts are audited following enrollment into the MI Choice Waiver program. supports coordinator peer reviews are completed bi-annually by all supports coordinators, which includes 3 charts per supports coordinator. • Information obtained through internal audits is utilized to determine needed staff trainings.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Region VII Area Agency on Aging** has provided trainings related to Critical Incidents, Back-Up Plans, Emergency Preparedness, and all information contained in the 2019 MI Choice Waiver Handbook. All of the information discussed was required to be provided to the MI Choice Waiver participant. All MI Choice Waiver participants are educated on and provided a **Region VII Area Agency on Aging** MI Choice Waiver resource folder that includes information on Critical Incidents and reporting them, emergency phone numbers, APS phone number, and the supports coordinators' phone numbers. • All Critical Incidents are required to be emailed to multiple staff members to ensure timely reporting in the MI Choice Critical Incident Portal.
c. Identify any barriers to implementing initiatives: • The PHE related to Covid-19 began in March 2020 did result in barriers to implementing initiatives. The PHE limited face-to-face and in-person visits (and assessments) with participants, making it more difficult for the supports coordinators to identify Critical Incidents. As a result of the PHE, education to participants was provided via phone, Zoom, and/or mail.
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 and improved performance in the Critical Incidents focus area, which received a *Substantial* compliance level in SFY 2022.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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*

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
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.
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** met compliance with all CAHPS domains. **Region VII Area Agency on Aging** continues to educate staff on communication, Person-Centered Planning, neglect/abuse, and other CAHPS-related findings.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During FY2019 **Region VII Area Agency on Aging** CAHPS report reflected 91.1% of MI Choice Waiver participants reported C*ase Manager is Helpful.* During FY2021 **Region VII Area Agency on Aging** CAHPS report reflected 96.4% of MI Choice Waiver participants reported C*ase Manager is Helpful.* • During FY2019 **Region VII Area Agency on Aging** CAHPS report reflected 91.1% of MI Choice Waiver participants reported *Choosing the Services that Matter to You.* During FY2021 **Region VII Area Agency on Aging** CAHPS report reflected 92.2% of MI Choice Waiver participants reported C*hoosing the Services that Matter to You.* • FY2019 **Region VII Area Agency on Aging** CAHPS report reflected 96.7% of MI Choice Waiver participants reported *Personal Safety and Respect.* During FY2021 **Region VII Area Agency on Aging** CAHPS report reflected 96.6% of MI Choice Waiver participants reported *Personal Safety and Respect.*
c. Identify any barriers to implementing initiatives: • The PHE related to Covid-19 began in March 2020 did result in barriers to implementing initiatives. The PHE limited face-to-face and in-person visits (and assessments) with participants. As a result of the PHE, finding and ensuring care for participants through community living supports also resulted in participant physical isolation, social isolation, lack of formal support, decreased informal support. • **Region VII Area Agency on Aging** continued to provide education in regards to communication via phone and Zoom, Person-Centered Planning, and neglect/abuse to MI Choice Waiver staff members via email, Zoom, and Paycor to overcome the PHE-related barriers. As a result of the PHE, education to participants was provided via phone, Zoom, and/or mail.
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 and the results of the SFY 2022 CAHPS activity. The *Case Manager is Helpful* and *Choosing the Services that Matter to You* domains scored above the statewide average and increased in performance from the prior year. However, *Personal Safety and Respect* continued to score below the statewide average and declined slightly from the prior year. As such, HSAG recommends that **Region VII Area Agency on Aging** explore additional/modified interventions to improve performance for each domain not demonstrating continued improvement.

Region 9 Northeast MI Community Service Agency

Table 4-12—Prior Year Recommendations and Responses for Region 9 Northeast MI Community Service Agency

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **Region 9 Northeast MI Community Service Agency**'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 Northeast MI Community Service Agency** when initiating the PIPs. 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 PIP unless documentation is provided to support the rationale for the change. Additionally, although **Region 9 Northeast MI Community Service Agency** identified in the SFY 2020–2021 QMP that it had determined a baseline data set for the PIPs, 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. HSAG recommends that **Region 9 Northeast MI Community Service Agency** 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 Northeast MI Community Service Agency** 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 Northeast MI Community Service Agency** ensure its QMP and annual report include baseline data and the year-over-year comparative analysis. • While **Region 9 Northeast MI Community Service Agency**'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 PIPs were limited. **Region 9 Northeast MI Community Service Agency**'s PIPs 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. HSAG recommends that **Region 9 Northeast MI Community Service Agency** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Region 9 Northeast MI Community Service Agency** 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 Northeast MI Community Service Agency** more clearly defined, aligned, and maintained goals established by MDHHS in our FY2022, FY2023 plans.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
• **Region 9 Northeast MI Community Service Agency** followed the methodology outlined in the EQR protocols when designing their PCP projects in FY2022 and FY2023
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • **Region 9 Northeast MI Community Service Agency** follows the directive of MDHHS in its reporting requirements.
HSAG's Assessment: HSAG determined that **Region 9 Northeast MI Community Service Agency** was unable to address the prior year's recommendations. While **Region 9 Northeast MI Community Service Agency** included its goals for each PIP in place during 2022, the reported outcome rates differed from the MDHHS-reported rates. Additionally, the goal identified for the *Falls with Injury* PIP beginning in SFY 2023 did not align with MDHHS' expected measurement, and instead restated the goals for the *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs from SFY 2022. HSAG continues to recommend that **Region 9 Northeast MI Community Service Agency** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Region 9 Northeast MI Community Service Agency** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report. Further, due to staff turnover, the waiver agency was unable to determine if any initiatives were implemented. As such, HSAG recommends that the waiver agency ensure more than one staff member participate in activities to improve performance and ensure documentation is available to those staff members.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • HSAG did not identify any substantial trends of weakness. Although **Region 9 Northeast MI Community Service Agency** met or exceeded the statewide performance rate for all performance measures, HSAG recommends that **Region 9 Northeast MI Community Service Agency** 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.
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 our **Region 9 Northeast MI Community Service Agency** FY 22-23 QMP. This process includes quarterly and random chart reviews that ensure compliance with these measures on an ongoing basis. **Region 9 Northeast MI Community Service Agency** conducts internal record reviews but does not report them to the state. Corrective action only requires reporting until compliance is achieved.

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): • N/A
c. Identify any barriers to implementing initiatives: • **Region 9 Northeast MI Community Service Agency** did not change our practice. **Region 9 Northeast MI Community Service Agency** conducts internal record reviews but is not required to report those results to the state. FY2022 and the majority of FY2023 activities were complete by the time the HSAG report was received.
HSAG's Assessment: HSAG determined that **Region 9 Northeast MI Community Service Agency** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and continued high performance on most performance measures in SFY 2022.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **Region 9 Northeast MI Community Service Agency** 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. MDHHS required **Region 9 Northeast MI Community Service Agency** to submit a CAP to remediate the deficiencies. **Region 9 Northeast MI Community Service Agency**'s CAP included, but was not limited to, staff training and education and a review of 13 records. While **Region 9 Northeast MI Community Service Agency** 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 Northeast MI Community Service Agency** 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.
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 our **Region 9 Northeast MI Community Service Agency** FY 22-23 QMP. This process includes quarterly and random chart reviews that ensure compliance with these measures on an ongoing basis. **Region 9 Northeast MI Community Service Agency** conducts internal record reviews but does not report them to the state. Corrective action only requires reporting until compliance is achieved.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • **Region 9 Northeast MI Community Service Agency** did not change our practice. **Region 9 Northeast MI Community Service Agency** conducts internal record reviews but is not required to report those results to the state. FY2022 and the majority of FY2023 activities were complete by the time the HSAG report was received.
HSAG's Assessment: HSAG determined that **Region 9 Northeast MI Community Service Agency** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
initiatives and improved performance in the Freedom of Choice focus area, which received a *Substantial* compliance level in SFY 2022 and was an improvement from the prior year.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **Region 9 Northeast MI Community Service Agency** 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. HSAG recommends that **Region 9 Northeast MI Community Service Agency** 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. • **Region 9 Northeast MI Community Service Agency** 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. HSAG recommends that **Region 9 Northeast MI Community Service Agency** 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.
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 Northeast MI Community Service Agency** conducts its own satisfaction survey. The MSU results are not for federal reporting for individual agencies. The findings are inconsistent with internal findings.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Region 9 Northeast MI Community Service Agency** did not change our practice. **Region 9 Northeast MI Community Service Agency** has always conducted an internal survey. The results are reported in the FY2023 QAPI and Activities & Outcomes report.
c. Identify any barriers to implementing initiatives: • N/A **Region 9 Northeast MI Community Service Agency** conducts an independent survey.
HSAG's Assessment: HSAG determined that **Region 9 Northeast MI Community Service Agency** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improved performance in the *Recommendation Measures* domain. However, while **Region 9 Northeast MI Community Service Agency**'s score for the *Case Manager is Helpful* domain increased, it was still below the statewide average for SFY 2022. HSAG recommends **Region 9 Northeast MI Community Service Agency** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores contributed to the low satisfaction score within the *Case Manager is Helpful* domain, develop interventions to improve the *Case Manager is Helpful* domain, and evaluate the results of the interventions regularly, making changes as necessary.

Reliance Community Care Partners

Table 4-13—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: • **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* PIPs 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 PIPs. 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. • **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 PIPs. 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 PIP 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%). 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. • 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 PIPs were unclear. **Reliance Community Care Partners**' PIPs 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

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
identification of barriers and subsequent development of relevant interventions. HSAG recommends that **Reliance Community Care Partners** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP 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** in collaboration with five (5) other agencies continues to work on improving turn-around times with monitoring contacts and reassessments. Great progress has been made with an average percentage of 93.29%. This is a performance measure that we will continue to monitor monthly. **Reliance Community Care Partners** continues to work on fall data and our score has increased after staff training and is currently at 39%. Additional root cause analysis identifies that annual assessments has a significant impact on how the quality indicator measures are reported as the reports are limited to 6 month snapshots within the same Fiscal Year.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Reliance has shown significant improvement with Monitoring contacts and reassessment timeliness with an average of 93.29% per month/quarter/annual result.
c. Identify any barriers to implementing initiatives: • **Reliance Community Care Partners** barriers are related to annual assessments and staff capturing fall data accurately. We have provided trainings with some change noted but in the wrong direction as this measure has increased to 39%. **Reliance Community Care Partners** recently implemented additional training with respect to answering the InterRAI-HC Fall questions.
HSAG's Assessment: HSAG determined that **Reliance Community Care Partners** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Reliance Community Care Partners** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals and included implemented interventions, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Reliance Community Care Partners** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Reliance Community Care Partners** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
consistent with the PCSP. 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. • **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. 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.
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 use of virtual visits and attempts at corresponding via United States Postal Service was a significant barrier for **Reliance Community Care Partners** business model. **Reliance Community Care Partners** moved back to using virtual visits in April 2022 and this has demonstration vast improvement at the case manager and business level along with the 2023 clinical quality audit preliminary results.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Reliance Community Care Partners** has better control over workflow processes and paperwork completion as a result of returning to home visits in May 2022. This one change has helped to improve compliance.
c. Identify any barriers to implementing initiatives: • The root cause analysis was the virtual visit being a significant barrier for obtaining paperwork signatures, assessing service receipt and building a strong relationship with program enrollees. It was also difficult to manage staff output related to requirements as 1/3 of the staff started during the public health emergency and had no experience with home visits.
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. Additionally, the SFY 2022 rate for Performance Measure 20 scored above the statewide average and improved from the prior year. Further, **Reliance Community Care Partners**' SFY 2022 rate for Performance Measure 30 scored below the statewide average; however, the review standards for this measure changed from SFY 2021. Therefore, HSAG was unable to assess a year-over-year comparison.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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. • **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. 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. • **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. 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.

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)***: • This measure as scored is difficult to show improvements since monitoring contacts and follow-up are all scored under Standard 11.2. **Reliance Community Care Partners** score is better but still isn't within the compliance score range.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The randomly identified State audits are random and **Reliance Community Care Partners** has identified through root-cause analysis that most of our score is the result of one team per audit year. Staff performance improvement initiatives have led to staff resignations which does improve the score.
c. Identify any barriers to implementing initiatives: • Staff completion of monitoring contacts and follow-up is better and it appears that we all have a different interpretation of follow-up items. Root-cause analysis identified that staff write notes from the perspective of no one else ever needing to read the note and they know what they did. This is a barrier that we are focusing on currently that we need to write as if someone else will take over managing the client or for an external review of the notes.
HSAG's Assessment: HSAG determined that **Reliance Community Care Partners** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Reliance Community Care Partners** improved performance in the Follow-Up and Monitoring focus area, its performance in the Freedom of Choice and Release of Information focus areas remained the same. Additionally, **Reliance Community Care Partners**' narrative appeared to only address the Follow-Up and Monitoring focus area and not the Freedom of Choice and Release of Information focus areas. HSAG recommends that **Reliance Community Care Partners** implement system prompts or another similar workflow that reminds supports coordinators to obtain FOC and ROI/consent signatures.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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.
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** is studying the past 2 years of satisfaction surveys with regards to personal safety. Root-cause analysis is currently being conducted.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Root-Cause Analysis is currently being conducted.
c. Identify any barriers to implementing initiatives: • Root-Cause Analysis is currently being conducted.
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 and improved performance in the *Personal Safety and Respect* domain during SFY 2022, as the waiver agency received a 100 percent score.

Senior Resources

Table 4-14—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: • **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 PIPs. 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. 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. • **Senior Resources**' interventions appeared to be ineffective as **Senior Resources** did not meet the statewide goals for four PIPs. Additionally, the prevalence rates for the *Prevalence of Neglect/Abuse* and *Prevalence of Any Injuries* PIPs 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. 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. • 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 PIPs were unclear. **Senior Resources**' PIPs 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. HSAG recommends that **Senior Resources** follow the CMS EQR

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
Protocols when initiating PIPs to ensure the technical structure of each PIP 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**, along with all the Waiver agents (WA) in Michigan implemented a new quality plan format for FY 2023. Known as a QAPI, this plan was formulated with one of the PIPs to be the same across all Michigan WA agents. This project is Prevalence of Falls with Injury with the goal being reduction in the percentage of these occurrences. The PIP that Senior Resources chose independently to follow is: Prevalence of Advance Directives with the goal of increasing the percentage of participants with Advance Directives. Baseline percentages of both PIPs are included in the plan. Action steps are included along with quarterly monitoring to determine effectiveness.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Senior Resources has noted improvement in both PIPs through the first three quarters of FY 23. This methodology is included in the QAPI for FY 23.
c. Identify any barriers to implementing initiatives: • Data regarding falls with injury must be collected manually as there are currently no specific questions within the participant electronic health record that collect this data. Supports coordinators currently report every fall with injury to the quality improvement coordinator who keeps a record of these incidents.
HSAG's Assessment: HSAG determined that **Senior Resources** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Senior Resources** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals and included implemented interventions, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Senior Resources** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Senior Resources** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • 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. 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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
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.
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)***: • Currently **Senior Resources** is reviewing at least 1 assessment per supports coordinator monthly. The future goal is to review all conducted assessments prior to finalization. During FY 23 the Quality Staff increased to 2 staff members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Fewer missing data fields along with incomplete data is being found upon subsequent reviews. Supports coordinators are receiving training as deficiencies are noted.
c. Identify any barriers to implementing initiatives: • Time spent reviewing all assessments is significant.
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. Additionally, **Senior Resources**' rate for Performance Measure 2 scored above the statewide average and improved from the prior year. However, please note that **Senior Resources** scored below the statewide average in SFY 2022 for Performance Measure 16 and declined in performance from the prior year. Therefore, HSAG recommends that **Senior Resources** explore additional/modified interventions to improve performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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.
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** Quality Staff is currently reviewing a minimum of 1 assessment monthly for every supports coordinator. Every initial assessment is reviewed by a supervisor or quality staff. The future goal is for all assessments to be reviewed prior to finalization.

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): • Supports coordinators are more detailed in their assessments and have less missing information. If there is missing information it is found through review.
c. Identify any barriers to implementing initiatives: • The barrier to implementation is the significant time taken to review all assessments.
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. However, the waiver agency received a low score for the Follow-Up and Monitoring and Complaints and Grievances focus areas and should explore additional interventions to ensure compliance requirements are met for these focus areas.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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.
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)***: • No new initiatives have been implemented. Upon review of the CAHPS the domain that is identified as being 5% below the statewide average (Staff are Reliable and Helpful) has 2 areas in which there were fewer than 5 respondents. These areas were suppressed however the results in this domain included some type of numerical value for the suppressed areas which brought **Senior Resources** overall score for the domain below the statewide score. If these were not included (due to being insufficient values) **Senior Resources** would be well above the statewide percentage in this domain at 94.9%. From the CAHPS-Due to the small number of responses in some questions, caution should be exercised when evaluating the results in the agency. **Senior Resources** follows up on all provider complaints made by participants through a formal complaint process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • No new initiatives have been put in place related to this identified deficiency.
c. Identify any barriers to implementing initiatives: • A barrier to implementing any initiative based on these scores is that the data is not taken from a significant number of participants who have these services therefore it is difficult to determine the specific issue.
HSAG's Assessment: HSAG determined that **Senior Resources** was unable to address the prior year's recommendations. Due to the small number of survey respondents for two survey questions and the suppressed scores, **Senior Resources** did not implement any new initiatives as determining the specific issue of dissatisfaction was difficult. However, the SFY 2022 results demonstrated that all six survey questions under

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
the *Staff are Reliable and Helpful* domain had reported rates, and all rates scored below the statewide average. HSAG recommends that **Senior Resources** review the results of all consumer satisfaction survey questions to determine if any questions that received low scores contributed to the low satisfaction score within the *Staff are Reliable and Helpful* domain; develop interventions to improve the *Staff are Reliable and Helpful* domain; and evaluate the results of the interventions regularly, making changes as necessary.

The Information Center

Table 4-15—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: • There was no SFY 2020–2021 QMP available for **The Information Center**. 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. • **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. 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. • 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* PIPs 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. 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. • 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 PIPs were unclear. **The Information Center**'s PIPs 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. HSAG recommends that **The Information Center** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **The Information Center** in a methodologically sound manner.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
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 Information Center** completed and submitted a QMP for SFY 2022/2023 that includes quality indicators (Performance Improvement Projects) with baseline measures to determine interventions and effectiveness of interventions. Evidence based Quality Indicators and interventions were developed and data is evaluated annually, quarterly and/or monthly based on the Quality Indicator. • The QAPI was developed in SFY 2023 for SFY2023/2024 based on HSAG recommendations to follow the CMS EQR Protocols. The project was developed as a group with The Statewide New Quality Focus Group. • The quality specialist provided a fall/injury training to the Care Management Department staff in SFY 2022 and to the providers/vendors in SFY 2023. The training was provided to assist the support coordinators and providers with identifying risks and educate them on utilizing root cause analysis to put strategies in place in an effort to reduce falls and injuries. • The quality specialist developed a fall/injury tool for the supports coordinators to utilize to assist with developing interventions to reduce participant injuries. he tool assists the supports coordinators with identifying hazards, short and long term effects that could lead to increased service interventions
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **The Information Center** now has an established QMP for FY2022 and will be able to measure data to implement initiatives if necessary based on data measured.
c. Identify any barriers to implementing initiatives: • CMS required MDHHS and Waiver Agents to focus on 2 Quality Indicators as of January 2022. The Quality Management Collaborative did not choose Prevalence of Pain with Inadequate Pain Control as a Quality Indicator that they wanted to monitor, a result it was not included in the SFY 2022-2023 QMP. **The Information Center** however continues to internally monitor.
HSAG's Assessment: HSAG determined that **The Information Center** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **The Information Center** submitted the appropriate documents and included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals and implemented interventions, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **The Information Center** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **The Information Center** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
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. 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. • **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. 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. • **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. 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.
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 quality and training coordinator audits a minimum of 10 charts per month to ensure compliance with MDHHS Guidelines/Standards. • Training based on deficiencies was provided in SFY 2022 as part of the CAP. This is an annual training that is provided to staff after the CQAR final results are received and analyzed.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
• The quality and training coordinator provides monthly reports for the supports coordinators, the training and development coordinator, and the Care Management Department clinical supervisor to review. The supports coordinators report to the Care Management Department clinical supervisor what the barriers are to meeting standards. The training and development coordinator determines if a group training needs to be provided. • The Care Management Department clinical supervisor provides monthly supervision to staff who are not meeting the standards to provide additional education. • The quality and training coordinator provided PCSP training to supports coordinators April 2023. Training materials utilized were provided to the supports coordinators were from the Statewide Training 12/19/2019. • The quality and training coordinator has created an internal chart review tool based on the CQAR tool to access that the supports coordinator are adhering MDHHS Contract Guidelines.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **The Information Center** improved in the following areas for SFY 2022: • PCSP including the provider, type, amount, frequency, and duration of services and supports. • Documenting the person responsible for monitoring the person centered service plan in the PCSP. • Authorizing a change in services in accordance with MDHHS policy and contract requirements or provided the member/guardian with appropriate alternatives.
c. Identify any barriers to implementing initiatives: • **The Information Center** had a staff shortage impact and difficulty with hiring new staff during the emergency pandemic order to implement the initiatives. • Incoming employee's orientation and staff training also impacted initiatives based on hiring and initiative data analysis. **The Information Center** has a work group who meets on an ongoing basis to strategically plan addressing barriers to initiative implementation.
HSAG's Assessment: HSAG determined that **The Information Center** addressed the prior year's recommendations based on the waiver agency's reported initiatives. However, **The Information Center** continued to score more than 5 percentage points below the statewide average for Performance Measures 1, 19, and 21 during SFY 2022. Therefore, HSAG recommends that **The Information Center** explore additional/modified interventions to improve performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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.
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)***:

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
• The quality and training coordinator audits a minimum of 10 charts per month to ensure compliance with MDHHS Guidelines/Standards. • Training based on deficiencies was provided in SFY 2022 as part of the CAP. This is an annual training that is provided to staff after the CQAR final results are received and analyzed. • The quality and training coordinator provides monthly reports for the supports coordinators, the training and development coordinator, and the Care Management Department clinical supervisor to review. The supports coordinators report to the Care Management Department clinical supervisor what the barriers are to meeting standards. The training and development coordinator determines if a group training needs to be provided. • The Care Management Department clinical supervisor provides monthly supervision to staff who are not meeting the standards to provide additional education. • The quality and training coordinator provided PCSP training to supports coordinators April 2023. Training materials utilized were provided to the supports coordinators was from the Statewide Training 12/19/2019.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **The Information Center** improved in the area of ensuring critical incidents are entered into the portal timely and that there is timely follow up and resolution.
c. Identify any barriers to implementing initiatives: • **The Information Center** had a staff shortage impact and difficulty with hiring new staff during the emergency pandemic order to implement the initiatives. • Incoming employee's orientation and staff training also impacted initiatives based on hiring and initiative data analysis. **The Information Center** has a work group who meets on an ongoing basis to strategically plan addressing barriers to initiative implementation.
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. However, **The Information Center** scored low on the Adverse Benefit Determination focus area and should explore additional interventions to ensure compliance requirements are met for this focus area.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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

4. Prior Year Recommendation From the EQR Technical Report for 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.
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 connect participants to Technology and /or assistive technology. • All participants were provided information to access the "Get Set Up" program for socialization and education. • **The Information Center** has implemented a test case with one participant to assist with obtaining assistive technology and open up the ability for her to be able to communicate independently. **The Information Center** will work with other agencies to determine if participants need assistive technology verses technology. • In person assessments started to be phased in starting November 2022 and as of May 11, 2023 all assessments are in person. • As of June 2023 supports coordinators complete all monitor calls as identified in the person centered service plan. • **The Information Center** provided participants with education on PPE, how to obtain COVID testing and vaccines. How to get in home COVID testing and vaccines for participants who were homebound or had a fear of leaving home. • **The Information Center** sends out information monthly to connect with participants and encouraged participation in the Consumer Advisory Council.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **The Information Center** improved in the following areas on the SFY2022 MI Choice Enrollee Satisfaction Survey: • Case Manager is Helpful. **The Information Center** improved the percent from SFY 2021 and the percent is above the Statewide percent for SFY 2022. • Choosing the Services that matter to you. **The Information Center** improved the percent from SFY 2021 and the percent is above the Statewide percent for SFY 2022. • Planning your time and activities: **The Information Center** improved the percent from SFY 2021 and the percent is above the Statewide percent for SFY 2022. • Met Needs: **The Information Center**'s percent is above the Statewide percent for SFY 2022.
c. Identify any barriers to implementing initiatives: • Lack of affordable technology in Wayne County and limited skill level related to using technology, memory issues, lack of interest, reluctance to utilize technology due to fear of scammers. • Participants socially isolated themselves due to fear of contracting COVID. As a result, participants' refused or significantly reduced Waiver Services.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
• **The Information Center** had a staff shortage impact and difficulty with hiring new staff during the emergency pandemic order to implement the initiatives. • Incoming employee's orientation and staff training also impacted initiatives based on hiring and initiative data analysis. **The Information Center** has a work group who meets on an ongoing basis to strategically plan addressing barriers to initiative implementation.
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. Additionally, **The Information Center**'s SFY 2022 rates scored above the statewide average for the *Case Manager is Helpful*, *Choosing the Services that Matter to You*, *Planning Your Time and Activities*, and *Met Need* domains, with three of those rates increasing from the prior year. However, the *Global Ratings Measures*, *Recommendation Measures*, and *Staff are Reliable and Helpful* domains scored more than 5 percentage points below the statewide average in SFY 2022 and declined from the prior year. Therefore, HSAG recommends that **The Information Center** explore additional/modified interventions to improve performance.

The Senior Alliance

Table 4-16—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: • There was no SFY 2020–2021 QMP available for **The Senior Alliance**. 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. • 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 PIP; 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. HSAG recommends that **The Senior Alliance** calculate PIP 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 PIP 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. • 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* PIP 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

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
interventions should be clearly evaluated. 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. • 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 PIPs were unclear. **The Senior Alliance**'s PIPs 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. HSAG recommends that **The Senior Alliance** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP 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** identified that only the Outcomes & Activities Report was submitted instead of the full FY2020-2021 QMP. The document was submitted on January 15,2020 and **The Senior Alliance** was not made aware of the error until August 25, 2021. Since then, **The Senior Alliance** has submitted QMP's and Activities & Outcome reports on time and as requested by MDHHS as evidenced by the QMPs for FY2022-2023 and FY2023-2024 submitted per instructions and on time to MDHHS. **The Senior Alliance** is also part of a Quality Focus Group with other wavier agencies and MDHHS and is involved in providing input and discussing requirements and due dates for future QMP's and Activities & Outcome reports. • **The Senior Alliance** will be running the annual percentage rates for the upcoming FY2023 PIP's and for FY2022 to use for comparison. This will be reported in the FY2023 Outcomes and Activities Report. • **The Senior Alliance** will implement the recommendation to include evaluation of each intervention for performance goals. These evaluations will be reported in the FY2023 Activities and Outcomes Report that will be submitted in January 2024. • **The Senior Alliance** included more detail in the FY2023-2024 QAPI in regard to data collection and implementation of the PIP's.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **The Senior Alliance** has submitted QMP's and Activities & Outcome reports on time and as requested by MDHHS as evidenced by the QMPs for FY2022-2023 and FY2023-2024 submitted per instructions and on time to MDHHS. • Performance improvement will be realized in the FY2023 Activities and Outcomes Report to be submitted in January 2024. • Performance improvement will be realized in the FY2023 Activities and Outcomes Report to be submitted in January 2024.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
• This recommendation was implemented for the FY2023-2024 QAPI.
c. Identify any barriers to implementing initiatives: • No barriers as **The Senior Alliance** has submitted all subsequent QMP's and Activities & Outcomes reports on time and following instructions received by MDHHS. • No barriers noted at this time as **The Senior Alliance** will not be able to implement and assess this recommendation until the FY2023 Activities and Outcomes Report. • No barriers noted at this time as **The Senior Alliance** will not be able to implement and assess this recommendation until the FY2023 Activities and Outcomes Report. • No barriers noted.
HSAG's Assessment: HSAG determined that **The Senior Alliance** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **The Senior Alliance** submitted all the appropriate documents and included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals and implemented interventions, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **The Senior Alliance** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **The Senior Alliance** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
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.
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)***: • Initiatives for Performance Measure 4 are as follows: o **The Senior Alliance** conducted annual training with all staff who conduct LOCDs. o **The Senior Alliance** has designated 2 staff members (1 Support Specialist and 1 Support Coordinator) to review all LOCDs upon submission for entry to ensure all fields were filled out correctly and that all documentation supports the door selected. o Home visits resumed in April of 2023 which has improved supports coordinators ability to complete an informed, comprehensive and accurate LOCD. • Initiatives for Performance Measure 17 are as follows: o **The Senior Alliance** is currently developing comprehensive training on PCSP requirements and strategies for completing/documenting an accurate PCSP. The training is scheduled to be presented to staff on September 13, 2023. o **The Senior Alliance** conducts monthly record reviews (internal monitoring) of PCSP standards ongoing, even after compliance is met. Monthly feedback is provided to supports coordinators via a QA Feedback Form.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Subsequent record reviews have shown 0 deficiencies in the completion of LOCDS. • Record reviews have shown supports coordinators continue to have difficulty in Performance Measure 17. **The Senior Alliance** expects to see an improvement after the staff training is conducted.
c. Identify any barriers to implementing initiatives: • No barriers noted in this area. • **The Senior Alliance** has had multiple staff changes and leaves of absence with supports coordinators. This has impacted quality outcomes. **The Senior Alliance** also will not realize optimal improvement in this area until the newly developed training is presented to staff. **The Senior Alliance** expects to realize improved outcomes in this area in FY2024.
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. Additionally, **The Senior Alliance**'s SFY 2022 rate for Performance Measure 4 scored above the statewide average and increased from the prior year. However, Performance Measure 17 continued to score more than 5 percentage points below the statewide average during SFY 2022 and declined from the prior year. Therefore, HSAG recommends that **The Senior Alliance** explore additional/modified interventions to improve performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. MDHHS required **The Senior Alliance** to submit a CAP to remediate the

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
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.
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** attending training provided by MDHHS on Critical Incidents and their requirements. • **The Senior Alliance** attended a meeting between **The Senior Alliance** and MDHHS to ask questions and receive further clarity on what is considered a Critical Incident and when it is required to be entered in the portal. • **The Senior Alliance** conducted training with all CCD staff to train on the information received from MDHHS.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **The Senior Alliance** did not receive any citations on the FY2022 CQAR Record Audit in the Focus of Critical Incidents.
c. Identify any barriers to implementing initiatives: • No barriers noted at this time
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 and improved performance in the Critical Incidents focus area during SFY 2022.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
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.
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** has requested a more detailed breakdown from MSU on the domains and is currently awaiting that information. **The Senior Alliance** would like to analyze this data to then be able to implement meaningful initiatives to improve in this area.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • No noted performance improvements at this time as **The Senior Alliance** is awaiting this year's results to be able to assess and analyze the data provided.
c. Identify any barriers to implementing initiatives: • [None identified.]
HSAG's Assessment: HSAG determined that **The Senior Alliance** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **The Senior Alliance** has requested additional data to analyze, it has yet to implement performance improvement initiatives. However, the *Global Ratings Measures*, *Recommendation Measures*, *Staff Listen and Communicate Well*, and *Met Need* domains scored above the statewide average in SFY 2022 and increased from the prior year. Additionally, while the *Staff are Reliable and Helpful*, *Choosing the Services that Matter to You*, and *Planning Your Time and Activities* domains continued to score below the statewide average in SFY 2022, these rates increased from the prior year. As such, HSAG recommends that **The Senior Alliance** continue to explore additional/modified interventions to improve performance.

Tri-County Office on Aging

Table 4-17—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: • **Tri-County Office on Aging** did not meet statewide goals for four of the five PIPs and also demonstrated worse year-over-year performance in three of the five PIPs as indicated in the SFY 2021 annual report. 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. • 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 PIPs were unclear. **Tri-County Office on Aging**'s PIPs 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. HSAG recommends that **Tri-County Office on Aging** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP 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)***: • **Tri-County Office on Aging** followed the MDHHS required reporting format in FY21, which did not include all elements listed above. Since the FY21 QMP was submitted, **Tri-County Office on Aging** has implemented various interventions to increase outcomes including; targeted evidence-based clinical training via an accredited training platform, internal policy changes, and expansion to the way outcomes data is being utilized to drive internal process change. Due to the implementation of the above interventions, it would be expected to see increases in outcomes data in FY23.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Due to the timeline of implementation of **Tri-County Office on Aging**'s QAPI plan, it would be expected to see evidence of performance improvement in FY23.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
c. Identify any barriers to implementing initiatives: • It was identified through case record auditing and data analysis that individual clinicians were not always coding for assessment questions that impact PIP data in the same way across the board, which can cause inaccuracies in data collection. Targeted training of all clinical staff related to consistent assessment and documentation for questions that impact PIP data was implemented over a period of several months in FY22-23.
HSAG's Assessment: HSAG determined that **Tri-County Office on Aging** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Tri-County Office on Aging** included its goals and outcomes for each PIP in place during 2022 that aligned with MDHHS-required goals and included implemented interventions, HSAG continues to recommend that **Tri-County Office on Aging** and MDHHS calculate results using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Tri-County Office on Aging** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **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. 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.
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 a result of the data results outlined above, **Tri-County Office on Aging** implemented a process by which every LOCD is audited for accuracy and completeness by clinical supervision prior to being input into the Champs system. All LOCDS will continue being audited moving forward. Because of timeline of implementation of the changes outlined above, **Tri-County Office on Aging** expects to see increases in performance measure 8 in FY23.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Due to the timeline of implementation of **Tri-County Office on Aging**'s QAPI plan, it would be expected to see evidence of performance improvement in FY23.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
c. Identify any barriers to implementing initiatives: • The audit process for LOCDs was implemented, but the initial process did not account for the times when clinical supervision was not in the office, which caused delays in the auditing process for LOCDs and overall greatly slowed the process. The audit process was updated to include a contingency plan for auditing LOCDs when one or more clinical supervisors is unavailable.
HSAG's Assessment: HSAG determined that **Tri-County Office on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improvement in SFY 2022 Performance Measure 8, which also scored above the statewide average.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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.
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)***: • **Tri-County Office on Aging** has implemented various interventions to adherence to Medication Record requirements including; targeted evidence-based clinical training via an accredited training platform, internal policy changes impacting how and when updates to the Medication Record are required, and expansion to the way outcomes data is being utilized to drive internal process change. Due to the implementation of the above interventions, it would be expected to see increases in outcomes data in FY23.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Due to the timeline of implementation of **Tri-County Office on Aging**'s QAPI plan, it would be expected to see evidence of performance improvement in FY23.
c. Identify any barriers to implementing initiatives: • **Tri-County Office on Aging** encountered a barrier within the electronic medical record system, Compass, utilized for case record management. At some point previous to FY21 a system change was made to exclude the prompt for environmental allergies within the Medication Record. Clinicians were not documenting environmental allergies because the prompt for that question was not visible to

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
clinicians. An update to the Compass system was implemented to include the prompt for environmental allergies.
HSAG's Assessment: HSAG determined that **Tri-County Office on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improvement in the Medication Record focus area, which also received a *Substantial* compliance level.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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.
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)***: • **Tri-County Office on Aging** employed a plethora of interventions aimed to decrease social isolation during and after the Covid-19 pandemic including; regular friendly reassurance calls, provision of technology training resources to participants and informal supports to foster use of video call features, etc. The aggregated CAHPS survey results from FY22 indicates **Tri-County Office on Aging** scored higher than the statewide average in all of the above listed categories.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Due to the timeline of implementation of **Tri-County Office on Aging**'s QAPI plan, it would be expected to see evidence of performance improvement in FY22-23.
c. Identify any barriers to implementing initiatives: • One of the main barriers to social activity and community engagement encountered by participants is reliable transportation. **Tri-County Office on Aging** has encountered barriers within the public transit system within the service area, both in accessibility and reliability. **Tri-County Office on Aging**'s

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
consumer advisory council has participated in advocacy efforts with local transportation authorities to address the need for increased accessibility and reliability.
HSAG's Assessment: HSAG determined that **Tri-County Office on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. Additionally, the SFY 2022 rates for the *Personal Safety and Respect*, *Planning Your Time and Activities*, and *Met Need* domains scored above the statewide average and increased from the prior year.

UPCAP Care Management, Inc.

Table 4-18—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: • 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. 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. • **UPCAP Care Management, Inc.**'s PIP performance results reported in the SFY 2021 annual report were not comparable across all waiver agencies. HSAG recommends that **UPCAP Care Management, Inc.**'s annual report includes an evaluation of the entire state fiscal year's performance results for each PIP quality indicator. • **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. 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. • 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 PIPs, suggesting that the interventions implemented did not have a positive effect on the outcomes of the PIPs. As significant and sustained improvement results from developing and implementing effective improvement strategies, these interventions should be clearly evaluated. 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

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
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. • 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 PIPs were unclear. **UPCAP Care Management, Inc.**'s PIPs 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. HSAG recommends that **UPCAP Care Management, Inc.** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP 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)***: • **UPCAP Care Management, Inc.**, along with all the Waiver Agencies in Michigan, implemented a new quality plan format for FY 2023. The plan is called the QAPI. This plan was formulated with the clinic PIP to be the same across all Michigan Waiver Agencies. This project is Prevalence of Falls with Injury with the goal being reduction in the percentage of these occurrences. The non-clinical PIP for **UPCAP Care Management, Inc.** is Satisfaction Surveys.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **UPCAP Care Management, Inc.** has noted improvement in both PIPs through the first three quarters of fiscal year 23 with a reduction in falls with injury and more education provided to those with falls. So far in FY23 **UPCAP Care Management, Inc.** has exceeded their satisfaction rate. • The methodology for the clinical and non-clinical PIPs is included in **UPCAP Care Management, Inc.**'s QAPI for FY23.
c. Identify any barriers to implementing initiatives: • The only barrier has encountered is making sure the data collection and interpretation of the Statewide PIP was the same across the State.
HSAG's Assessment: HSAG determined that **UPCAP Care Management, Inc.** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **UPCAP Care Management, Inc.** included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals and included implemented interventions, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **UPCAP Care Management, Inc.** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **UPCAP Care Management, Inc.** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

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

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
update the PCSP according to MDHHS requirements. 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. • **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. 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.
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 FY23 **UPCAP Care Management, Inc.** implemented the QAPI. **UPCAP Care Management, Inc.** also completed a corrective action plan for issues identified and continues to monitor a percentage of files on an ongoing basis through Supervisory Reviews, peer reviews and running monthly performance measures on data. **UPCAP Care Management, Inc.** also redesigned and updated its policy and procedure manual to be user-friendly and include guides for performance measures.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **UPCAP Care Management, Inc.** has noticed an improvement in performance measures through initial supervisory reviews and monthly peer reviews. The monthly peer review results are analyzed for trends by performance measure specific to a particular care manager, which identified areas in need of training.
c. Identify any barriers to implementing initiatives: • [None identified.]
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 and improvement in SFY 2022 Performance Measures 4, 18, and 19, which also scored above the statewide average. However, Performance Measure 17 scored above the statewide average, but performance declined from SFY 2021. Further, **UPCAP Care Management, Inc.**'s rate for Performance Measure 30 scored below the statewide average. While Performance Measure 30 also decreased from its rate in SFY 2021, there was a

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
change in the methodology for this measure, so HSAG did not compare year-over-year performance. As such, HSAG recommends that **UPCAP Care Management, Inc.** explore additional/modified interventions to improve performance for Performance Measures 17 and 30.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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. • **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. 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.
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 FY23 **UPCAP Care Management, Inc.** implemented the QAPI. **UPCAP Care Management, Inc.** also completed a corrective action plan for issues identified and continues to monitor a percentage of files on an ongoing basis through Supervisory Reviews, peer reviews and running monthly performance measures on data. **UPCAP Care Management, Inc.** also redesigned and updated its policy and procedure manual to be user-friendly and include guides for performance measures.

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): • **UPCAP Care Management, Inc.** has noticed an improvement in performance measures through initial supervisory reviews and monthly peer reviews. The monthly peer review results are analyzed for trends by performance measure specific to a particular care manager, which identified areas in need of training.
c. Identify any barriers to implementing initiatives: • [None identified.]
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, and improved performance in the Freedom of Choice and Follow-Up and Monitoring focus areas in SFY 2022.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. 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.
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.** reviewed the CAHPS report and provided education to participant on the transportation services. **UPCAP Care Management, Inc.** also updated its non-emergency medical transportation policy. Through our satisfaction surveys no transportation issues were identified. Transportation resources are limited in rural areas for the Upper Peninsula. This is a contributing factor to the low satisfaction score. We have done advertisement for volunteer drives and have utilized the self-determination option to improve transportation access.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • [None identified.]
c. Identify any barriers to implementing initiatives: • [None identified.]
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 and improved performance in the *Transportation to Medical Appointments* domain, which also scored above the statewide average in SFY 2022.

Valley Area Agency on Aging

Table 4-19—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: • There was no SFY 2020–2021 QMP available for **Valley Area Agency on Aging**. 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. • **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. 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. • The interventions implemented by **Valley Area Agency on Aging** to meet performance goals were not specified for three of the five PIPs. Additionally, the statewide goals were not met for three of the five PIPs, and the prevalence rate for the *Prevalence of Neglect/Abuse* PIP 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. 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. • 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 PIPs were unclear. **Valley Area Agency on Aging**'s PIPs 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. HSAG recommends that **Valley Area Agency on Aging** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **Valley Area Agency on Aging** in a methodologically sound manner.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
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** submitted Fiscal Year (FY) 2020-2021 QMP to MDHHS on August 24, 2021. A separate annual FY 2022-2023 QMP Activities and Outcomes Report & FY 2021 Outcomes and Activities Quality Management (QM) report sent to MDHHS on January 13, 2022. • **Valley Area Agency on Aging** completed and submitted a revised FY 2022-2023 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. • FY 2022 **Valley Area Agency on Aging** made modification on how the Quality Indicator report calculated the numerator data. The report originally analyzed initial assessments and should have been only evaluating follow-up assessments. Once this issue was identified and corrected, **Valley Area Agency on Aging**'s baseline numbers were reduced and were below statewide baseline.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Valley Area Agency on Aging** received HSAG recommendations for FY 2020-2021 on November 21, 2022, and implemented recommendation in FY 2023. • **Valley Area Agency on Aging** is measuring performance improvement as part of the FY 2023 QAPI Performance Improvement Project. • **Valley Area Agency on Aging** was below Statewide baseline in FY 2022 for Prevalence of Injuries per FY 2023 Outcomes and Activities report submitted to MDHHS on January 17, 2023. Prevalence of Injuries related to falls statewide baseline set for 3%, **Valley Area Agency on Aging** reported 0.47%. • Neglect/Abuse statewide goal was 3%. **Valley Area Agency on Aging** was below statewide goal of 3%, first three quarters. Quarter four **Valley Area Agency on Aging** was above at .8%. After analyzing data, education was provided to Adult Foster Care (AFC) facilities regarding bedrails being a restraint. • Prevalence of Hospitalizations, **Valley Area Agency on Aging** was higher than statewide percentage. After analyzing the data, education was provided on Urinary Tract Infection (UTI) and fall prevention, and post hospital discharge calls were made to provide education and services, as needed. • Prevalence of Dehydration, statewide goal was 1.5%. **Valley Area Agency on Aging** was at or below statewide goal of 1.5%. **Valley Area Agency on Aging** continues to monitor to ensure maintenance of statewide goal. • Prevalence of Pain statewide goal was 20%. **Valley Area Agency on Aging** was at or below statewide goal of 20%. **Valley Area Agency on Aging** continues to monitor to ensure maintenance of statewide goal. • Prevalence of Falls statewide goal was 23%. **Valley Area Agency on Aging** was at or below statewide goal of 23% in quarters two and three. After analyzing the data, fall education was provided via mail to all participants on October 21, 2020. Fall education was also provided on October 18, 2020, at the Quality Collaboration meeting and continues to be discussed at quarterly meetings. Fourth quarter analysis reflected that there were 11 falls reported at opening assessments, which were prior to opening in the MI Choice Waiver program. • Prevalence of Injuries statewide goal was 3%. **Valley Area Agency on Aging** was at or below statewide goal of 3% in quarters two and four. After analyzing the data, the majority of injuries were related to skin, such as skin ulcers.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
c. Identify any barriers to implementing initiatives: • **Valley Area Agency on Aging** received the HSAG recommendations for FY 2021 on November 21, 2022, at that time **Valley Area Agency on Aging** implemented the recommendations.
HSAG's Assessment: HSAG determined that **Valley Area Agency on Aging** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **Valley Area Agency on Aging** submitted the appropriate documents and included its goals for each PIP in place during 2022 that aligned with MDHHS-required goals and implemented interventions, the reported outcome rates differed from the MDHHS-reported rates. HSAG continues to recommend that **Valley Area Agency on Aging** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **Valley Area Agency on Aging** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **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. 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.
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** had utilized the social work technicians to assist the supports coordinators as needed with contacting the participant regarding their service satisfaction and monthly calls. Per CQAR findings, **Valley Area Agency on Aging** was made aware that social work technicians cannot be utilized for this purpose. The social work technicians were no longer contacting the participant regarding their service satisfaction and monthly calls as supports coordinators were then making contacts.

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): • After implementation, **Valley Area Agency on Aging** was 100% compliant.
c. Identify any barriers to implementing initiatives: • None.
HSAG's Assessment: HSAG determined that **Valley Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improvement in SFY 2022 Performance Measure 20, which also scored above the statewide average.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **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. 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.
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**'s supports coordinators were not signing the Freedom of Choice electronically and were found to be using a typed signature. Education was provided to prohibit a typed signature.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • After implementation, **Valley Area Agency on Aging** was 100% compliant.
c. Identify any barriers to implementing initiatives: • None.
HSAG's Assessment: HSAG determined that **Valley Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improved performance in the Freedom of Choice focus area in SFY 2022.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **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. HSAG recommends that **Valley Area Agency on Aging** review the results of the member satisfaction survey to

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
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.
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** educated their supports coordinators on providing help with coordination of services and resources when identified or requested. • **Valley Area Agency on Aging** also educated their supports coordinators to ask their peers and supervision for assistance coordinating services and resources when necessary.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Valley Area Agency on Aging** received 100% score for FY 2022 for Case Manager is Helpful section.
c. Identify any barriers to implementing initiatives: • CAHPS Survey does not identify how many responses were received or what the individual score is for each question. This lack of data places a barrier to identify whether this is an individual/participant issue or an overall multiple participant issue to determine an action plan.
HSAG's Assessment: HSAG determined that **Valley Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improved performance in the *Case Manager is Helpful* domain in SFY 2022, which also scored above the statewide average.

WellWise Services Area Agency on Aging

Table 4-20—Prior Year Recommendations and Responses for WellWise Services Area Agency on Aging

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • The **WellWise Services 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. HSAG recommends that **WellWise Services 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 PIP 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). • **WellWise Services 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. HSAG recommends **WellWise Services 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. • In the SFY 2021 annual report, **WellWise Services 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. HSAG recommends that **WellWise Services 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 PIP. • The interventions implemented by **WellWise Services Area Agency on Aging** to meet performance goals were unclear. Additionally, the prevalence rate for the *Prevalence of Dehydration* PIP increased, indicating that the interventions implemented by **WellWise Services 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. HSAG recommends that **WellWise Services 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). **WellWise Services Area Agency on Aging** should analyze and interpret results at multiple points in time and test for statistical significance. **WellWise Services 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. • 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 PIPs were unclear. **Region 2 Area Agency on Aging**'s PIPs 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

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects:
identification of barriers and subsequent development of relevant interventions. HSAG recommends that **WellWise Services Area Agency on Aging** follow the CMS EQR Protocols when initiating PIPs to ensure the technical structure of each PIP is designed, conducted, and reported by **WellWise Services 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)***: • **WellWise Services Area Agency on Aging** received the HSAG recommendations for SFY 2021 in December 2021, with the additional recommendations above received in July 2023. Therefore, the above suggestions were not implemented during SFY 2021. • However, **WellWise Services Area Agency on Aging** has implemented the above recommendations for SFY 2022. Specifically, **WellWise Services Area Agency on Aging** included 14 measurable goals on its SFY 2023/SFY 2024 QAPI, including planned interventions, details on methodology, frequency of ongoing monitoring, a static baseline, and targets that are specific, measurable, and static. • **WellWise Services Area Agency on Aging** continues monitoring the quality indicators at Quality Improvement Risk Management (QIRM) meetings occurring every other month. 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 monitoring calls and at subsequent Reassessments and Person Centered Planning meetings. **WellWise Services 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, **WellWise Services Area Agency on Aging** was unable to make improvements as indicated in the HSAG findings due to receiving the document after the end of that fiscal year.
c. Identify any barriers to implementing initiatives: • **WellWise Services 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 SFY 2021) was too limited to allow for a test of statistical significance. This is a significant flaw in the methodology utilized and has been addressed in the current SFY 2023/SFY 2024 QAPI.
HSAG's Assessment: HSAG determined that **WellWise Services Area Agency on Aging** partially addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. While **WellWise Services Area Agency on Aging** included its goals and outcomes for each PIP in place during 2022 that aligned with MDHHS-required goals and outcomes and included implemented interventions, HSAG continues to recommend that **WellWise Services Area Agency on Aging** and MDHHS calculate results using the same timing; specifically, using data for the full state fiscal year. Additionally, although there was some improvement in the design of the PIPs within the 2023–2024 QAPI, the documentation did not fully comply with CMS EQR Protocol 1 and CMS EQR Protocol 8. HSAG continues to recommend that **WellWise Services Area Agency on Aging** ensure its PIP documentation aligns with the nine activities outlined in CMS EQR Protocol 1 and CMS EQR Protocol 8, and the elements included in Worksheets 1.1 through 1.9. Please review the Weaknesses and Recommendations related to the PIP activity in Section 3 of this report.

2. Prior Year Recommendation From the EQR Technical Report for Performance Measures:
HSAG recommended the following: • 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. MDHHS required **WellWise Services 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 **WellWise Services 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.
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)***:
• **WellWise Services Area Agency on Aging** continually provides training regarding all performance Measures. Supports coordinator meetings are held biweekly and performance measure trainings are an ongoing topic.
• For Performance 2: The number of qualified participants enrolled in the MI Choice Waiver Program consistent with MDHHS policies and Procedures:
  o Quality staff review one chart per supports coordinator per month for 8-10 months of the year. Any discrepancies are immediately brought to the supports coordinator and supervisor's attention. The situation is remedied.
  o Quality Staff provided education on qualifications for waiver after SFY 2021 CQAR Audit, and annually thereafter.
  o Nursing Facility Level of Care Determination education was provided after the SFY 2021 CQAR Audit and annually. The NFLOC adoption process was noted as an issue for our agency. Extensive training was completed after the SFY 2021 CQAR audit. The SFY 2022 CQAR audit began less 3 months after SFY 2021 was completed so there was not time to identify the trainings success until SFY 2023.
• For Performance Measure 15: Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.
  o Quality Staff review one chart per supports coordinator per month for 8-10 months of the year. Any discrepancies are immediately brought to the supports coordinator and supervisor's attention.
• Quality staff provided education on PCSP and follow up and monitoring which includes the PCSP after the SFY 2021 CQAR audit, again after the SFY 2022 audit which began less than 3 months after the completion of SFY 2021 audit. Quality continues to educate supports coordinators annually on the PCSP and other performance measures.

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): • During SFY 2021 and SFY 2022, **WellWise Services Area Agency on Aging** monitored overall scores for each chart review completed, which included Performance Measure 2 and Performance Measure 15. For Monthly Audit Scores, the baseline was 97% (average chart audit score during SFY 2021). The SFY 2022 average score was 97.8%, which is an absolute increase of 0.8%. • Following SFY 2022 and previous HSAG recommendations, **WellWise Services Area Agency on Aging** made improvements in various areas of its data collection and monitoring processes. In addition to existing audit and report processes, **WellWise Services Area Agency on Aging** implemented new audits (i.e., all new charts, all medication lists, etc.), new routine reports for monitoring purposes (regarding topics like LOCD's and enrollment), and improved data analysis processes (per Performance Improvement Projects: A Mandatory EQR Activity). These efforts remain in process and **WellWise Services Area Agency on Aging** is pursuing various means of effectively sharing the gathered data with appropriate parties to facilitate swift action.
c. Identify any barriers to implementing initiatives: • The biggest barrier to our initiatives was the unfortunate close timing of the SFY 2021 and SFY 2022 audits. The SFY 2021 audit ended in April of 2022 and the SFY 2022 audit began in June. It left little time for a thorough and complete trainings and for the supports coordinators to show in their work.
HSAG's Assessment: HSAG determined that **WellWise Services Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives. Additionally, the SFY 2022 rate for Performance Measure 2 increased from the prior year and scored above the statewide average. However, the SFY 2022 rate for Performance Measure 15 continued to score below the statewide average and decreased from the prior year.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **WellWise Services 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. MDHHS required **WellWise Services 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 **WellWise Services 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.
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 2022, **WellWise Services Area Agency on Aging** Quality Department continued reviewing all NFLOCs and FOC completed by supports coordinators. If errors or discrepancies are noted, the

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review:
supports coordinator and supervisor are notified immediately and asked to correct. Quality Assistants monitor for error trends and develop supports coordinator education after discussing with supervisors.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For Focus 2: Freedom of Choice, the baseline was 1.0 on a 4.0 scale according to the Final Agency Compliance Determination from the SFY 2021 MI Choice CQAR (Clinical Quality Assurance Review). The SFY 2022 CQAR Review resulted in a score of 3.0 on a 4.0 scale, which is an absolute increase of 2.0 (according to Final Agency Compliance Determination from the SFY 2022 MI Choice CQAR).
c. Identify any barriers to implementing initiatives: • The biggest barrier to our initiatives was the unfortunate close timing of the SFY 2021 and SFY 2022 audits. The SFY 2021 audit ended in April of 2022 and the SFY 2022 audit began in June of 2022. It left little time for a thorough and complete trainings and for the supports coordinators to show in their work.
HSAG's Assessment: HSAG determined that **WellWise Services Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improved performance in the Freedom of Choice focus area in SFY 2022, which received a *Substantial* compliance level.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
HSAG recommended the following: • **WellWise Services 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. Although no substantial weaknesses were identified within any of the CAHPS domains, **WellWise Services Area Agency on Aging** scored below the statewide average on the *Staff Listen and Communicate Well* domain; therefore, HSAG recommends that **WellWise Services 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.
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)***: • CAHPS survey results are shared with providers as part of process improvement. Additionally, supports coordinators inquire on service satisfaction at participant monitoring visits and phone calls. Supports coordinators and contract and provider specialist work with providers to remedy issues. Participants are encouraged to file a grievance or complaint if they are not satisfied with results. Chief Quality Officer handles grievances and complaints and, again, works with participant and provider to develop a solution to the issue. In SFY 2021, there was 1 grievance and in SFY 2022 there were 6. All had satisfactory resolution to the issue at hand.

4. Prior Year Recommendation From the EQR Technical Report for CAHPS:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As specified in the recommendations above, the 2021 CAHPS report indicates **WellWise Services Area Agency on Aging** received a 94.6% in the *Staff Listen and Communicate Well* domain, which was 0.4% lower than the Statewide percent for this domain. **WellWise Services Area Agency on Aging** identifies 94.6% as the baseline for this domain. According to the 2022 CAHPS report, **WellWise Services Area Agency on Aging** scored 97.1% on the specified domain, which was an absolute increase of 2.5 percentage points from the previous year.
c. Identify any barriers to implementing initiatives: • The primary barrier in this area was the direct care worker shortage in addition to the frequent turnover in caregiving staff.
HSAG's Assessment: HSAG determined that **WellWise Services Area Agency on Aging** addressed the prior year's recommendations as indicated through an evaluation of the waiver agency's reported initiatives and improved performance for the *Staff are Reliable and Helpful* domain in SFY 2022, which also scored above the statewide average.

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 External Quality Review 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 2022 for the two state-required PIPs, as reported by MDHHS. Lower prevalence rates are indicative of higher performance for the PIPs. **Bold** font indicates the statewide goal was met for SFY 2022.

The methodology for developing the PIPs was not provided to HSAG for this EQR; however, the rates were calculated by MDHHS and reported for the first six months of the state fiscal year. Additionally, HSAG did not validate any of the data provided in the MDHHS-provided PIP documents (i.e., PIP Goals Chart, QMPs, and annual reports), as HSAG did not conduct the PIP validation activity.

Table 5-1—Comparison of PIP Outcomes*

Waiver Agency	*Prevalence of Falls*	*Prevalence of Any Injuries*
A&D Home Health Care	**18.80%**	**1.30%**
Area Agency on Aging 1-B	**22.60%**	**2.00%**
Area Agency on Aging of Northwest Michigan	29.20%	7.00%
Area Agency on Aging of Western Michigan	**19.80%**	3.70%
Detroit Area Agency on Aging	**17.80%**	**2.70%**
Easterseals/MORC	25.30%	**1.40%**
Milestone Senior Services	32.00%	4.10%
Northern Health Care Management	29.30%	4.70%
Region 3B Area Agency on Aging/Carewell Services	**20.30%**	**0.80%**
Region IV Area Agency on Aging	24.50%	**2.50%**

Waiver Agency	*Prevalence of Falls*	*Prevalence of Any Injuries*
Region VII Area Agency on Aging	**22.70%**	3.40%
Region 9 Northeast MI Community Service Agency	**18.70%**	3.80%
Reliance Community Care Partners	36.50%	**2.40%**
Senior Resources	23.10%	4.80%
The Information Center	**23.00%**	3.70%
The Senior Alliance	27.10%	**2.20%**
Tri-County Office on Aging	29.90%	5.60%
UPCAP Care Management, Inc.	33.70%	6.10%
Valley Area Agency on Aging	**20.60%**	**1.70%**
WellWise Services Area Agency on Aging	**21.90%**	5.60%
SFY 2022 Statewide Result	**23.50%**	**3.30%**
SFY 2022 Statewide Goal	**23.00%**	**3.00%**
Count of Waiver Agencies That Met SFY 2022 Statewide Goal	**10**	**9**

Prevalence rates displayed in **bold** font met the SFY 2022 statewide goal.

*Waiver agency results and goals are displayed as reported by MDHHS and not validated by HSAG.

Waiver agency with the lowest reported prevalence rate per PIP.

Waiver agency with the highest reported prevalence rate per PIP.

Table 5-2 compares the SFY 2023 PIPs implemented by each of the waiver agencies. The clinical PIP was mandated by MDHHS to be *Falls with Injury*, and the waiver agencies were permitted to choose their own nonclinical PIPs.

Table 5-2—SFY 2023 PIP Topics

Waiver Agency	*Clinical PIP and Baseline*	*Nonclinical PIP and Baseline*
A&D Home Health Care	Falls with Injury—20.35%	Timeliness of Monitoring Contacts and Reassessments: Monitoring Contacts—89.2% Assessment Timeliness—91.9%
Area Agency on Aging 1-B	Falls with Injury—Not reported	Completion of Individual Emergency Preparedness Plans—65.09%
Area Agency on Aging of Northwest Michigan	Falls with Injury—Not reported	Fall Prevention Interventions—Not reported
Area Agency on Aging of Western Michigan	Falls with Injury—0.008%	ABN Accuracy—66%

Waiver Agency	Clinical PIP and Baseline	Nonclinical PIP and Baseline
Detroit Area Agency on Aging	Falls with Injury—Less than 1%	Complete Critical Incident Timely and per Requirement—91%
Easterseals/MORC	Falls with Injury—Not reported	Follow-Up and Monitoring—Not reported
Milestone Senior Services	Falls with Injury—3.0%	Timeliness of Monitoring Contacts—80%
Northern Health Care Management	Falls with Injury—3.54%	Timeliness of Monitoring Contacts—93.92%
Region 3B Area Agency on Aging/Carewell Services	Falls with Injury—17.6%	Completion of ABDs—56%
Region IV Area Agency on Aging	Falls with Injury—0%	Required AFC Documentation—54%
Region VII Area Agency on Aging	Falls with Injury—Not reported	Service Summaries—Not reported
Region 9 Northeast MI Community Service Agency	Falls with Injury—Not reported	Nursing Home Admission Rates—13.41%
Reliance Community Care Partners	Falls with Injury—Not reported	Timeliness of Monitoring Contacts: Waiver Agency Reporting Baseline—96.2% CQAR Baseline—70.82%
Senior Resources	Falls with Injury—8.3%	Advance Directives—42.8%
The Information Center	Falls with Injury—Not reported	Timeliness of Monitoring Contacts: Waiver Agency Reporting Baseline—91.30% CQAR Baseline—50%
The Senior Alliance	Falls with Injury—Not reported	Medical Record Completeness and Accuracy: Standard 7.1—75% Standard 7.2—68.75%
Tri-County Office on Aging	Falls with Injury—.084%	Follow-Up After Hospital Discharge—84.15%
UPCAP Care Management, Inc.	Falls with Injury—5.5%	Satisfaction Rate—91%
Valley Area Agency on Aging	Falls with Injury—0.47%	Self-Determination Participants—18%
WellWise Services Area Agency on Aging	Falls with Injury—0.42%	Residential Care Agreements—8.20%

Performance Measure Validation

Table 5-3 displays the MI Choice Waiver Program statewide performance measure rates for the SFY 2022 PMV activity as presented through the MI Choice Performance Measure Report FY 2022, 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 5-4. Additionally, as confirmed by MDHHS, no benchmarks have been established specific to performance measure rates.

Table 5-3—Statewide Performance Measure Rates

Performance Measure		2021 Statewide (%)	2022 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**	**86.65**
2	*Number and percent of qualified participants enrolled in the MI Choice program consistent with MDHHS policies and procedures.*	**96.06**	**93.72**
3	*Number and percent of waiver agencies who submit annual QMP activity and outcome reports that illustrate they are adhering to their QMP.*	**100**	**100**
4	*Number and percent of appropriate LOCDs found after MDHHS review.*	**99.21**	**98.95**
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**	**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**	**100**
7	*Number and percent of LOCDs made by a qualified evaluator.*	**100**	**100**
8	*Number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.*	**99.14**	**100**
9	*Number and percent of MI Choice disenrollments based upon no longer meeting NFLOC criteria that were determined correctly.*	**Not reviewed**	**Unable to gather data**
10	*Number and percent of providers continuing to meet applicable licensure & certification standards in accordance with state law following initial enrollment.*	**99.56**	**100**

Performance Measure		2021 Statewide (%)	2022 Statewide (%)
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**	**100**
12	*Number and percent of non-licensed or non-certified waiver providers that initially met provider qualifications.*	**100**	**100**
13	*Number and percent of non-licensed or non-certified waiver providers that continue to meet provider qualifications.*	**97.95**	**100**
14	*Number and percent of providers who meet provider training requirements.*	**98.66**	**99.95**
15	*Number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.*	**97.11**	**94.76**
16	*Number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.*	**98.69**	**93.19**
17	*Number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant.*	**91.34**	**82.72**
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**	**91.10**
19	*Number and percent of participant person-centered service plans that are updated according to requirements by MDHHS.*	**88.45**	**88.74**
20	*Number and percent of participants who received all of the services and supports identified in their person-centered service plan.*	**93.18**	**90.31**
21	*Number and percent of waiver participants whose records indicate choice was offered among waiver services.*	**95.01**	**89.27**
22	*Number and percent of waiver participants whose records indicate choice was offered among waiver service providers.*	**99.74**	**100**
Participant Safeguards			
23	*Number and percent of participant critical incidents for which investigations by the waiver agencies were resolved within 60 days.*	**82.98%**	**81.74**
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**	**100**
25	*Number and percent of critical incidents due to unexplained death reported within two business days of notification that the incident occurred.*	**85.00**	**96.55**

Performance Measure		2021 Statewide (%)	2022 Statewide (%)
26	*Number and percent of all critical incidents EXCEPT unexplained death reported within 30 days of notification that the incident occurred.*	**96.38**	**96.73**
27	*Number and percent of waiver agencies that utilize the critical incident database to track incidents through effective resolution.*	**100**	**100**
28	*Number and percent of waiver agencies with staff who have completed required training to prevent incidents.*	**100**	**100**
29	*Number and percent of unauthorized use of restraints, restrictive interventions, or seclusions that were reported as a critical incident.*	**100**	**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**	**42.67***
31	*Number and percent of participant suicide attempts that resulted in follow up by the waiver agency.*	**100**	**100**
32	*Number and percent of participants requiring emergency medical treatment or hospitalization due to medication error.*	**53.16**	**47.83**
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**	**100**
34	*Number and percent of properly reported suicide attempts in the critical incident database.*	**100**	**100**
Financial Accountability			
35	*Number and percent of encounters submitted to MDHHS with all required data elements.*	**96.78**	**96.78**
36	*Number and percent of capitation payments made to the waiver agencies only for MI Choice participants with active Medicaid eligibility.*	**100**	**100**
37	*Number and percent of encounters submitted to MDHHS within required timeframes.*	**99.98**	**100**
38	*Number and percent of service plans that supported paid services.*	**99.48**	**99.48**
39	*Number and percent of capitation payments that have been paid at rates approved by the Actuary.*	**100**	**100**

*The methodology for Performance Measure 30 was updated to include only CQAR measure 13.1 in SFY 2022. Therefore, HSAG did not compare this performance measure to the prior year's rate.

For 16 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. Table 5-4 displays the remaining 12 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 5-4—Waiver Agency Impact on Statewide Performance Measure Rates and Comparison of Performance

Waiver Agency	Performance Measures (%)															
	1	2	4	7	8	15	16	17	18	19	20	21	22	24	30	38
A&D Home Health Care	93.55	93.71	100	100	100	94.57	95.16	70.97	91.18	94.64	88.89	90.32	100	100	32.26	100
Area Agency on Aging 1-B	75.86	89.83	100	100	100	92.56	100	84.48	92.94	74.51	82.86	93.10	100	100	24.14	100
Area Agency on Aging of Northwest Michigan	100	95.96	100	100	100	95.92	95.45	86.36	92.41	93.75	100	90.91	100	100	54.55	100
Area Agency on Aging of Western Michigan	77.42	96.72	100	100	100	96.18	91.94	90.32	92.00	80.77	97.14	90.32	100	100	41.94	100
Detroit Area Agency on Aging	73.68	91.97	100	100	100	96.15	92.11	76.32	89.16	72.88	91.49	76.32	100	100	44.74	100
Easterseals/ MORC	100	98.04	100	100	100	100	100	90.00	98.47	93.75	100	100	100	100	60.00	100
Milestone Senior Services	80.00	93.91	100	100	100	95.12	95.00	70.00	93.08	87.50	92.86	90.00	100	100	40.00	100
Northern Health Care Management	70.00	93.20	100	100	100	95.24	90.00	60.00	86.05	77.78	78.57	70.00	100	100	30.00	100
Region 3B Area Agency on Aging/ Carewell Services	92.86	95.80	92.86	100	100	93.22	96.43	67.86	91.16	95.24	100	92.86	100	100	50.00	100
Region IV Area Agency on Aging	100	96.32	100	100	100	97.10	97.06	67.65	94.10	92.59	90.48	94.12	100	100	23.53	100
Region VII Area Agency on Aging	89.29	95.73	100	100	100	93.91	92.86	92.86	93.56	88.89	88.10	100	100	100	75.00	96.43

Waiver Agency	Performance Measures (%)															
	1	2	4	7	8	15	16	17	18	19	20	21	22	24	30	38
Region 9 Northeast MI Community Service Agency	93.33	98.69	100	100	100	100	83.33	90.00	92.82	95.00	94.44	100	100	100	60.00	100
Reliance Community Care Partners	95.83	88.26	100	100	100	100	87.50	85.42	91.64	94.12	96.88	91.67	100	100	20.83	100
Senior Resources	76.19	94.12	100	100	100	96.55	92.86	92.86	92.88	77.78	84.00	90.48	100	100	76.19	100
The Information Center	80.00	96.12	100	100	100	92.68	95.00	85.00	87.64	81.25	100	70.00	100	100	40.00	90.00
The Senior Alliance	100	88.89	100	100	100	93.85	90.63	75.00	89.93	96.43	86.36	56.25	100	100	56.25	100
Tri-County Office on Aging	83.33	91.90	91.67	100	100	90.20	89.58	70.83	86.84	77.78	86.67	95.83	100	100	16.67	100
UPCAP Care Management, Inc.	100	98.52	100	100	100	90.57	100	88.46	93.20	95.65	92.86	92.31	100	100	38.46	100
Valley Area Agency on Aging	91.67	90.91	91.67	100	100	92.16	86.96	58.33	89.35	90.91	91.67	91.67	100	100	16.67	100
WellWise Services Area Agency on Aging	88.89	97.28	100	100	100	93.24	97.22	83.33	93.74	90.91	80.00	100	100	100	61.11	100
CMS-372 Report Statewide % Rate*	**86.65**	**93.72**	**98.95**	**100**	**100**	**94.76**	**93.19**	**82.72**	**91.10**	**88.74**	**90.31**	**89.27**	**100**	**100**	**42.67**	**99.48**

*Statewide percentage rates are displayed as reported by MDHHS.

Indicates the performance measure rate as calculated by HSAG is lower than the statewide rate.

Compliance Review

Table 5-5 provides the overall percentage of compliance for each waiver agency's SFY 2022 CQAR record review and home interview results. Table 5-5 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 5-5—Summary of SFY 2022 Compliance Review Results—CQARs

Waiver Agency	2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Rating for Compliance	2021 MDHHS Rating for Compliance
A&D Home Health Care	89.52%	99.88%	**3.75**	**3.91**
Area Agency on Aging 1-B	88.44%	99.45%	**3.68**	**3.91**
Area Agency on Aging of Northwest Michigan	90.22%	100%	**3.79**	**3.62**
Area Agency on Aging of Western Michigan	90.12%	99.64%	**3.72**	**3.86**
Detroit Area Agency on Aging	88.19%	99.34%	**3.60**	**3.73**
Easterseals/MORC	95.23%	99.60%	**3.90**	**4.00**
Milestone Senior Services	91.21%	100%	**3.74**	**3.59**
Northern Health Care Management	85.28%	99.60%	**3.40**	**3.89**
Region 3B Area Agency on Aging/Carewell Services	90.76%	99.71%	**3.71**	**3.91**
Region IV Area Agency on Aging	92.25%	99.08%	**3.86**	**3.90**
Region VII Area Agency on Aging	93.05%	99.71%	**3.92**	**3.91**
Region 9 Northeast MI Community Service Agency	92.62%	99.76%	**3.83**	**3.98**
Reliance Community Care Partners	86.21%	98.10%	**3.62**	**3.84**
Senior Resources	91.37%	98.53%	**3.76**	**3.96**
The Information Center	88.87%	99.59%	**3.75**	**3.92**
The Senior Alliance	87.23%	99.75%	**3.73**	**3.88**
Tri-County Office on Aging	84.88%	99.30%	**3.43**	**3.82**
UPCAP Care Management, Inc.	90.72%	100%	**3.66**	**3.84**

Waiver Agency	2022 Medical Record Review Percent Evident	2022 Home Interview Review Percent Evident	2022 MDHHS Rating for Compliance	2021 MDHHS Rating for Compliance
Valley Area Agency on Aging	87.24%	99.65%	**3.39**	**3.89**
WellWise Services Area Agency on Aging	92.80%	99.77%	**3.80**	**3.95**

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.

Table 5-6 provides a summary of the number of waiver agencies that scored within each compliance level for each focus area.

Table 5-6—Summary of SFY 2022 Compliance Review Results—CQARs*

Focus Area	Number of Waiver Agencies With *Substantial* Compliance Level	Number of Waiver Agencies With *Some Compliance, Needs Improvement* Compliance Level	Number of Waiver Agencies With *Not Full or Substantial* Compliance Level	Number of Waiver Agencies With *Not Demonstrated* Compliance Level
Level of Care Determination	20	0	0	0
Freedom of Choice	8	3	2	7
Release of Information	11	1	2	6
Status	17	3	0	0
Pre-Planning	20	0	0	0
Assessment	20	0	0	0
Medication Record	19	1	0	0
Person-Centered Service Planning	20	0	0	0
MI Choice Services	20	0	0	0
Linking and Coordinating	14	5	1	0
Follow-Up and Monitoring	10	3	7	0
Service Provider	19	0	0	1
Contingency Plan	8	5	7	0

Focus Area	Number of Waiver Agencies With *Substantial* Compliance Level	Number of Waiver Agencies With *Some Compliance, Needs Improvement* Compliance Level	Number of Waiver Agencies With *Not Full or Substantial* Compliance Level	Number of Waiver Agencies With *Not Demonstrated* Compliance Level
Critical Incidents	7	1	11	0
Adverse Benefit Determination	7	2	5	5
Complaints and Grievances	9	1	2	7
Home and Community Based	16	0	0	0

*Not all focus areas total 20 waiver agencies as some waiver agencies scored NA in some focus areas.

Encounter Data Validation

Table 5-7 presents the EDV results for all waiver agencies. Results for the administrative profile are stratified by category of service. For both analyses, cells with a "✓" indicate no or minor concerns noted, cells a "–" indicate moderate concerns noted, and cells with an "x" indicate major concerns noted. For waiver agency-specific results, refer to Section 3.

Table 5-7—EDV Waiver Agency Comparison

Waiver Agency	IS Review			Administrative Profile				
	Encounter Data Sources and Systems	Payment Structures	Encounter Data Quality Monitoring	Encounter Data Completeness	Encounter Data Timeliness	Field-Level Completeness and Accuracy	Encounter Referential Integrity	Encounter Data Logic
A&D Home Health Care	✓	✓	–	✓	✓	–	✓	✓
Area Agency on Aging 1-B	✓	✓	✓	✓	x	✓	✓	✓
Area Agency on Aging of Northwest Michigan	✓	✓	✓	✓	✓	–	✓	✓
Area Agency on Aging of Western Michigan	✓	✓	–	✓	✓	–	✓	✓
Detroit Area Agency on Aging	✓	✓	–	✓	–	–	✓	✓
Easterseals/MORC	✓	✓	–	–	✓	–	✓	✓

Waiver Agency	IS Review			Administrative Profile				
	Encounter Data Sources and Systems	Payment Structures	Encounter Data Quality Monitoring	Encounter Data Completeness	Encounter Data Timeliness	Field-Level Completeness and Accuracy	Encounter Referential Integrity	Encounter Data Logic
Milestone Senior Services	✓	✓	–	✓	✓	–	✓	✓
Northern Health Care Management	✓	✓	–	✓	✓	–	✓	✓
Region 3B Area Agency on Aging/Carewell Services	✓	✓	–	✓	✓	–	✓	✓
Region IV Area Agency on Aging	✓	✓	–	✓	✓	–	✓	✓
Region VII Area Agency on Aging	✓	✓	–	✓	✓	–	✓	✓
Region 9 Northeast MI Community Service Agency	✓	✓	–	✓	✓	–	✓	✓
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	✓	✓	–	✓	✓	–	✓	✓
WellWise Services Area Agency on Aging	✓	✓	–	✓	✓	–	✓	✓

✓	No or minor concerns noted.
–	Moderate concerns noted.
×	Major concerns noted.

Consumer Assessment of Healthcare Providers and Systems: Home- and Community-Based Services Analysis

Table 5-8 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 5-8—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	87.9%	94.6%	94.4%	96.3%	97.4%	92.7%	97.2%	98.3%	79.2%	97.0%	100%
Area Agency on Aging 1-B	91.2%	90.1%	89.0%	94.4%	87.7%	86.3%	91.4%	97.2%	77.6%	95.3%	100%
Area Agency on Aging of Northwest Michigan	93.2%	94.2%	94.2%	96.8%	97.9%	92.7%	98.0%	99.2%	80.6%	94.1%	100%
Area Agency on Aging of Western Michigan	87.5%	88.9%	93.9%	91.1%	93.9%	88.5%	90.7%	95.7%	77.9%	90.2%	100%
Detroit Area Agency on Aging	92.9%	94.4%	93.1%	97.5%	100%	93.4%	90.1%	98.3%	77.2%	95.4%	100%
Easterseals/MORC	92.5%	87.6%	97.4%	92.7%	100%	88.3%	92.3%	95.2%	81.3%	94.9%	100%
Milestone Senior Services	92.8%	94.2%	92.9%	96.2%	95.0%	88.8%	92.7%	99.1%	78.5%	91.0%	100%
Northern Health Care Management	89.7%	85.2%	93.0%	94.0%	87.9%	88.7%	94.4%	98.0%	76.0%	97.2%	100%
Region 3B Area Agency on Aging/Carewell Services	91.6%	97.1%	95.8%	94.8%	100%	91.8%	93.9%	94.0%	79.7%	89.9%	100%
Region IV Area Agency on Aging	94.4%	94.6%	90.8%	92.3%	99.0%	93.8%	89.9%	95.8%	76.4%	85.6%	100%
Region VII Area Agency on Aging	94.3%	95.5%	89.9%	95.7%	96.4%	92.2%	92.5%	96.6%	78.5%	92.6%	100%
Region 9 Northeast MI Community Service Agency	91.8%	90.7%	93.7%	91.6%	85.8%	88.5%	92.8%	96.0%	76.9%	94.2%	100%
Reliance Community Care Partners	96.0%	96.4%	97.3%	98.0%	100%	87.7%	94.1%	100%	86.8%	96.6%	100%
Senior Resources	88.9%	88.4%	85.7%	94.3%	93.9%	88.7%	95.3%	97.5%	77.8%	93.9%	100%
The Information Center	83.2%	85.5%	85.8%	92.0%	98.7%	93.8%	90.5%	97.8%	79.4%	93.4%	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 Senior Alliance	93.9%	92.1%	91.8%	97.4%	94.7%	90.3%	85.8%	97.5%	75.1%	94.5%	100%
Tri-County Office on Aging	93.8%	94.0%	93.7%	95.7%	100%	96.3%	91.1%	99.2%	81.3%	96.4%	100%
UPCAP Care Management, Inc.	93.7%	94.4%	90.6%	97.2%	95.0%	88.7%	93.3%	98.1%	78.2%	87.0%	100%
Valley Area Agency on Aging	89.8%	88.0%	90.4%	91.1%	100%	86.3%	89.1%	95.8%	77.9%	91.9%	100%
WellWise Services Area Agency on Aging	94.9%	96.6%	94.6%	97.1%	97.7%	95.4%	93.7%	98.4%	78.8%	91.8%	100%
2022 Statewide	**91.8%**	**92.1%**	**92.1%**	**94.6%**	**95.8%**	**90.8%**	**92.4%**	**97.4%**	**78.5%**	**93.0%**	**100%**
2021 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

6. Programwide Conclusions and Recommendations

MDHHS contracts with HSAG to conduct the EDV, as permitted under 42 CFR §438.358(a), and the EQR technical report, as required by 42 CFR §438.364. MDHHS performs EQR activities or contracts with another vendor to conduct the remaining required and optional activities described in this EQR technical report. MDHHS provides the data and documentation to HSAG to compile and evaluate the completion of these activities. As part of the EQR, HSAG assessed MDHHS' implementation of EQR-related activities in accordance with 42 CFR §438.358 and in alignment with the CMS EQR Protocols. Table 6-1 describes HSAG's conclusions and recommendations for MDHHS related to the implementation of the EQR activities.

Table 6-1—Programwide Conclusions and Recommendations by EQR Activity

EQR Activity	Overall Performance Impact	Performance Domain
Validation of PIPs	**Conclusions:** PIPs are used to design projects for improvement using targeted initiatives to positively change behavior at a member, provider, or system level. Effective PIPs must have a baseline, a goal, and at least two remeasurement periods. In SFY 2022, MDHHS required all waiver agencies to conduct PIPs for the *Prevalence of Falls* and *Prevalence of Any Injuries* in an effort to decrease the two rates. As several waiver agencies already met the statewide goals, those waiver agencies' goals were reduced to the prior year's rate; therefore, these waiver agencies could meet the goal without any performance improvement. However, since the purpose of a PIP is continuous sustainable improvement, the goals for those waiver agencies did not encourage improvement in the rates and a reduction in falls and injuries. Additionally, MDHHS required the PIP related to *Falls with Injury* for SFY 2023, and while several waiver agencies have room to improve this rate, based upon baselines reported by some waiver agencies, their rate is already between 0 percent and 1 percent, leaving very little room to improve the prevalence of falls resulting in injuries. As the purpose of a PIP is to improve upon rates that are not meeting performance thresholds, the PIP is not conducive for performance improvement for those waiver agencies. Additionally, for PIPs for which data are collected less than annually (i.e., six months) the waiver agencies and MDHHS should also report results using data for the entire state fiscal year. Although waiver agencies and MDHHS were able to obtain data for the entire year or at any point during the year, MDHHS and the waiver agencies compared the baseline data for only the first six months of the state fiscal year, then the results of only the first six months of the following state fiscal year. An entire six months of	☒ Quality ☐ Timeliness ☐ Access

EQR Activity	Overall Performance Impact	Performance Domain
	data were not used by MDHHS for the entire annual remeasurement period to identify and analyze all falls and injuries that had occurred during that time and to learn if there are differences in the types of falls and injuries that may occur during the time period for which data were not compared. Omitting these data from the study does not provide a complete assessment of falls and injuries for the entire year and may limit the waiver agencies from identifying initiatives that could support the reduction of all falls and injuries that may occur over the state fiscal year (i.e., falls occurring due to seasonal changes, such as icy conditions). Further, several waiver agencies' PIP documentation demonstrated the following findings: • PIP designs and the methodologies used for evaluating outcomes and the success of the PIPs were not comprehensive or were unclear. • Documentation of 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 PIP documentation. 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. Lastly, while MDHHS provided limited feedback to the waiver agencies regarding their PIPs through an annual review of the QAPI program description, MDHHS, MDHHS' agent who is not a waiver agency, or an EQRO did not validate each waiver agency's PIP in accordance with the CMS EQR Protocols, as determined through the documentation issues noted during the EQR. **Recommendations:** 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.	

EQR Activity	Overall Performance Impact	Performance Domain
	• 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 a clinical and nonclinical PIP and has emphasized the CMS EQR Protocol 1 requirements for a PIP that must be included in the waiver agencies' QAPI program descriptions, HSAG recommends that MDHHS require the waiver agencies to set goals that encourage improvement from the baseline rate. HSAG also recommends that MDHHS select PIP topics that support opportunities for improvement (i.e., address lower performing program areas) for 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. MDHHS may want to consider whether it would be appropriate to require a general area of focus and request that each waiver agency identify specific PIP topics within the general area of focus that would support improvement for their particular waiver agency through internal data analyses (e.g., a baseline rate of 90 percent may not signify an appropriate area requiring improvement). Additionally, MDHHS should require the waiver agencies to continue the PIP for at least two remeasurement periods after the baseline (i.e., at least three full years of data collection and analysis) to monitor improvement over time and give the waiver agencies sufficient time to implement interventions and improve member outcomes. Further, 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 using the documentation provided by the waiver agencies to verify that each waiver agency used sound methodology in its design, implementation, and outcomes of the PIPs. HSAG strongly recommends that MDHHS reference the PIP worksheets within CMS EQR Protocol 1 to ensure all validation requirements are met. MDHHS must also assign two validation ratings based on the assessment of whether the PIP adhered to an acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement in accordance with the CMS EQR Protocol 1.	

EQR Activity	Overall Performance Impact	Performance Domain
PMV	**Conclusions:** MDHHS must use performance measures to monitor the performance of individual waiver agencies at a point in time, to track performance over time, to compare performance among waiver agencies, and to inform the selection and evaluation of quality improvement activities. MDHHS must specify standard performance measures which the waiver agencies must include in their QAPI programs. Based on the documentation provided for the PMV activity, HSAG determined that 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 measure data 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 assessed waiver agency compliance with waiver-specific standards and contract requirements through a sample of record reviews and home visits, the CQAR process did not assess aggregated waiver agency performance in alignment with the performance measures reported by MDHHS in the CMS-372 report. The contract with the waiver agencies also does not outline specific performance measure reporting as required by 42 CFR §438.330(c), and subsequently, the waiver agencies were not annually measuring and reporting to MDHHS on any required performance measure standards. **Recommendations:** 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 for validation. MDHHS should specifically require the waiver agencies to report the numerators, denominators, and performance measure rates that align with the MI Choice Waiver Program performance measures identified within Appendix D: 2023–2026 CQS Goals & Objectives Metrics Table of the 2023–	☒ Quality ☐ Timeliness ☐ Access

EQR Activity	Overall Performance Impact	Performance Domain
	2026 MDHHS CQS. Currently, MDHHS collects a limited sample of data per waiver agency through the CQAR process (e.g., 10 records per waiver agency, and some selected records may not be applicable for all standards being reviewed). Performance measure rates should include all applicable data (i.e., denominators should include the entire population, as applicable) or, in lieu of the entire population when it is not appropriate for a particular performance measure, a statistically significant representative sample per waiver agency in accordance with the performance measure specification. In addition to the performance measures identified within the 2023–2026 MDHHS CQS, MDHHS should also consider identifying standard performance measures that relate specifically to quality of life, rebalancing, and community integration activities. 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. CMS offers nationally standardized LTSS quality measures, which are available at www.Medicaid.gov. For the performance measures identified for waiver agency reporting, MDHHS should update its contract to specifically include each required performance measure. MDHHS should also notify the waiver agencies of the reporting requirements and the performance measures' specifications for calculating numerators and denominators and the percentage rates. MDHHS should also provide a timeline in which the waiver agencies must submit to MDHHS the calculated rates and supporting data for each performance measure identified so that MDHHS can conduct the validation activities (i.e., pre-site visit, site visit, and post-site visit) in accordance with CMS EQR Protocol 2. For future EQR technical reports, MDHHS must provide the EQRO (i.e., HSAG) the individual waiver agency performance measure rates for all required performance measures. HSAG can use the MDHHS-established performance measure benchmarks to gauge waiver agency performance against MDHHS' set expectations.	
Compliance Review	**Conclusions:** Federal regulations require waiver agencies to have undergone a review within the three-year period preceding each annual EQR to determine waiver agency compliance with federal standards. The standards that are the subject of the compliance review activity are stipulated within 42 CFR §438.358(b)(1)(iii). While MDHHS has contracted with a vendor to conduct an annual waiver agency record and home visit review (i.e., CQAR), which	☒ Quality ☐ Timeliness ☐ Access

EQR Activity	Overall Performance Impact	Performance Domain
	focus on waiver-specific requirements and whether care management and service delivery processes 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 poststabilization 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 within the previous three-year period. Further, HSAG provided MDHHS with a crosswalk to compare MDHHS' compliance review standards with the federally required standards. Although the crosswalk identified specific standards within focus areas that MDHHS associated with a federal standard, most of MDHHS' cited standards did not align with most requirements under each of the federal standards. For example, MDHHS cited *15.3 Did the Waiver Agent (WA) adhere to MDHHS policy when the participant/guardian filed an appeal?* but the file review tool used by the vendor did not include all federal appeals requirements that apply to timeliness, extensions, content of notices, etc. Therefore, HSAG is unable to confirm that all rules associated with federal standards are included in MDHHS' compliance review process. **Recommendations:** 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 member rights requirements described in 42 CFR §438.100, the emergency and poststabilization services requirements described in 42 CFR §438.114, and the	

EQR Activity	Overall Performance Impact	Performance Domain
	quality assessment and performance improvement requirements described in 42 CFR §438.330. MDHHS must ensure that it conducts a comprehensive compliance review during each three-year cycle. The review must include all federally mandated standards for MCEs, which include PAHPs (i.e., the waiver agencies). The compliance review activity must align with CMS EQR Protocol 3 using documents from and interviews with the waiver agencies to verify compliance with federal regulations and State requirements. HSAG strongly recommends that MDHHS reference the compliance review worksheets within CMS EQR Protocol 3 to ensure a comprehensive review. MDHHS should also use the crosswalk (included in Section 3 of this EQR technical report) of the standards currently reviewed as part of the CQAR and compare to the standards required to be part of a compliance review according to 42 CFR §438.358(b)(1)(iii). As part of this review, MDHHS should identify all federal requirements under a standard including all subelements (e.g., 42 CFR §438.210[a]-[e] referenced under the Coverage and Authorization of Services standard) and compare to the current standards being reviewed to identify gaps in the scope of MDHHS' compliance review activity and requirements being assessed. Based on the comparison findings, MDHHS should immediately begin preparations to address all gaps identified.	

HSAG also performed a comprehensive assessment of the performance of the waiver agencies and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the MI Choice Waiver Program to identify programwide conclusions. The programwide conclusions are not intended to be inclusive of all EQR activity results; rather, only those results that had a substantial impact on a CQS goal. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the Michigan CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members.

Table 6-2—Programwide Conclusions and Recommendations by CQS Goal

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1—Ensure high quality and high levels of access to care	**Conclusions:** The results of the PMV activity confirmed that MDHHS and the MI Choice Waiver Program are making improvements in achieving Goal #1 of the CQS in the following performance measures: • Performance Measure 15—*number and percent of participants whose person-centered service plan includes services and supports that align with their assessed needs.* Although the statewide rate decreased by 2.35 percentage points from the prior year, the rate continued to demonstrate high performance at 94.76 percent. • Performance Measure 16—*number and percent of participants whose person-centered service plan had strategies to address their assessed health and safety risks.* Although the statewide rate decreased by 5.5 percentage points from the prior year, the rate continued to demonstrate high performance at 93.19 percent. • Performance Measure 20—*number and percent of participants who received all of the services and supports identified in their person-centered service plan.* Although the statewide rate decreased by 2.87 percentage points from the prior year, the rate continued to demonstrate high performance at 90.31 percent. • Performance Measure 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.* The statewide rate for this measure improved to 100 percent. Additionally, the results of the CQAR activity demonstrated high performance in the following focus areas: • MI Choice Services—All 20 waiver agencies received a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. • Service Provider—19 waiver agencies received a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. Further, the results of the CAHPS HCBS activity demonstrated high performance across all measures that affect access to quality services, including *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, *Personal Safety and Respect*, *Met Need*, and *Physical Safety Measure*.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	However, the results of the PMV activity also demonstrated continued opportunities to enhance access to quality care as several performance measure rates declined from the previous year. Additionally, two performance measure rates indicated a negative impact to quality and timely access to care, including Performance Measure 1 (*number and percent of service plans for participants that were completed in time frame specified in the agreement with MDHHS*) and Performance Measure 30 (*number and percent of participants with an individualized contingency plan for emergencies [e.g., severe weather or unscheduled absence of a caregiver]*) as the statewide rate for Performance Measure 1 was 86.65 percent and for Performance Measure 30 was 42.67 percent, demonstrating opportunities to improve timely completion of service plans and the prevalence of contingency plans available in the event of emergencies. Further, the results of the CQAR activity showed continued opportunities to enhance access to quality care as several focus areas demonstrated low performance: • Follow-Up and Monitoring—Seven waiver agencies received a *Not Full or Substantial* compliance level, indicating more than a third of the waiver agencies did not fully or substantially adhere to MI Choice waiver requirements. • Contingency Plan—Seven waiver agencies received a *Not Full or Substantial* compliance level, indicating more than a third of the waiver agencies did not fully or substantially adhere to MI Choice waiver requirements. • Critical Incidents—Eleven waiver agencies received a *Not Full or Substantial* compliance level, indicating more than half of the waiver agencies did not fully or substantially adhere to MI Choice waiver requirements. • Adverse Benefit Determination—Ten waiver agencies received a *Not Full or Substantial* or *Not Demonstrated* compliance level, indicating half of the waiver agencies did not fully or substantially adhere to or did not adhere to MI Choice waiver requirements. Lastly, within the PIP activity, the statewide rate for the *Prevalence of Falls* PIP scored 23.5 percent, which is 0.5 percentage points above the goal, and the statewide rate for the *Prevalence of Any Injuries* PIP scored 3.3 percent, which is 0.3 percentage points above the goal. For both PIPs, a lower percentage is a better rate. Therefore, performance has slightly worsened from the prior year's statewide	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	rates, indicating that more members experienced falls or injuries during the assessment period. These results indicate that while most members received all the services and supports they needed according to their assessed needs, were assisted with identifying and mitigating any risks to their health and safety, and were generally happy with the services, MDHHS and the MI Choice Waiver Program continue to have opportunities to improve access to waiver services for all members and ensure members' health and safety when risks are identified, particularly when supports coordinators are not directly providing services (i.e., during times when the member is not with the supports coordinator). **Recommendations:** MDHHS could continue to request that the waiver agencies consider system enhancements and/or use existing system capabilities to remind supports coordinators when assessments are due (Performance Measure 1) and to require a contingency plan to be completed before moving forward in the system (Performance Measure 30). System reminders can also be used for other time bound requirements to ensure supports coordinators complete those requirements timely, which could support improvement in the Follow-Up and Monitoring and Critical Incidents CQAR focus areas. Additionally, MDHHS could collaborate with the waiver agencies and determine fields within the system that should be required to prevent supports coordinators from moving forward until those fields are complete. System enhancements could also improve performance in several performance measures and CQAR focus areas and assist supports coordinators with identifying any new health and safety concerns members may have or any new health conditions to better coordinate the care members need. Additionally, identifying critical incidents and the root causes of those incidents helps supports coordinators address and mitigate causes of incidents, which can improve member safety and health outcomes. MDHHS has retired the *Prevalence of Falls* and *Prevalence of Any Injuries* PIPs; however, waiver agencies are still required to monitor performance in these measures, and interventions implemented could support improvement in the SFY 2023 required PIP, *Falls with Injury*. Therefore, HSAG recommends that MDHHS and its contracted waiver agencies collaborate to identify evidence-based interventions that improve performance in preventing falls and implement those interventions statewide.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** The results of the PMV activity confirmed that MDHHS and the MI Choice Waiver Program are making improvement in achieving Goal #2 of the CQS in the following performance measures: • Performance Measure 4—*number and percent of appropriate LOCDs found after MDHHS review*. Although the rate for this measure decreased slightly from the SFY 2021 rate, the rate continued to demonstrate high performance at 98.95 percent. • Performance Measure 8—*number and percent of participants who had initial LOCDs or redeterminations where the NFLOC criteria were accurately applied.* The rate improved to 100 percent for this measure. • 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.* Although this performance measure decreased by 3.65 percentage points, the rate continued to demonstrate high performance at 91.1 percent. • Performance Measure 22—*number and percent of waiver participants whose records indicate choice was offered among waiver service providers.* The rate improved to 100 percent for this measure. • Performance Measure 38—*number and percent of service plans that supported paid services.* The rate for this measure demonstrated high performance at 99.48 percent. Additionally, through the CQAR activity, the MI Choice Waiver Program demonstrated strong performance in the following focus areas related to person-centered care coordination: • Pre-Planning—All 20 waiver agencies scored a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. • Assessment—All 20 waiver agencies scored a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. • Person-Centered Service Planning—All 20 waiver agencies scored a *Substantial* compliance level, indicating that the waiver agencies adhered to MI Choice waiver requirements. Further, the results of the CAHPS HCBS activity demonstrated high performance across several measures that affect person-centered care, including *Global Ratings Measures*, *Recommendation*	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Measures, *Staff are Reliable and Helpful*, *Staff Listen and Communicate Well*, and *Case Manager is Helpful*. However, the results of the PMV activity also demonstrated continued opportunities to enhance person-centered care as several performance measure rates declined from the previous year or were below 90 percent. These performance measure results that indicated a negative impact on quality and access to care included Performance Measure 17 (*number and percent of participants whose person-centered service plan includes goals and preferences desired by the participant*), Performance Measure 19 (*number and percent of participant person-centered service plans that are updated according to requirements by MDHHS*), and Performance Measure 21 (*number and percent of waiver participants whose records indicate choice was offered among waiver services*). Additionally, through the CAHPS HCBS activity, although the rate increased 3.1 percentage points from SFY 2021, the MI Choice Waiver Program demonstrated low performance in the *Planning Your Time and Activities* domain, with a statewide rate of 78.5 percent. These results indicate that members were generally being assessed appropriately and were satisfied with their supports coordinators, care team, and the waiver agency. However, many members were not always offered choices among the services they received and felt that they were not able to participate in their communities or enjoy time with family and friends as much as they would have liked. Patients who have a say in their care are more likely to follow the recommendations of their healthcare team and comply with treatment plans. Additionally, to have a good quality of life, it is important that members can participate in their communities and be with family and friends. Person-centered care coordination helps members to achieve these goals. **Recommendations:** Person-centered care is paramount to overall good health outcomes. To improve performance in person-centered care coordination, MDHHS could continue to request that the waiver agencies consider system enhancements and/or use existing system capabilities to remind supports coordinators when tasks are due and to require certain fields to be completed before moving forward in the system. Additionally, MDHHS could conduct periodic statewide trainings that focus on the CQAR requirements frequently missed by a large percentage of the waiver agencies. To	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	help improve the *Planning Your Time and Activities* CAHPS domain, MDHHS could require the waiver agencies to deep dive into the questions on the CAHPS survey that directly impact this domain and conduct a root cause analysis determining why the domain has a low score and implement interventions to eliminate barriers. Further, MDHHS should require the waiver agencies to report and evaluate their CAHPS HCBS results through their QAPI programs and include activities to address lower performing areas.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)	**Conclusions:** Because the MI Choice Waiver Program provides only the HCBS benefits for Medicaid members and medical care and behavioral healthcare are provided through other Michigan Medicaid programs, it is important that the MI Choice Waiver Program coordinate benefits and care between all programs to ensure the best possible outcomes for members. The results of the CQAR activity demonstrated high performance in the Linking and Coordinating focus area as 19 waiver agencies received a *Substantial* or *Some Compliance, Needs Improvement* compliance level. This result indicates that supports coordinators help link members with the waiver and non-waiver services they may need. However, MDHHS does not currently have other performance metrics to measure meaningful collaboration across program areas and delivery systems; support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations; or promote the use and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize member outcomes. **Recommendations:** Although most waiver agencies scored high in the Linking and Coordinating CQAR focus area, MDHHS should develop additional metrics to measure the waiver agencies' collaboration across programs and other payers of services (e.g., FFS and PIHPs), transitions across the continuum of care, and adoption of health information technology to optimize member outcomes.	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** According to the CDC, "racial and ethnic minority groups, throughout the United States, experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts."[6-1] In order to improve outcomes for racial and ethnic minority groups, MDHHS and its waiver agencies should develop initiatives directed toward these individuals, taking into account any cultural needs and preferences. Through the review of the existing EQR activities, HSAG did not identify activities or performance metrics that focused on and addressed racial and ethnic disparities that align with MDHHS' objectives under Goal #4. However, the MDHHS CQS 2023–2026 indicates that MDHHS received a grant from MHEF, which provided funding for various programs under MDHHS, including the MI Choice Waiver Program, to develop a health equity project to assist the MI Choice Waiver Program with identifying barriers to and increasing the use of HCBS. Through this project, the MI Choice Waiver Program goals are to provide opportunities, services, and programs to ensure equitable access to Michigan's HCBS programs. Project activities include working with local communities to learn what keeps someone from using HCBS services and analysis of Medicaid data to determine if HCBS services offered to individuals differ based on race or ethnicity. **Recommendations:** HSAG recommends that MDHHS and the MI Choice Waiver Program continue work on the health equity project, and through this project, identify specific performance metrics to monitor the reduction of racial and ethnic disparities across the MI Choice Waiver Program. MDHHS should also update the CQS to add new objectives under Goal #4 that align to the newly created performance metrics specific to the MI Choice Waiver Program. Additionally, MDHHS could require each waiver agency to conduct a PIP that focuses on health disparities identified within its low-performing program areas.	☒ Quality ☐ Timeliness ☒ Access

[6-1] Centers for Disease Control and Prevention. Racism and Health, September 18, 2023. Available at: https://www.cdc.gov/minorityhealth/racism-disparities/index.html. Accessed on: Jan 8, 2024.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** The aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had on improving quality outcomes and disparity reduction through value-based initiatives and payment reform. **Recommendations:** If appropriate, MDHHS could implement requirements for waiver agencies to use value-based payment models to improve quality of care. This could include incentives for specific HCBS that may be lacking in their service area in order to incentivize providers to employ additional staff. Additionally, MDHHS could collaborate with other programs' leaders to identify potential value-based payment models that have supported improvement in quality outcomes and disparity reduction.	☒ Quality ☐ Timeliness ☒ Access

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:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve quality improvement.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and 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 QAPI Program Description (previously the 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 PIP topics, goals, and strategies. Progress of these PIPs are reported annually to MDHHS through the MI Choice Summary of Quality Management Plan Activities & Outcomes Report. MDHHS reviews and analyzes waiver agency QAPI Program Descriptions and the associated annual reports. MDHHS also compiles and compares individual waiver agency PIPs and statewide goals. Table A-1 outlines the selected two PIPs for the waiver agencies for the SFY 2022 and SFY 2023 review years and the goals of each PIP.

Table A-1—PIP Indicators and Goals

PIP Indicators	MDHHS Statewide Goals
2022 PIPs	
1. *Prevalence of Falls*	23%
2. *Prevalence of Any Injuries*	3%

PIP Indicators	MDHHS Statewide Goals
2023 PIPs	
1. *Prevalence of Falls with Injury*	No established statewide goal; goal determined by each waiver agency.
2. *[Determined by Waiver Agency]*	Goal determined by each waiver agency.

Description of Data Obtained and Related Time Period

For SFY 2022, MDHHS ran a report from the interRAI system, used by all waiver agencies. The baseline data for the two PIPs in 2022 were collected between October 1, 2020, through April 30, 2021, and the SFY 2022 results were collected between October 1, 2021, through April 30, 2022. Additionally, each waiver agency's PIPs are reported to MDHHS through a yearly activities and outcomes report. These reports provide data about each of the PIPs and the activities completed. However, as the data may be run from interRAI at any time during the year, the waiver agency data reported through the QMP and/or Quality Management Plan Activities & Outcomes Report may have differed from the data run by MDHHS. Both the MI Choice Summary of Quality Management Plan Activities & Outcomes Report and each waiver agency's QMP and MDHHS data 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 PIP information included through the SFY 2022 QMP and MI Choice Summary of Quality Management Plan Activities & Outcomes Reports and the SFY 2023 QAPI to ensure the waiver agencies used a sound methodology in their design, implementation, analysis, and reporting of the PIP 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. HSAG determined each waiver agency's substantial strengths and weaknesses as follows:

- Strength—Any PIP that met the statewide goal or *New Goal*.
- Weakness—Any PIP that did not meet the statewide goal or *New Goal* and any identified issues with the design, methodology, analysis, or implementation of PIPs.
- 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.

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 calculated and/or 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

Table A-2—Performance Measures and Source Data

Performance Measure		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 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

	Performance Measure	Source Data	Sampling Approach
	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 or redeterminations 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

Performance Measure		Source Data	Sampling Approach
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
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

	Performance Measure	Source Data	Sampling Approach
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
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 2022
   b. The numerator was determined by completing the following:
      i. Performance Measure 1 Example:
         1. SFY 2022 382 records were reviewed
         2. Overall percentage of compliance of 86.65 percent
         3. After manually changing the numerator, MDHHS determined that 331/382 participants had an overall percentage of compliance of 86.65 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 statewide performance measure rates were calculated by MDHHS using data collected between October 1, 2021, and September 30, 2022 (SFY 2022).

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 determined each waiver agency's substantial strengths and weaknesses as follows:

- Strength—Any performance measure that achieved a 100 percent compliance score.
- Weakness—Any performance measure that scored 5 percentage points or more below the statewide performance measure rate.
- HSAG further analyzed the results of the waiver agency's 2022 performance measure rates based on comparisons to the statewide rates to identify strengths and weaknesses (i.e., findings that resulted in the strength or weakness) and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG determined by how much the performance measure decreased from the SFY 2021 rate and 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 poststabilization 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 an EQRO, MPHI, to complete 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 participant. The CQAR includes a review of whether PCSPs 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 2022 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 interview.

Table A-3—CQAR Standards

Standard		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	✓	✓
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 citations identified within the 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
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 2022 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, 2021–September 30, 2022
Information obtained through member home interviews	October 1, 2021–September 30, 2022

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 level 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 determined if the overall compliance level decreased from SFY 2021 to SFY 2022; identified any focus areas for which the waiver agency received a noncompliant determination over multiple years; and 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 received a crosswalk that compared federal standards required under 42 CFR §438.358(b)(1)(iii) to the standards included as part of the CQAR. Based on this crosswalk and a review of the home interview and record review tools, HSAG determined the CQAR tools did not include all requirements that align to federal Medicaid managed care standards. Specifically, the Practice Guidelines program area was not reviewed by MDHHS, and while MDHHS indicated HSAG conducts an EDV activity, the HSAG EDV activity is not a substitute for conducting a compliance review of the Health Information Systems program area.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCEs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2023, MDHHS contracted with HSAG to conduct an EDV study. HSAG conducted the following two core evaluation activities for all 20 waiver agencies:

- IS review—assessment of MDHHS' and the MCEs' IS and processes. The goal of this activity is to examine the extent to which MDHHS' and the waiver agencies' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the waiver agencies in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

Information Systems Review

To ensure the collection of critical information, HSAG employed a three-stage process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- In Stage 1: HSAG conducted a document review, examining various documents related to MDHHS' encounter data initiatives. This review included data dictionaries, process flow charts, system diagrams, and other relevant materials. The information from this review was used to create a questionnaire for MDHHS.
- In Stage 2: HSAG worked with MDHHS to develop a customized questionnaire that delved into specific data processing procedures, staff responsibilities, and data acquisition capabilities. This assessment also considered additional data systems and key topics important to MDHHS.
- In Stage 3: HSAG followed up with key staff members to clarify questionnaire responses. These follow ups allowed HSAG to document current processes and create a process map highlighting crucial factors affecting the quality of encounter data submissions.

Administrative Profile

HSAG submitted a data submission requirements document to notify MDHHS of the required data needed. The data submission requirements document was developed based on the study objectives and data elements to be evaluated in the study. It included a brief description of the study, the review period, required data elements, and information regarding the submission of the requested files.

To assist MDHHS in preparing the requested data files, HSAG took two actions. First, since it was the first-time requesting data from MDHHS' warehouse, HSAG asked for test files before the complete data extraction. These smaller test files, covering a month's encounters, served two purposes. They helped detect extraction issues early and allowed HSAG to begin analysis preparations while waiting for complete data. Details were provided in the data requirements document.

Secondly, after submitting the draft data submission requirements to MDHHS, HSAG scheduled a meeting to address questions about data preparation and extraction. Depending on the complexity, an updated/final document was submitted for MDHHS review and approval.

Once the data arrived from MDHHS, HSAG conducted a preliminary file review. This ensured that the data were reasonable for evaluation, checking data extraction, field presence, and value validity. If necessary, HSAG requested data resubmission based on these results.

Once the final data had been received and processed, HSAG conducted a series of analyses for metrics listed in the sections below. In general, HSAG calculated rates for each metric by encounter type (i.e., 837 Professional [837P]) and waiver agency. However, when the results indicated a data quality issue(s), HSAG conducted an additional investigation to determine whether the issue was for a specific category of service or subpopulation. HSAG documented all noteworthy findings in this aggregate report.

Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur or the last date of service): If the number of members remains stable and there are no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month indicates incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key is based on the member ID, rendering provider NPI, and date of service.
- Monthly encounter volume (i.e., visits) per 1,000 member months by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each waiver agency based on the member enrollment data extracted by MDHHS.

- Paid amount PMPM by service month: This metric will help MDHHS determine whether the encounter data were complete from a payment perspective. Of note, HSAG used the detail paid amount to calculate this metric.
- Percentage of duplicate encounters: HSAG determined the detailed methodology (e.g., data elements and criteria) for defining duplicates after reviewing the encounter data extracted for the study and documented the method in the final report. This metric will allow MDHHS to assess the number of potential duplicate encounters in MDHHS' database.

Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by MDHHS within 360 days from the waiver agency payment date, in 30-day increments. This metric allows MDHHS to evaluate the extent to which the waiver agencies were in compliance with MDHHS' encounter data timeliness requirements.
- Claims lag triangle to illustrate the percentage of encounters received by MDHHS within two calendar months, three months, etc., from the service month. This metric allows MDHHS to evaluate how soon it may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters were complete and accurate through the two study indicators described in Table A-8 for the key data elements listed in Table A-9. In addition, Table A-8 shows the criteria HSAG used to evaluate the validity of each data element. These criteria are based on standard reference code sets or referential integrity checks against member or provider data.

Table A-8—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table A-9 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-9.
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-9.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-9. The criteria for validity are listed in Table A-9.

Table A-9—Key Data Elements for Percent Present and Percent Valid

Key Data Element	837P Encounters	Criteria for Validity
Member ID[H]	√	• In member file • Enrolled in a specific waiver agency on the date of service • Member date of birth is on or before date of service
Header Service From Date[H]	√	• Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date
Header Service To Date[H]	√	• Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date
Detail Service From Date[D]	√	• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date[D]	√	• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Billing Provider NPI[H]	√	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider NPI[H]	√	• In provider data when service occurred • Meets Luhn formula requirements
Referring Provider NPI[H]	√	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider Taxonomy Code[H]	√	• In standard taxonomy code set • Matches the value in provider data
Primary Diagnosis Codes[H]	√	• In national ICD-10-Clinical Modification (CM) diagnosis code sets for the correct code year (e.g., in 2022, code set for services that occurred between October 1, 2021, and September 30, 2022)
Secondary Diagnosis Codes[H]	√	• In national ICD-10-CM diagnosis code sets for the correct code year
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Codes[D]	√	• In national CPT/HCPCS code sets for the correct code year (e.g., in 2022, code set for services that occurred in 2022) AND satisfies CMS' Procedure-to-Procedure edits
National Drug Codes (NDCs)[D]	√	• In national NDC code sets

Key Data Element	837P Encounters	Criteria for Validity
Submit Date[D]	√	• Waiver Agency Submission Date (i.e., the date when Waiver Agency submits encounters to MDHHS) ≥ Waiver Agency Paid Date
Waiver Agency Paid Date[D]	√	• Waiver Agency Paid Date ≥ Detail Service To Date
Header Paid Amount[H]	√	• Header Paid Amount equal to sum of the Detail Paid Amount
Detail Paid Amount[D]	√	• Zero or positive
Header Third-Party Liability (TPL) Paid Amount[H]	√	• Header TPL Paid Amount equal to sum of the Detail TPL Paid Amount
Detail TPL Paid Amount[D]	√	• Zero or positive

[H] Conduct evaluation at the header level
[D] Conduct evaluation at the detail level

Encounter Data Referential Integrity

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID, unique provider NPI) was present in both data sources (i.e., unique member IDs that are in both the encounter and member enrollment files). If an encounter contained more than one NPI (e.g., rendering provider NPI and billing provider NPI on a professional encounter), HSAG included both unique NPIs in the analysis. Table A-10 lists the study indicators that HSAG calculated.

Table A-10—Key Indicators of Referential Integrity

Data Source	Indicator
Medical Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Medical Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Medical Encounter
Medical Encounters vs Provider File	• Direction 1: Percentage of Providers in the Medical Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical Encounter File

Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG developed logic-based checks to ensure the encounter data could appropriately support additional activities.

Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provides insight into how well encounter data may be used to support future analyses, such as Healthcare Effectiveness Data and Information Set (HEDIS®)[A-1] performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

Description of Data Obtained and Related Time Period

Information Systems Review

Representatives from each waiver agency completed the MDHHS-approved questionnaire and then submitted their responses and relevant documents to HSAG for review. Of note, the questionnaire included an attestation statement for waiver agencies' chief executive officer or responsible individual to certify that the information provided was complete and accurate.

Administrative Profile

Data obtained from MDHHS included:

- Claims and encounter data with dates of service from October 1, 2021, through September 30, 2022.
- Member demographic and enrollment data.
- Provider data.

Process for Drawing Conclusions

Information Systems Review

HSAG compiled findings from the review of the received questionnaire responses, identifying critical points that affected the submission of quality encounter data. HSAG made conclusions based on CMS EQR Protocol 5, MCO contract, MDHHS' data submission requirements (e.g., companion guides), and HSAG's experience working with other states regarding the IS review.

Administrative Profile

To draw conclusions about the quality of each waiver agency's encounter data submissions to MDHHS, HSAG evaluated the results based the predefined study and/or key metrics described above. To identify strengths and weaknesses, HSAG assessed the results based on its experience in working with other states in assessing the completeness, accuracy, and timeliness of the waiver agencies' encounter data submissions to MDHHS. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to MDHHS.

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

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. Members must have met the following criteria for the sampling frame: (1) enrolled in the MI Choice Waiver Program for at least three months between December 2021 and February 2022; (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 9,564 members 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 evaluated the results of the CAHPS HCBS survey domains as compared with the prior year's performance. HSAG determined each waiver agency's substantial strengths and weaknesses as follows:

- Strength—Any domain that achieved a 100 percent rate or scored above the statewide rate.
- Weakness—Any standard that scored 5 percentage points or more below the statewide rate. Additionally, all waiver agencies received a weakness for the *Planning Your Time and Activities* domain as it received a low rate across all waiver agencies.
- 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 identified the specific questions within the domain that scored lower than the statewide rate, and made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to each waiver agency's members. The complete waiver agency CAHPS HCBS reports can be found at https://www.michigan.gov/mdhhs/assistance-programs/healthcare/seniors/michoicewaiver/mi-choice-waiver-program.