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State Fiscal Year 2022 External Quality Review Technical Report

for Medicaid Health Plans

March 2023

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.

The Behavioral and Physical Health and Aging Services Administration (BPHASA)[1-1] within MDHHS administers and oversees the Michigan Medicaid managed care program; specifically, the Comprehensive Health Care Program (CHCP), which contracts with nine MCEs, referred to as Medicaid health plans (MHPs), to provide physical health and mild-to-moderate behavioral health services to Medicaid members in Michigan. The MHPs contracted with MDHHS during state fiscal year (SFY) 2022 are displayed in Table 1-1.

Table 1-1—MHPs in Michigan

MHP Name	MHP Short Name
Aetna Better Health of Michigan	AET
Blue Cross Complete of Michigan	BCC
HAP Empowered	HAP
McLaren Health Plan	MCL
Meridian Health Plan of Michigan	MER
Molina Healthcare of Michigan	MOL
Priority Health Choice	PRI
UnitedHealthcare Community Plan	UNI
Upper Peninsula Health Plan	UPP

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

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment that were performed by HSAG were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the "CMS EQR Protocols").[1-2] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to the quality, timeliness, and accessibility of care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective high-value care and to achieve higher performing healthcare delivery systems for their Medicaid members. For the SFY 2022 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each MHP. Detailed information about each activity's methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS EQR Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MHP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)[1-3]	This activity assesses whether the performance measures calculated by an MHP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review[1-4]	This activity determines the extent to which an MHP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP [Children's Health Insurance Program] Managed Care Regulations

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 26, 2023.

[1-3] The MHPs contract with a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) (HEDIS® is a registered trademark of the NCQA) vendor annually to undergo a full audit of their HEDIS reporting processes. As such, the results of each MHP's HEDIS audit are used for the EQR in lieu of completion of the mandatory PMV activity described in 42 CFR §438.358(b)(ii).

[1-4] The compliance review activity was performed by MDHHS. MDHHS provided HSAG with the results of the compliance review activity to include in the annual EQR.

Activity	Description	CMS EQR Protocol
Network Adequacy Validation (NAV)	This activity assesses the extent to which an MHP has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy[1]
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-5] Analysis	This activity assesses member experience with an MHP and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys
Quality Rating*	This activity assigns a quality rating (using indicators of clinical quality management; member satisfaction; and/or plan efficiency, affordability, and management) to each MHP serving Medicaid managed care members that enables members and potential members to consider quality when choosing an MHP.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans

* The quality rating results (2022 Michigan Consumer Guide) are included as part of Section 5 to demonstrate MHP comparative information for potential and enrolled Michigan Medicaid managed care members to consider when selecting a Michigan MHP.

Michigan Comprehensive Health Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2022 activities to comprehensively assess the MHPs' performance in providing quality, timely, and accessible healthcare services to Medicaid members. For each MHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MHP's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all MHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Medicaid managed care program specific to the CHCP. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for MDHHS, to drive progress toward achieving the goals of Michigan's Comprehensive Quality Strategy (CQS) and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to its Medicaid managed care members.

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

Table 1-3—Michigan CHCP Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1—Ensure high quality and high levels of access to care	**Conclusions:** The results of the EQR activities demonstrated mixed performance related to high quality and high levels of access to care though the PMV activity. Within the Women—Adult Care domain, the total performance measure rate for *Chlamydia Screening in Women* ranked between the 50th and 74th Medicaid Quality Compass®,[6] percentile and demonstrated a statistically significant improvement from the previous year, indicating more CHCP-enrolled women had at least one test for chlamydia. However, the *Cervical Cancer Screening* and *Breast Cancer Screening* performance measure rates ranked between the 25th and 49th Medicaid Quality Compass percentile and demonstrated a statistically significant decline from the prior year. Overall, the CHCP has substantial opportunities to increase the number of women who receive screening for cervical and breast cancer. Within the Living With Illness domain, all five rates under the *Comprehensive Diabetes Care* performance measure and the *Controlling High Blood Pressure* performance measure rate ranked between the 50th and 74th Medicaid Quality Compass percentile. The *Controlling High Blood Pressure* performance measure rate and four out of five rates for the *Comprehensive Diabetes Care* performance measure also demonstrated a significant improvement from the previous year, indicating more CHCP members had proper diabetes management and blood pressure control. Additionally, while the *Kidney Health Evaluation for Patients With Diabetes—Total* performance measure rate ranked between the 50th and 74th Medicaid Quality Compass percentile, its rate remained stable with no significant improvement or decline. The *Child and Adolescent Well-Care Visits—Total* performance measure rate also ranked between the 50th and 74th Medicaid Quality Compass percentile and demonstrated a significant improvement, while both indicator rates for the *Well-Child Visits in the First 30 Months of Life* performance measure demonstrated a significant decline. While the CHCP increased the number of children and adolescent members 3 to 21 years of age receiving a well-care visit with a primary care provider (PCP) or obstetrics and gynecology (OB/GYN) provider, enhanced focus is needed to improve the number of children 15 months or younger who receive all recommended well-child visits. The results of the NAV activity and compliance review activity suggest that the CHCP may be experiencing barriers to accessing care and services. Through the NAV activity, the secret shopper survey revealed a generally high percentage of providers who could	☒ Quality ☒ Timeliness ☒ Access

[6] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	not be reached (response rate of 67.2 percent) and a generally low percentage of providers who offered the requested specialty (68.8 percent) or offered the caller an appointment (79.2 percent). Additionally, through the provider directory validation (PDV), the provider telephone number was only accurate 87.8 percent of the time. Further, all MHPs were placed on a compliance review correction action plan (CAP) due to provider data discrepancies in the provider directories. These results suggest that barriers to care may include inaccurate information on provider networks, and challenges in reaching providers and scheduling timely appointments. Members may also have negative perceptions of the CHCP, due to programwide low ratings in several CAHPS measures for the adult and child Medicaid populations such as *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Coordination of Care*. Negative perceptions about the MHPs and their contracted providers may prevent members from accessing needed healthcare services. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #1. These objectives should follow the SMART methodology (i.e., be specific, measurable, attainable, relevant, and time-bound) and take into consideration the health status of all populations served by MDHHS' MHPs. Additionally, although MDHHS has mandated a PIP related to the timeliness of prenatal care, MDHHS could consider adding contract language requiring the MHPs to conduct a minimum number (e.g., two clinical and two nonclinical) of PIPs that align with specific areas of focus identified by MDHHS in support of Goal #1. For example, focus areas could include prevention and care of acute and chronic conditions, high-volume services, continuity and coordination of care, and social determinants of health (SDOH), etc.	
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** Through the compliance review activity, MDHHS evaluates the MHPs' policies and procedures related to collaboration with local health departments (LHDs) to coordinate care for members who receive Children's Special Health Care Services (CSHCS). MHP care coordination plans must include how each MHP assesses the need for a care manager and develops a family-centered care plan in conjunction with a member's family and care team. CSHCS members are also assigned to CSHCS-attested PCP practices that provide family-centered care. MDHHS also evaluates the MHPs' community health worker (CHW)	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	programs, which must include interventions delivered by CBOs and address SDOH, and promote health prevention and health education. CHWs must assist members in the community and navigate community resources, outreach, and culture responsiveness. All MHPs achieved full compliance for these requirements. However, through the CAHPS activity, parents/guardians of CSHCS members reported some negative experiences in several measures such as *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of CMDS* [Children's Multidisciplinary Specialty] *Clinic*, *Access to Specialized Services*, *Transportation*, and *Local Health Department Services*. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #2. These objectives should follow the SMART methodology and take into consideration the health status of all populations served by MDHHS' MHPs. In addition to the CAHPS activity, HSAG recommends MDHHS consider adding contract language requiring the MHPs to conduct ongoing member experience surveys that target specific populations (e.g., CSHCS members) to obtain member-specific data to use to drive improvement in the care provided to these target populations, increase member satisfaction, and make progress toward achieving Goal #2.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)	**Conclusions:** Many Medicaid members receiving services from MHPs are also enrolled in a prepaid inpatient health plan (PIHP) for specialty behavioral health and substance use disorder services. Therefore, MDHHS requires the MHPs to collaborate with the PIHPs to improve integration of behavioral health and physical health services and to maintain coordinating agreements with all PIHPs in their service area for the purpose of referrals, care coordination, grievance and appeal resolution, and the overall continuity of care for members served by PIHPs. To incentivize collaboration and integration between the MHPs and PIHPs, MDHHS has developed a performance bonus program with shared metrics to measure the quality of care provided to members jointly served by the MHPs and PIHPs. Additionally, MDHHS monitors MHP care coordination processes through the compliance review activity, primarily through the Members standard. The CHCP received an overall compliance score of 98.7 percent, indicating the MHPs had the necessary processes in place to ensure members receive adequate care management and care coordination. Further, MDHHS, through its contract with the MHPs, requires the MHPs to	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	support initiatives to increase the use of health information exchange and health information technology to improve care management and coordination, including the electronic exchange of member-level information. This includes maintaining an electronic data system that allows providers, LHDs, and CMDS clinics to exchange member-level information. However, many members reported that they did not feel their personal doctor seemed informed about the care they received from other doctors as demonstrated through *Poor* or *Fair* overall ratings for the *Coordination of Care* measure included as part of the CAHPS activity for the adult Medicaid, child Medicaid, and the Healthy Michigan Plan (HMP) populations. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #3. These objectives should follow the SMART methodology and take into consideration the health status of all populations served by MDHHS' MHPs. Additionally, in support of Goal #3, MDHHS should continue its efforts to support integration of the Medicaid managed care programs (e.g., MHPs, PIHPs) and the services provided to promote communication and coordination of care and positively impact the health outcomes for all Medicaid populations.	
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** For SFY 2022, MDHHS required the MHPs to initiate a new PIP topic that focused on disparities in the timeliness of prenatal care. As demonstrated through the PIP validation activity, eight of the nine MHPs received an overall validation status of *Met*, indicating that overall, the MHPs designed methodologically sound PIPs. The interventions implemented through the course of the PIP cycle are, or will be, aimed at eliminating the racial and ethnic disparity identified by each MHP, or improving timeliness of prenatal care for the lowest-performing population for those MHPs without an identified disparity. The interventions implemented by the MHPs should also have a positive effect on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* performance measure, as the rate for this performance measure ranked below the Medicaid 50th percentile and did not demonstrate an improvement from measurement year (MY) 2020 to MY 2021. These results demonstrate improvement is needed to ensure CHCP pregnant members are accessing a prenatal visit in the first trimester or within 42 days of enrollment with an MHP. Additionally, through the compliance review activity, MDHHS requires the MHPs to submit policies and procedures addressing health disparities through population health	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	management. All MHPs received a score of *Met* for this requirement, demonstrating the CHCP had adequate processes for providing population health management services where telephonic and mail-based care management were not sufficient or appropriate, including services provided at adult and family shelters for members who are homeless, at a member's home, and/or at a member's place of employment or school. The CHCP's overall score for the Quality standard was 98.9 percent, indicating that all MHPs had sufficient quality assessment and performance improvement (QAPI) programs in which various initiatives can be implemented and focused on eliminating healthcare disparities identified within the Medicaid population in Michigan. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #4. These objectives should follow the SMART methodology and take into consideration the health status of all populations served by MDHHS' MHPs. Additionally, MDHHS has required PIPs to support the reduction in disparities in the timeliness of prenatal care. As four MHPs have yet to implement interventions, MDHHS should consider reviewing planned interventions, when identified, to confirm that these interventions specifically target the disparate populations and have the likelihood of removing the barriers that prevent members' access to needed services. MDHHS could also consider whether state-required interventions would be appropriate for the MHPs to implement for the PIPs mandated by MDHHS for SFY 2023. MDHHS could consult with HSAG through these processes.	
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** MDHHS has implemented several value-based initiatives, including the following: • Pay for Performance: H M P Cost-Sharing and Value-Based Services—Incentivizes MHPs to improve performance on HMP measures and key dental services metrics. • Performance Bonus: Integration of Behavioral Health and Physical Health Services—Incentivizes collaboration and integration between MHPs and PIHPs through joint care planning and reporting on select behavioral health performance measures. • Alternative Payment Model—Incentivizes MHPs to improve quality of care while better managing costs through reporting on select deliverables.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	However, the aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact these value-based initiatives and payment reforms had on improving quality outcomes. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #5. These objectives should follow the SMART methodology and take into consideration the health status of all populations served by MDHHS' MHPs. While MDHHS stipulates its expectations related to value-based initiatives and payment reforms within its contract with the MHPs, HSAG did not evaluate the results of these activities as part of this EQR since they are not included as part of the annual EQR activities or tied to a performance measure that aligns to an objective under the CQS. Therefore, no additional recommendations can be provided in support of Goal #5.	

2. Overview of the Michigan Medicaid Managed Care Program

Managed Care in Michigan

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

Table 2-1—Medicaid Managed Care Programs in Michigan

Medicaid Managed Care Program	MCEs
CHCP, including: • Children's Health Insurance Program (CHIP)—MIChild • CSHCS Program • HMP (Medicaid Expansion) • Flint Medicaid Expansion Waiver	MHPs
Managed LTSS, including: • MI Health Link Demonstration • MI Choice Waiver Program • Program of All-Inclusive Care for the Elderly (PACE)	Integrated Care Organizations (ICOs) PIHPs Prepaid Ambulatory Health Plans (PAHPs, also referred to as waiver agencies) PACE organizations
Dental Managed Care Programs, including: • Healthy Kids Dental • Pregnant Women Dental • HMP Dental	Dental PAHPs
Behavioral Health Managed Care	PIHPs

Comprehensive Health Care Program

MDHHS contracts with nine MHPs in targeted geographical service areas comprised of 83 counties (divided into 10 regions) and provides medically necessary services to over 2.25 million[2-1] Medicaid and CHIP managed care members in the state. Michigan's waiver requires managed care members to obtain services from specified MHPs based on the county of residence. MDHHS enrolls a diverse set of populations into the CHCP managed care program, including the disabled, foster children, pregnant women, and children dually eligible for Title V and Title XIX under the Social Security Act. Individuals dually eligible for Medicare and Medicaid may enroll in MHPs voluntarily. Additionally, since 2016, MDHHS implemented the HMP, which is Michigan's Medicaid expansion. The HMP benefit package includes a comprehensive dental benefit in addition to primary, preventive, and behavioral healthcare. Michigan's stand-alone CHIP, known as MIChild, is also administered through the CHCP.

Overview of Medicaid Health Plans

During the SFY 2022 review period, MDHHS contracted with nine MHPs. These MHPs were responsible for the provision of medically necessary services to Medicaid members. Table 2-2 provides a profile for each MHP. Table 2-2 also presents the number of Michigan CHCP members enrolled in managed care as of September 2022.

[2-1] Michigan Department of Health and Human Services. *Medicaid and Healthy Michigan Enrollees, September 2022*. Available at: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Monthly-MHP-Enrollment/JE02-(092022).pdf?rev=a20306093dcf45e58ed3fafcac80ea67&hash=A0EF2CC2B59937EF5D878EDF667C7558. Accessed on: Jan 27, 2023.

Table 2-2—MHP Profiles and Enrollment Data

MHP	Covered Services[2-2]	Operating Region(s)[2-3]	Number of Counties Served[2-4]	Members Enrolled[2-5]
AET	All MHPs cover medically necessary services such as the following: • Ambulance • Chiropractic • Doctor visits • Emergency services • Family planning • Health checkups • Hearing and speech • Home health • Hospice care • Hospital care • Immunizations • Laboratory and X-rays • Medical supplies • Medicine • Mental health • Physical and occupational therapy • Podiatry • Prenatal care and delivery • Surgery • Vision	8, 9, 10	16	52,989
BCC		4, 6, 7, 9, 10	32	342,842
HAP		6, 10	10	34,791
MCL		2, 3, 4, 5, 6, 7, 8, 9, 10	68	265,767
MER		2, 3, 4, 5, 6, 7, 8, 9, 10	68	557,407
MOL		2, 3, 4, 5, 6, 7, 8, 9, 10	68	396,707
PRI		4, 8, 10	23	250,531
UNI		2, 3, 4, 5, 6, 8, 9, 10	65	302,309
UPP		1	15	53,457
			Total Member Enrollment	**2,256,800**

2-2 Michigan Department of Health and Human Services. *A Guide to Michigan Medicaid Health Plans, Quality Checkup, January 2022*. Available at: https://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf. Accessed on: Jan 27, 2023.

2-3 Michigan Department of Health and Human Services. *Medicaid Health Plans by Region*, updated 10/01/21. Available at: https://www.michigan.gov/documents/mdhhs/MHP_Counties_Map_502832_7.pdf. Accessed on: Jan 27, 2023.

2-4 Michigan Department of Health and Human Services. *Michigan Medicaid Health Plan Listing by County*, updated 11/1/2021. Available at: https://www.michigan.gov/documents/mdch/MHP_Service_Area_Listing_326102_7.pdf. Accessed on: Jan 27, 2023.

2-5 Michigan Department of Health and Human Services. *Medicaid and Healthy Michigan Enrollees*, September 2022. Available at: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Monthly-MHP-Enrollment/JE02-(092022).pdf?rev=a20306093dcf45e58ed3fafcac80ea67&hash=A0EF2CC2B59937EF5D878EDF667C7558. Accessed on: Jan 27, 2023.

Quality Strategy

The 2020–2023 MDHHS CQS [2-6] provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including 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. The MDHHS CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3, and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and specifically were designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

Table 2-3—Michigan CQS Goals and Objectives

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

[2-6] Michigan Department of Health and Human Services. *Comprehensive Quality Strategy, 2020–2023*. Available at: https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf. Accessed on: Jan 27, 2023.

MDHHS CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #2: Strengthen person and family-centered approaches		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 2.1**: Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.
		Objective 2.2: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.
		Objective 2.3: Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches.
		Objective 2.4: Encourage community engagement and systematic referrals among healthcare providers and to other needed services.
		Objective 2.5: Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a networkwide, effective approach to healthcare within the community.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
		Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.3: Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
NQS Aim #1: Better Care	Improve maternal-infant health and reduce outcome disparities	**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.

MDHHS CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
MDHHS Pillar #1: Give all kids a healthy start 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 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 (CBOs) and public health entities across the state to address racial inequities.
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform		
NQS Aim #3: Affordable Care MDHHS Pillar #4: Use data to drive outcomes	Drive value in Medicaid Ensure we are managing to outcomes and investing in evidence-based solutions	**Objective 5.1:** Promote the use of value-based payment models to improve quality of care.
		Objective 5.2: Align value-based goals and objectives across programs.

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

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

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

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

Quality Initiatives and Interventions

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

- **Accreditation**—MCEs, including all MHPs and some ICOs and PIHPs, are accredited by a national accrediting body such as NCQA, Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehabilitation Facilities (CARF), and/or the Joint Commission.
- **Opioid Strategy**—MDHHS actively participates in and supports Michigan's opioid efforts to combat the opioid epidemic by preventing opioid misuse, ensuring individuals using opioids can access high quality recovery treatment, and reducing the harm caused by opioids to individuals and their communities.
- **Health Home Models**—Michigan established three Health Home models in accordance with Section 2703 of the Affordable Care Act including the Opioid Health Home, MI Care Team, and the Behavioral Health Home. These Health Homes focus on high-need/high-cost members with chronic conditions, provide flexibility to create innovative and integrated care management models, and offer sustainable reimbursement to affect the SDOH. Federally mandated core services include comprehensive care management and care coordination, health promotion, comprehensive transitional care and follow-up, individual and family support, and referral to community and social services. Participation in the Health Home models is voluntary, and enrolled members may opt out at any time.
- **Behavioral Health Integration**—All Medicaid managed care programs address the integration of behavioral health services by requiring MHPs and ICOs to coordinate behavioral health services and services for persons with disabilities with the Community Mental Health Services Programs (CMHSPs)/PIHPs. While contracted MHPs and ICOs may not be responsible for the direct delivery of specified behavioral health and developmental disability services, they must establish and maintain agreements with MDHHS-contracted local behavioral health and developmental disability agencies or organizations. Plans are also required to work with MDHHS to develop initiatives to better integrate services and to provide incentives to support behavioral health integration.
- **Value-based Payment**—MDHHS employs a population health management framework and intentionally contracts with high-performing plans to build a Medicaid managed care delivery system that maximizes the health status of members, improves member experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology/health information exchange, and a robust quality strategy. Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on

the SDOH, creating health equity and supporting efforts to build more resilient communities. MDHHS supports payment reform initiatives that pay providers for value rather than volume, with "value" defined as health outcome per dollar of cost expended over the full cycle of care. In this regard, performance metrics are linked to outcomes. The Medicaid managed care programs are at varying degrees of payment reform; however, all programs utilize a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize QI and improved outcomes.

- **Health Equity Reporting and Tracking**—MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the healthcare services provided to Medicaid members. Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs, as indicated by the CQS goal to reduce racial and ethnic disparities in healthcare and health outcomes.

3. Assessment of Medicaid Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2022 review period to evaluate the performance of the MHPs on providing quality, timely, and accessible healthcare services to CHCP members. Quality, as it pertains to EQR, means the degree to which the MHPs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to MDHHS' network adequacy standards) and §438.206 (adherence to MDHHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2022 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For the SFY 2022 PIP validation activity, the MHPs initiated new[3-1] PIP topics that focused on disparities in timeliness of prenatal care, reporting baseline data for each specified performance indicator. MHPs with an existing disparity have a minimum of two performance indicators (a disparate sub-group performance indicator and a comparison sub-group performance indicator), and MHPs without an existing disparity have one performance indicator. HSAG conducted validation on the PIP Design (steps 1 through 6) and Implementation (Step 7 and Step 8, as applicable) stages of the selected PIP topic for each MHP in accordance with CMS' EQR protocol for the validation of PIPs (CMS EQR Protocol 1).

Table 3-1 outlines the selected PIP topics and performance indicator(s) as defined by each MHP.

Table 3-1—PIP Topic and Performance Indicator(s)

MHP	PIP Topic	Performance Indicator(s)
AET	*Addressing Disparities in Timeliness of Prenatal Care*	1. Timeliness of prenatal care in rural designated ZIP Codes. 2. Timeliness of prenatal care in urban designated ZIP Codes.
BCC	*Reducing Racial Disparities Within Timeliness of Prenatal Care*	1. Black women residing in Region 10 (disparate group). 2. White women residing in Region 10 (comparison group).
HAP	*Improving the Timeliness of Prenatal Care*	Measuring the percentage of Black/African-American pregnant women who have a prenatal visit within 42 days of enrollment or within the first trimester.
MCL	*Addressing Disparities in Timeliness of Prenatal Care*	1. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for Black members. 2. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for White members.
MER	*Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities*	1. Improve the PPC [Prenatal and Postpartum Care]-Timeliness of Prenatal Care rate for the Black (non-Hispanic) population residing in Region 6 in order to reduce the disparity to the comparison subgroup. 2. Maintain the performance of the HEDIS PPC-Timeliness of Prenatal Care performance result for eligible White (non-Hispanic) members residing in Region 6.

[3-1] While the previous PIP cycle (ending in SFY 2021) also focused on disparities in the timeliness of prenatal care, MDHHS elected to have the MHPs start a new PIP cycle with the same PIP topic (beginning SFY 2022) due to several factors such as the updated CMS EQR Protocols, MHP mergers, and the impact of the coronavirus disease 2019 (COVID 19) public health emergency (PHE). Additionally, several MHPs did not show a statistically significant improvement in the previous PIP cycle; therefore, the MHPs were provided the opportunity to continue with the same topic to demonstrate that improvement.

MHP	PIP Topic	Performance Indicator(s)
MOL	*Addressing Disparities for Timeliness of Prenatal Care*	1. Timeliness of Prenatal Care—Black. 2. Timeliness of Prenatal Care—White.
PRI	*Improving Timeliness of Prenatal Care for African-American Women*	1. The percentage of African-American women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health. 2. The percentage of Caucasian women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health.
UNI	*Addressing Disparities in Timeliness of Prenatal Care*	Timeliness of prenatal care for African-American/Black members in Region 10.
UPP	*Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members Ages 20–44*	1. Annual Ambulatory or Preventative Visit for UPP Black members. 2. Annual Ambulatory or Preventative Visit for UPP White members.

Performance Measure Validation

Each MHP underwent an NCQA HEDIS Compliance Audit™,[3-2] conducted by an NCQA licensed organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's MY 2021 Volume 5, *HEDIS Compliance Audit: Standards, Policies and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the MHPs' processes consistent with the CMS EQR Protocols. To complete the validation of the performance measure process according to CMS' EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019 (CMS EQR Protocol 2), HSAG performed an independent evaluation of the HEDIS MY 2021 Compliance Audit Report, which contained findings related to the following seven Information Systems (IS) standards:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

[3-2] HEDIS Compliance Audit™ is a trademark of NCQA.

Additionally, MDHHS expects its contracted MHPs to support claims systems, membership and provider files, as well as hardware/software management tools that facilitate valid reporting of the HEDIS measures. MDHHS contracted with HSAG to calculate statewide average rates based on the MHPs' rates and evaluate each MHP's current performance level, as well as the statewide performance, relative to national Medicaid percentiles.

MDHHS provided HSAG with a selected list of HEDIS measures to evaluate the Michigan MHPs for the annual assessment. These measures were within the following three domains, and are listed in Table 3-2:

- Child & Adolescent Care
- Women—Adult Care
- Living With Illness

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending; evaluate the degree to which the MHP addressed the prior year's recommendations; and determine overall MHP-specific conclusions related to quality, timeliness, and accessibility of healthcare services.

Table 3-2—Performance Measures for Validation

Performance Measure	HEDIS Data Collection Methodology
Child & Adolescent Care	
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*	Administrative
Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, *Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total*	Administrative
Women—Adult Care	
Chlamydia Screening in Women—Ages 16 to 20 Years, *Ages 21 to 24 Years*, and *Total*	Administrative
Cervical Cancer Screening	Hybrid
Breast Cancer Screening	Administrative
Living With Illness	
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Poor Control (>9.0%)**, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	Hybrid
Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years, *Ages 65 to 74 Years*, *Ages 75 to 85 Years*, and *Total*	Administrative
Controlling High Blood Pressure	Hybrid

* For this indicator, a lower rate indicates better performance.

Compliance Review

MDHHS evaluated the MHPs' compliance with federal Medicaid managed care regulations using an annual compliance review process. HSAG examined, compiled, and analyzed the results as presented in the MHP compliance review documentation provided by MDHHS. The SFY 2022 MDHHS compliance review included an evaluation of each MHP's performance in six program areas, called standards, identified in Table 3-3. These standards are reviewed annually by MDHHS in accordance with an established timeline that spans the state fiscal year.

Table 3-3—Compliance Review Standards[1]

MDHHS Compliance Review Standard		Federal Standard and Citation
1	Administrative	§438.224 Confidentiality
2	Providers	§438.10 Information requirements §438.206 Availability of services §438.207 Assurances of adequate capacity and services §438.210 Coverage and authorization of services §438.214 Provider selection §438.230 Subcontractual relationships and delegation
3	Members	§438.10 Information requirements §438.100 Enrollee Rights §438.114 Emergency and poststabilization services §438.206 Availability of services §438.208 Coordination and continuity of care §438.210 Coverage and authorization of services §438.228 Grievance and appeal systems §438.230 Subcontractual relationships and delegation Subpart F Grievance and Appeal System
4	Quality	§438.208 Coordination and continuity of care §438.210 Coverage and authorization of services §438.236 Practice guidelines §438.330 Quality assessment and performance improvement program
5	MIS [Management Information System]/Financial	§438.56 Disenrollment: Requirements and limitations §438.242 Health information systems
6	OIG [Office of Inspector General]/Program Integrity	§438.230 Subcontractual relationships and delegation Subpart H Additional Program Integrity Safeguards

[1] HSAG and MDHHS created a crosswalk to compare MDHHS compliance review standards to federal standards, but 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).

Network Adequacy Validation

HSAG completed a network validation survey (NVS) among PCPs, pediatric providers, and OB/GYN providers contracted with one or more MHP to ensure members have appropriate access to provider information. The NVS included a PDV in which HSAG compared key indicators published in each online provider directory with the data in the MHP's provider file to confirm whether each MHP's website met the federal requirements in 42 CFR§438.10(h) and the Medicaid Care Management (MCM) Services Contract, Amendment #6 requirements in §4.4.1.5. HSAG then validated the accuracy of the online provider directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories. The secret shopper survey also provided information on appointment availability and wait times with the sampled providers for routine visits. HSAG used an MDHHS-approved methodology and script to conduct the secret shopper telephone surveys of provider offices. The secret shopper approach allows for objective data collection from healthcare providers without potential bias introduced by revealing the surveyors' identities. Specific survey objectives included the following:

- Determine whether service locations accept patients enrolled with the requested MHP for the Medicaid program and the degree to which MHP and Medicaid acceptance aligns with the MHPs' provider data.
- Determine whether service locations accepting Medicaid for the requested MHP accept new patients and the degree to which new patient acceptance aligns with the MHPs' provider data.
- Determine appointment availability with the sampled provider service locations for PCP, pediatric, or OB/GYN visits.

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

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask adult members and parents/caretakers of child members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The MHPs were responsible for obtaining CAHPS vendors to administer the CAHPS surveys on the MHPs' behalf. HSAG presents top-box scores, which indicate the percentage of members or parents/caretakers who responded to the survey with positive experiences in a particular aspect of their healthcare. Table 3-4 outlines an overview of the populations and survey types used for each of the applicable programs.

Table 3-4—CAHPS Surveys

Program	Population	Survey Type
Adult and Child Medicaid	Adult Medicaid and parents/caretakers of child Medicaid members enrolled in the MHPs	Adult and Child Medicaid Health Plan Surveys
CSHCS	Parents/caretakers of child members enrolled in the CSHCS Program	Modified version of the CAHPS Child Medicaid Health Plan Survey with the children with chronic conditions (CCC) measurement set
HMP	Adult members enrolled in the HMP health plans	Adult Medicaid Health Plan Survey

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Quality Rating to review the 2022 Michigan Consumer Guide.

External Quality Review Activity Results

Aetna Better Health of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Aetna Better Health of Michigan**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met)*. Table 3-5 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-5—Overall Validation Rating for AET

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities in Timeliness of Prenatal Care	*Partially Met*	1. Timeliness of prenatal care in rural designated ZIP Codes.	47.5%			Yes
		2. Timeliness of prenatal care in urban designated ZIP Codes.	63.9%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals of **Aetna Better Health of Michigan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (rural population) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (urban population), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-6 displays the interventions, as available, initiated by the MHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-6—Baseline Interventions for AET

Intervention Descriptions	
Execution of contract with Health Intelligence Platform to offer pregnant members solutions to improve their quality of care and engagement in the healthcare system. The Health Intelligence platform will allow pregnant women access to the Baby Smart coaching program that supports appointment and transportation scheduling, pregnancy and parenting education, pregnancy monitoring and postpartum health goals, quick	Racial and culturally concordant mailings and text message campaigns were deployed to pregnant mothers that include QR [quick response] codes on the mailings and links in the text messages to take members to "Every Mother Counts: Choices in Childbirth" resources and videos on the importance of advocating for themselves during appointments, asking questions at every visit, and

Intervention Descriptions	
connections to any needed critical resources for social risks/social determinants of health as well as virtual doula pairing for high-risk pregnant women.	that mothers have the right to make informed choices in their pregnancy, birth, and as a parent with physicians.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Aetna Better Health of Michigan's technical design of the PIP was sufficient to measure and monitor PIP outcomes. The MHP collected and reported accurate performance indicator results using a systematic data collection process. [**Quality**]

Strength #2: Aetna Better Health of Michigan used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to their corresponding barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan did not achieve a *Met* score for all requirements in the Design stage of the project, indicating gaps in the MHP's documentation, specifically within the analysis and reporting of plan-specific data used to select the PIP topic, which resulted in the overall validation rating of *Partially Met*. [**Quality**]

Why the weakness exists: While **Aetna Better Health of Michigan** identified through data analysis a disparity between its rural and urban populations for the PIP topic, the MHP did not report its statistical testing between the two subgroups to support selection of the PIP topic.

Recommendation: HSAG recommends **Aetna Better Health of Michigan** conduct statistical testing between the two PIP populations to establish an existing disparity between the two subgroups.

Performance Measure Validation

Performance Results

Aetna Better Health of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **Aetna Better Health of Michigan** was fully compliant with all seven IS standards.

According to the auditor's review, **Aetna Better Health of Michigan** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-7 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-3] for **Aetna Better Health of Michigan**.

Table 3-7—HEDIS MY 2021 Performance Measure Results for AET

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	41.30%	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	41.89%	★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	52.37%	★★★
Ages 12 to 17 Years	44.76%	★★
Ages 18 to 21 Years	24.29%	★★
Total	44.00%	★★
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	65.21%	★★★★
Ages 21 to 24 Years	65.67%	★★★★
Total	65.46%	★★★★
Cervical Cancer Screening		
Cervical Cancer Screening	46.47%	★

[3-3] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Breast Cancer Screening		
Breast Cancer Screening	46.79%	★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	81.02%	★★
*HbA1c Poor Control (>9.0%)**	41.36%	★★★
HbA1c Control (<8.0%)	50.12%	★★★
Eye Exam (Retinal) Performed	51.58%	★★★
Blood Pressure Control (<140/90 mm Hg)	51.34%	★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	20.01%	★
Ages 65 to 74 Years	23.71%	★
Ages 75 to 85 Years	23.35%	★
Total	20.82%	★
Controlling High Blood Pressure		
Controlling High Blood Pressure	60.10%	★★★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2021 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Aetna Better Health of Michigan's performance ranked between the 75th and 89th percentile for all *Chlamydia Screening in Women* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement

year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-4] [**Quality**]

Strength #2: Aetna Better Health of Michigan demonstrated overall strength in its HEDIS data reporting, as **Aetna Better Health of Michigan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan's performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators ranked below the 25th percentile, indicating children who turned 15 months old during the measurement year were not always getting at least six well-child visits with a PCP during their first 15 months of life. Additionally, children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-5] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for both *Well-Child Visits in the First 30 Months of Life* measure indicators ranked below the 25th percentile, suggesting barriers exist for children to receive timely well-child visits.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life* measure.

Weakness #2: Aetna Better Health of Michigan's performance for the *Cervical Cancer Screening* measure ranked below the 25th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer was one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-6] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Cervical Cancer Screening* measure ranked below the 25th percentile, suggesting barriers exist for women to be screened for cervical cancer.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure.

3-4 National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Jan 30, 2023.

3-5 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

3-6 National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2023.

Weakness #3: Aetna Better Health of Michigan's performance for the *Breast Cancer Screening* measure ranked below the 25th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3-7] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Breast Cancer Screening* measure ranked below the 25th percentile, suggesting barriers exist for women to be screened for breast cancer.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure.

Weakness #4: Aetna Better Health of Michigan's performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked below the 25th percentile, indicating some members with diabetes did not have controlled blood pressure. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-8] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked below the 25th percentile, suggesting that barriers exist for members with diabetes to have controlled blood pressure.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled blood pressure. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator.

Weakness #5: Aetna Better Health of Michigan's performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked below the 25th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-9] [**Quality** and **Access**]

Why the weakness exists: The rates for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked below the 25th percentile, suggesting that barriers exist for members with diabetes to receive kidney health evaluations.

3-7 National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.

3-8 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

3-9 Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Jan 30, 2023.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.

Weakness #6: Aetna Better Health of Michigan's performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th percentile and 49th percentile, indicating some children were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-10] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some children to receive timely well-child visits.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure.

Weakness #7: Aetna Better Health of Michigan's performance for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes were not having an HbA1c test performed during the measurement year. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-11] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator ranked between the 25th percentile and 49th percentile, suggesting that barriers exist for some members with diabetes to have HbA1c testing.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have HbA1c testing. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator.

[3-10] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

[3-11] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

Compliance Review

Performance Results

Table 3-8 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-8 also presents **Aetna Better Health of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Aetna Better Health of Michigan** was subject to a corrective action review process outlined in Appendix A.

Table 3-8—Compliance Review Results for AET

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	AET	Statewide[1]
1	Administrative	5	0	100%	95.6%
2	Providers	20	1	95%	88.9%
3	Members	26	0	100%	98.7%
4	Quality	21	0	100%	98.9%
5	MIS/Financial	34	2	94%	95.7%
6	OIG/Program Integrity	33	0	100%	96.3%
Overall		**139**	**3**	**98%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Aetna Better Health of Michigan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Aetna Better Health of Michigan achieved full compliance in the Member standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; collaboration with LHDs for members with special health care needs; care coordination; a fair grievance and appeal system; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Aetna Better Health of Michigan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, clinical practice guidelines (CPGs), quality improvement plan (QIP) description, work plan, and evaluation; utilization management (UM) program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Strength #4: Aetna Better Health of Michigan achieved full compliance in the Program Integrity standard, demonstrating a sufficient compliance program, which included, but was not limited to, adequate policies and procedures; adequate staffing and employee training; communication between internal and external partners; and internal monitoring, auditing, and investigation practices. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan scored below the statewide average in the MIS standard. The MHP received a *Not Met* score for elements *5.6 Pharmacy/MCO Common Formulary* and *5.11 Claims Processing (Non-Pharmacy)*. [**Quality**]

Why the weakness exists: Aetna Better Health of Michigan identified coding discrepancies that led to noncompliant claims for products covered on the common formulary. Additionally, the MHP's classification process for pending claims, which could not be paid due to an incorrect provider address, also created inflated numbers of ending inventory to exceed 45 days. Three monthly claims reports also included inaccurate data due to transcription errors between **Aetna Better Health of Michigan**'s internal source file and the completed report template submitted to MDHHS.

Recommendation: As **Aetna Better Health of Michigan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **Aetna Better Health of Michigan** ensure its CAP is fully implemented to mitigate the deficiencies.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 321 cases by comparing provider data that **Aetna Better Health of Michigan** submitted to HSAG against **Aetna Better Health of Michigan**'s online provider directory. The sample included 107 PCPs, 107 pediatric providers, and 107 OB/GYN providers (Table 3-9). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 92.5 percent (n=297) of the reviews. The sampled providers were not found in the online provider directory in 7.5 percent of the reviewed cases.

Table 3-9—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	107	103	96.3%	4	3.7%
Pediatric Providers	107	96	89.7%	11	10.3%
OB/GYN Providers	107	98	91.6%	9	8.4%
AET Total	**321**	**297**	**92.5%**	**24**	**7.5%**

Table 3-10 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Aetna Better Health of Michigan**'s provider data submission to HSAG and **Aetna Better Health of Michigan**'s online provider directory.

Table 3-10—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	103	100%	96	100%	98	100%	297	100%
Provider Address	102	99.0%	94	97.9%	97	99.0%	293	98.7%
Provider City	100	97.1%	92	95.8%	97	99.0%	289	97.3%
Provider State	102	99.0%	94	97.9%	97	99.0%	293	98.7%
Provider Zip Code	102	99.0%	93	96.9%	97	99.0%	292	98.3%
Provider Telephone Number	102	99.0%	93	96.9%	97	99.0%	292	98.3%
Provider Type/Specialty	101	98.1%	94	97.9%	96	98.0%	291	98.0%

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider Gender	102	99.0%	94	97.9%	97	99.0%	293	98.7%
Provider Accepting New Patients	102	99.0%	94	97.9%	87	88.8%	283	95.3%
Non-English Language Speaking Provider (including American Sign Language)	98	95.1%	88	91.7%	79	80.6%	265	89.2%
Provider Primary Language	102	99.0%	94	97.9%	97	99.0%	293	98.7%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 278 sampled provider locations (i.e., "cases") for **Aetna Better Health of Michigan**, with an overall response rate of 77.0 percent (n=214). Table 3-11 summarizes the secret shopper survey results for **Aetna Better Health of Michigan**.

Table 3-11—Summary of AET Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	99	70	70.7%	62	88.6%	41	66.1%	35	85.4%	34	97.1%
Pediatric Providers	92	78	84.8%	62	79.5%	44	71.0%	44	100%	44	100%
OB/GYN Providers	87	66	75.9%	41	62.1%	28	68.3%	24	85.7%	24	100%
AET Total	**278**	**214**	**77.0%**	**165**	**77.1%**	**113**	**68.5%**	**103**	**91.2%**	**102**	**99.0%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-12 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Aetna Better Health of Michigan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-12—Appointment Availability Results

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)[1]	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	107	31	91.2%	27	25.2%	87.1%	1	28	9	7
Pediatric Providers	107	42	95.5%	39	36.4%	92.9%	0	127	17	7
OB/GYN Providers	107	23	95.8%	21	19.6%	91.3%	0	89	21	11
AET Total	**321**	**96**	**94.1%**	**87**	**27.1%**	**90.6%**	**0**	**127**	**16**	**8**

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Reviewers located over 92 percent of the sampled providers in **Aetna Better Health of Michigan**'s online provider directory. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 77 percent of the responsive cases reported that the location offered services for the requested specialty. [**Access**]

Why the weakness exists: **Aetna Better Health of Michigan**'s provider data matched the online provider directory; however, the directory information was not confirmed by the provider's office staff members. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory as it relates to the location's specialty.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect specialty information) to address the provider data deficiencies.

Weakness #2: Of the survey respondents that offered the correct specialty, only 68.5 percent were affiliated with the sampled provider listed in **Aetna Better Health of Michigan**'s online provider directory. [**Access**]

Why the weakness exists: **Aetna Better Health of Michigan**'s provider data matched the online provider directory; however, the directory information was not confirmed by the location's office staff members. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory as it relates to the provider's location (i.e., address).

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect location information) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-13 presents **Aetna Better Health of Michigan**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-13—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for AET

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	65.3%	64.8%
Rating of All Health Care	51.6%	63.4%$^{+}$
Rating of Personal Doctor	67.7%	72.4%$^{+}$
Rating of Specialist Seen Most Often	66.3%$^{+}$	80.0%$^{+}$
Composite Measures		
Getting Needed Care	83.4%	88.3%$^{+}$
Getting Care Quickly	84.4%$^{+}$	88.7%$^{+}$
How Well Doctors Communicate	92.7%	91.8%$^{+}$
Customer Service	89.9%*	85.2%$^{+}$
Individual Item Measure		
Coordination of Care	79.7%+	88.5%$^{+}$
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	72.4%	

	2022 Adult Medicaid	2022 Child Medicaid
Discussing Cessation Medications	57.9%	
Discussing Cessation Strategies	50.3%	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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: Aetna Better Health of Michigan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA adult or child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult and child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-14 presents **Aetna Better Health of Michigan**'s 2022 CSHCS CAHPS survey top-box scores. The following measures could not be displayed in the table because these measures had fewer than 11 responses and were suppressed: *Rating of Specialist Seen Most Often*, *Rating of CMDS Clinic*, *Customer Service*, *Access to Specialized Services*, *Transportation*, *CSHCS Family Center*, *Access to Prescription Medicines*, *CMDS Clinic*, and *Local Health Department Services*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-14—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for AET

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	58.3%+
Rating of Health Care	
Rating of Health Care	69.2%+ NA
Composite Measure	
How Well Doctors Communicate	95.5%+ NA
Individual Item Measures	
Not Felt Treated Unfairly: Race and Ethnicity	81.8%+ NA
Not Felt Treated Unfairly: Health Insurance Type	81.8%+ NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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

Strengths

Strength #1: Aetna Better Health of Michigan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-15 presents **Aetna Better Health of Michigan**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-15—Summary of 2022 HMP CAHPS Top-Box Scores for AET

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	56.4%
Rating of All Health Care	50.9%+
Rating of Personal Doctor	61.9%+
Rating of Specialist Seen Most Often	59.0%*
Composite Measures	
Getting Needed Care	83.1%+
Getting Care Quickly	84.2%+
How Well Doctors Communicate	92.2%+
Customer Service	80.6%+
Individual Item Measure	
Coordination of Care	79.2%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	81.5%+
Discussing Cessation Medications	58.0%+
Discussing Cessation Strategies	43.8%+

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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

Strengths

Strength #1: Aetna Better Health of Michigan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **Aetna Better Health of Michigan**'s performance.

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

HSAG performed a comprehensive assessment of **Aetna Better Health of Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Aetna Better Health of Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Aetna Better Health of Michigan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-16 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to **Aetna Better Health of Michigan**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-16—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **Aetna Better Health of Michigan** identified through its data analysis a disparity between its rural and urban populations in the timeliness of prenatal care. While **Aetna Better Health of Michigan** did not report its statistical testing between the two subgroups to support selection of the PIP topic, the technical design of the PIP was sufficient to measure and monitor PIP outcomes, and the MHP timely implemented interventions that were reasonably linked to their corresponding barriers. Interventions implemented through this PIP have the potential of reducing/eliminating the disparity between the two subgroups. The interventions implemented through the PIP activity should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* performance measure as **Aetna Better Health of Michigan**'s rate ranked below the 25th Medicaid Quality Compass percentile and was the lowest rate among the MHPs. Additionally, as demonstrated through the compliance review activity, **Aetna Better Health of Michigan** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare conditions and reduce disparities in care. **Aetna Better Health of Michigan** also achieved full compliance in the Quality standard, indicating that it had a sufficient QAPI program in which various initiatives can be implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—Opportunities for improvement were identified in increasing access to preventive services for **Aetna Better Health of Michigan**'s child and adolescent members. Both indicator rates under the *Well-Child Visits in the First 30 Months of Life* performance measure ranked below the 25th Medicaid Quality Compass percentile, while the total rate, and the rate for two of the three age subgroups, for the *Child and Adolescent Well-Care Visits* performance measure ranked between the 25th and 49th percentile. Additionally, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure rate demonstrated a statistically significant decline in performance from the previous year. **Aetna Better Health of Michigan** was also among the lowest-performing MHPs for these measures. Further, the secret shopper survey identified multiple providers, including pediatric providers, who either reported the location did not offer services for the requested specialty, or offered the correct specialty but the provider was not affiliated with the location listed in the online provider directory, demonstrating inaccurate information in the MHP's provider data files and/or the online provider directory. **Aetna Better Health of Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider

Performance Area	Overall Performance Impact
	directory. These results suggest that members may not always have access to accurate information to locate a pediatric provider for preventive care. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors which may also be a barrier to accessing care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—**Aetna Better Health of Michigan** demonstrated mixed results as it related to the care and services provided to members with chronic conditions. **Aetna Better Health of Michigan** received a *Met* score for element *3.10 CSHCS PCP Requirements* through the compliance review activity, demonstrating that the MHP had the necessary processes in place to ensure CSHCS members are assigned to a CSHCS-attested PCP who is willing to accept new CSHCS members with potentially complex chronic health conditions, regularly serve children or youth with complex chronic conditions, and has mechanisms to identify children or youth with chronic health conditions. As demonstrated through the PMV activity, the *Controlling High Blood Pressure* performance measure rate and three of the five rates for the *Comprehensive Diabetes Care* performance measure ranked between the 50th and 74th Medicaid Quality Compass percentile. However, the rate for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and all four rates for the *Kidney Health Evaluation for Patients With Diabetes* measure ranked below the 25th Medicaid Quality Compass percentile, and the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure rate ranked between the 25th and 49th percentile. **Aetna Better Health of Michigan** was also among the lowest-performing MHPs for many of these measures, suggesting that some members diagnosed with diabetes are not receiving adequate diabetes management or kidney health evaluations. Additionally, the secret shopper survey identified multiple providers who reported the location either did not offer services for the requested specialty, or offered the correct specialty but the provider was not affiliated with the location listed in the online provider directory, demonstrating inaccurate information in the MHP's provider data files and/or the online provider directory. **Aetna Better Health of Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for proper management of chronic conditions. The results of the CAHPS activity also indicate some members have negative perceptions of their personal doctors which may also be a barrier to accessing care.
Health and Wellness of Women	**Quality**—**Aetna Better Health of Michigan** demonstrated strong performance in chlamydia screening for women. Through the PMV activity, all three rates for the *Chlamydia Screening for Women* measure ranked between the 75th and 89th Medicaid Quality Compass percentile, with two of those rates demonstrating a statistically significant improvement from the previous year, indicating many sexually active women were being appropriately tested for chlamydia. **Aetna Better Health of Michigan** was also the highest-performing MHP for this performance measure. Additionally, **Aetna Better Health of Michigan** received a *Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of

Performance Area	Overall Performance Impact
	the compliance review activity, demonstrating the MHP had the necessary processes in place to notify MDHHS and ensure pregnant women were eligible for dental services. However, the rates for the *Cervical Cancer Screening* and *Breast Cancer Screening* measures ranked below the 25th Medicaid Quality Compass percentile and demonstrated a statistically significant decline from the previous year. **Aetna Better Health of Michigan** was also among the lowest-performing MHPs for both measures, suggesting that women were not always receiving the recommended cervical cytology and/or high-risk human papillomavirus (HPV) testing, or mammograms. Further, the secret shopper survey identified multiple providers, including OB/GYN providers, who reported either the location did not offer services for the requested specialty, or offered the correct specialty but the provider was not affiliated with the location listed in the online provider directory, demonstrating inaccurate information in the MHP's provider data files and/or the online provider directory. **Aetna Better Health of Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for appropriate women's health screenings.

Blue Cross Complete of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Blue Cross Complete of Michigan**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-17 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-17—Overall Validation Rating for BCC

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Reducing Racial Disparities Within Timeliness of Prenatal Care	*Met*	1. Black women residing in Region 10 (disparate group)	66.98%			Yes
		2. White women residing in Region 10 (comparison group)	76.61%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Blue Cross Complete of Michigan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-18 displays the interventions, as available, initiated by the MHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-18—Baseline Interventions for BCC

Intervention Descriptions
Blue Cross Complete of Michigan had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

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

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

Strengths

Strength #1: Blue Cross Complete of Michigan designed a methodologically sound PIP. The MHP collected and reported accurate performance indicator results using a systematic data collection process and conducted appropriate statistical testing for comparison between the two subgroups to determine a disparity. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **Blue Cross Complete of Michigan** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

Performance Measure Validation

Performance Results

Blue Cross Complete of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **Blue Cross Complete of Michigan** was fully compliant with all seven IS standards.

According to the auditor's review, **Blue Cross Complete of Michigan** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-19 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-12] for **Blue Cross Complete of Michigan**.

[3-12] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Table 3-19—HEDIS MY 2021 Performance Measure Results for BCC

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.80%	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	62.98%	★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	59.20%	★★★
Ages 12 to 17 Years	49.83%	★★★
Ages 18 to 21 Years	31.08%	★★★
Total	51.22%	★★★
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	58.41%	★★★
Ages 21 to 24 Years	63.32%	★★★
Total	61.08%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	59.49%	★★★
Breast Cancer Screening		
Breast Cancer Screening	52.25%	★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	85.40%	★★★
*HbA1c Poor Control (>9.0%)**	37.96%	★★★★
HbA1c Control (<8.0%)	50.85%	★★★
Eye Exam (Retinal) Performed	54.99%	★★★
Blood Pressure Control (<140/90 mm Hg)	59.37%	★★★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	28.07%	★★
Ages 65 to 74 Years	29.59%	★★
Ages 75 to 85 Years	25.53%	★★
Total	28.08%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	57.95%	★★★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.

MY 2021 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Blue Cross Complete of Michigan's performance ranked between the 75th and 89th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, indicating children who turned 15 months old during the measurement year were getting at least six well-child visits with a PCP during their first 15 months of life most of the time. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-13] [**Quality**, **Timeliness**, and **Access**]

Strength #2: Blue Cross Complete of Michigan's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Control—HbA1c Poor Control (>9.0%)* measure indicator, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-14] [**Quality** and **Access**]

Strength #3: Blue Cross Complete of Michigan demonstrated overall strength in its HEDIS data reporting, as **Blue Cross Complete of Michigan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with

[3-13] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.
[3-14] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-15] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, suggesting barriers exist for children to receive timely well-child visits.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

Weakness #2: Blue Cross Complete of Michigan's performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3-16] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some women to be screened for breast cancer.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure.

Weakness #3: Blue Cross Complete of Michigan's performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-17] [**Quality** and **Access**]

Why the weakness exists: The rates for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked between the 25th percentile and 49th percentile, suggesting that barriers exist for some members with diabetes to receive kidney health evaluations.

3-15 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

3-16 National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.

3-17 Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Jan 30, 2023.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.

Compliance Review

Performance Results

Table 3-20 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-20 also presents **Blue Cross Complete of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Blue Cross Complete of Michigan** was subject to a corrective action review process outlined in Appendix A.

Table 3-20—Compliance Review Results for BCC

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	BCC	Statewide[1]
1	Administrative	5	0	100%	95.6%
2	Providers	19	2	90%	88.9%
3	Members	26	0	100%	98.7%
4	Quality	21	0	100%	98.9%
5	MIS/Financial	36	0	100%	95.7%
6	OIG/Program Integrity	32	1	97%	96.3%
Overall		**139**	**3**	**98%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

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: Blue Cross Complete of Michigan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Blue Cross Complete of Michigan achieved full compliance in the Member standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; collaboration with LHDs for members with special health care needs; care coordination; a fair grievance and appeal system; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Blue Cross Complete of Michigan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs, QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Strength #4: Blue Cross Complete of Michigan achieved full compliance in the MIS standard, demonstrating the MHP maintained a health information system (HIS) that collected, analyzed, integrated, and reported data in various program areas and functions, including but not limited to, provider data; member enrollment and disenrollment; financial statements and reports; third-party recovery and subrogation requests; the common formulary; provider enrollment; claims payment; grievance and appeal tracking; and quality reporting. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for **Blue Cross Complete of Michigan** through the compliance review activity.

Why the weakness exists: NA

Recommendation: NA

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 342 cases by comparing provider data that **Blue Cross Complete of Michigan** submitted to HSAG against **Blue Cross Complete of Michigan**'s online provider directory. The sample included 114 PCPs, 114 pediatric providers, and 114 OB/GYN providers (Table 3-21). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 96.2 percent (n=329) of the reviews. The sampled providers were not found in the online provider directory in 3.8 percent of the reviewed cases.

Table 3-21—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	114	110	96.5%	4	3.5%
Pediatric Providers	114	108	94.7%	6	5.3%
OB/GYN Providers	114	111	97.4%	3	2.6%
BCC Total	**342**	**329**	**96.2%**	**13**	**3.8%**

Table 3-22 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Blue Cross Complete of Michigan**'s provider data submission to HSAG and **Blue Cross Complete of Michigan**'s online provider directory.

Table 3-22—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	110	100%	108	100%	111	100%	329	100%
Provider Address	100	90.9%	89	82.4%	99	89.2%	288	87.5%
Provider City	97	88.2%	91	84.3%	104	93.7%	292	88.8%
Provider State	101	91.8%	94	87.0%	104	93.7%	299	90.9%
Provider Zip Code	100	90.9%	94	87.0%	104	93.7%	298	90.6%

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider Telephone Number	99	90.0%	86	79.6%	98	88.3%	283	86.0%
Provider Type/Specialty	100	90.9%	94	87.0%	104	93.7%	298	90.6%
Provider Gender	101	91.8%	94	87.0%	103	92.8%	298	90.6%
Provider Accepting New Patients	101	91.8%	94	87.0%	104	93.7%	299	90.9%
Non-English Language Speaking Provider (including American Sign Language)	96	87.3%	85	78.7%	95	85.6%	276	83.9%
Provider Primary Language	101	91.8%	94	87.0%	104	93.7%	299	90.9%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 269 sampled provider locations (i.e., "cases") for **Blue Cross Complete of Michigan**, with an overall response rate of 64.7 percent (n=174). Table 3-23 summarizes the secret shopper survey results for **Blue Cross Complete of Michigan**.

Table 3-23—Summary of BCC Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	93	60	64.5%	39	65.0%	23	59.0%	23	100%	23	100%
Pediatric Providers	81	64	79.0%	54	84.4%	46	85.2%	44	95.7%	43	97.7%
OB/GYN Providers	95	50	52.6%	18	36.0%	7	38.9%	6	85.7%	6	100%
BCC Total	**269**	**174**	**64.7%**	**111**	**63.8%**	**76**	**68.5%**	**73**	**96.1%**	**72**	**98.6%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-24 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Blue Cross Complete of Michigan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-24—Appointment Availability Results

				Cases Offered an Appointment			Appointment Wait Time (Days)			
Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)[1]	Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	114	21	91.3%	19	16.7%	90.5%	0	111	36	30
Pediatric Providers	114	36	83.7%	28	24.6%	77.8%	0	78	19	10
OB/GYN Providers	114	6	100%	4	3.5%	66.7%	3	42	16	9
BCC Total	**342**	**63**	**87.5%**	**51**	**14.9%**	**81.0%**	**0**	**111**	**25**	**19**

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Reviewers located over 96 percent of the sampled providers in **Blue Cross Complete of Michigan**'s online provider directory. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 64.7 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **Blue Cross Complete of Michigan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of cases in which the survey respondent reported that the provider location accepted **Blue Cross Complete of Michigan**, Medicaid, and new patients, 81 percent of cases offered the caller an appointment date. However, pediatric providers had an appointment availability rate of 77.8 percent, while OB/GYN provider locations had an appointment availability rate of 66.7 percent. [**Access**]

Why the weakness exists: For new **Blue Cross Complete of Michigan** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid identification (ID), or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Blue Cross Complete of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-25 presents **Blue Cross Complete of Michigan**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-25—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for BCC

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	69.1% ↑	71.0%
Rating of All Health Care	59.2%	74.8%
Rating of Personal Doctor	65.6%	72.9%
Rating of Specialist Seen Most Often	74.1%	70.8%+
Composite Measures		
Getting Needed Care	83.5%	82.8%+
Getting Care Quickly	80.3%	88.3%*
How Well Doctors Communicate	92.1%	95.3%
Customer Service	92.7%+ ↑	85.0%+
Individual Item Measure		
Coordination of Care	90.8%+	75.5%+
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	74.5%	
Discussing Cessation Medications	51.6%	
Discussing Cessation Strategies	44.0%	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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

Strengths

Strength #1: Blue Cross Complete of Michigan's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for two measures: *Rating of Health Plan* and *Customer Service*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult and child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-26 presents **Blue Cross Complete of Michigan**'s 2022 CSHCS CAHPS survey top-box scores. The following measure could not be displayed in the table because this measure had fewer than 11 responses and was suppressed: *CSHCS Family Center*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-26—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for BCC

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	69.4%
Rating of Health Care	69.6% NA
Rating of Specialist Seen Most Often	73.7%
Rating of CMDS Clinic	63.6%+ NA
Composite Measures	
Customer Service	82.1%+ ↓
How Well Doctors Communicate	94.3% NA
Access to Specialized Services	67.7%+ NA
Transportation	55.7%+ NA
Individual Item Measures	
Access to Prescription Medicines	87.5%
CMDS Clinic	76.5%+ NA
Local Health Department Services	76.2%+ NA

	2022 Top-Box Score
Not Felt Treated Unfairly: Race and Ethnicity	95.3% NA
Not Felt Treated Unfairly: Health Insurance Type	94.3% NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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

Strengths

Strength #1: Blue Cross Complete of Michigan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Customer Service*. [**Quality**]

Why the weakness exists: Parents/caretakers of child members enrolled in **Blue Cross Complete of Michigan** may not be receiving the information or help needed, or may be dissatisfied with the level of courtesy and respect offered by customer service.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** explore the drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **Blue Cross Complete of Michigan** should consider obtaining direct patient feedback from members to drill down into areas that need improvement.

Performance Results—HMP

Table 3-27 presents **Blue Cross Complete of Michigan**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-27—Summary of 2022 HMP CAHPS Top-Box Scores for BCC

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	61.6%
Rating of All Health Care	58.5%
Rating of Personal Doctor	68.4%
Rating of Specialist Seen Most Often	67.6%+
Composite Measures	
Getting Needed Care	83.6%+
Getting Care Quickly	82.2%+
How Well Doctors Communicate	96.2%* ↑
Customer Service	86.3%+
Individual Item Measure	
Coordination of Care	88.9%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	82.1% ↑
Discussing Cessation Medications	63.4% ↑
Discussing Cessation Strategies	55.4%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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

Strengths

Strength #1: Blue Cross Complete of Michigan's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for three measures: *How Well Doctors Communicate*, *Advising Smokers and Tobacco Users to Quit*, and *Discussing Cessation Medications*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **Blue Cross Complete of Michigan**'s performance.

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

HSAG performed a comprehensive assessment of **Blue Cross Complete of Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Blue Cross Complete of Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Blue Cross Complete of Michigan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-28 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to **Blue Cross Complete of Michigan**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-28—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **Blue Cross Complete of Michigan** identified through its data analysis a disparity between Black women and White women in the timeliness of prenatal care. While **Blue Cross Complete of Michigan** designed a methodologically sound PIP, the MHP had not yet progressed to initiating interventions. Future interventions implemented through the PIP activity have the potential to reduce/eliminate the disparity. Future interventions should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* performance measure rate, which ranked between the 50th and 74th Medicaid Quality Compass percentile, demonstrated a statistically significant improvement from the previous year, and was among the highest rate across the MHPs. Further, as demonstrated through the compliance review activity, **Blue Cross Complete of Michigan** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare conditions and reduce disparities in care. **Blue Cross Complete of Michigan** also achieved full compliance in the Quality standard, indicating that it had a sufficient QAPI program in which various initiatives can be implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—As indicated through the PMV activity, **Blue Cross Complete of Michigan** demonstrated some strengths in impacting progress related to access to child and adolescent preventive services. All four *Child and Adolescent Well-Care Visits* measure indicator rates ranked between the 50th and 74th percentile and demonstrated a statistically significant improvement from the previous year. However, while the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator rate showed strong performance and ranked between the 75th and 89th percentile, this rate demonstrated a statistically significant decline from the previous year, as did the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator rate, which also ranked below the 25th percentile. Additionally, the secret shopper survey identified multiple providers, including pediatric providers, who could not be reached. Overall, of the providers that could be reached and were accepting the MHP, Medicaid, and new patients, the appointment availability rate was low. **Blue Cross Complete of Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest

Performance Area	Overall Performance Impact
	that members may not always have access to accurate information to locate a provider for appropriate child and adolescent preventive services or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—**Blue Cross Complete of Michigan** demonstrated mixed results as it related to the care and services provided to members with chronic conditions. **Blue Cross Complete of Michigan** received a *Met* score for element *3.10 CSHCS PCP Requirements* through the compliance review activity, demonstrating that the MHP had the necessary processes in place to ensure CSHCS members are assigned to a CSHCS-attested PCP who is willing to accept new CSHCS members with potentially complex chronic health conditions, regularly serve children or youth with complex chronic conditions, and has mechanisms to identify children or youth with chronic health conditions. As demonstrated through the PMV activity, four of the five indicator rates under the *Comprehensive Diabetes Care* performance measure ranked between the 50th and 74th Quality Compass Medicaid percentile, with the fifth indicator rate ranking between the 75th and 89th percentile. The *Controlling High Blood Pressure* performance measure rate also ranked between the 50th and 74th Quality Compass Medicaid percentile. These results indicate that many of **Blue Cross Complete of Michigan**'s members diagnosed with diabetes are receiving appropriate diabetes management, and many members diagnosed with hypertension have their blood pressure adequately controlled. Additionally, three of the four rates under the *Kidney Health Evaluation for Patients With Diabetes* performance measure demonstrated a statistically significant improvement from the previous year; however, all four measure indicator rates ranked between the 25th and 49th Quality Compass Medicaid percentile, indicating continued opportunities to increase the number of members diagnosed with diabetes who are routinely tested for kidney disease. Further, the secret shopper survey identified a significant number of providers who could not be reached. Overall, of the providers that could be reached and were accepting the MHP, Medicaid, and new patients, the appointment availability rate was low. **Blue Cross Complete of Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for recommended chronic care management or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.

Performance Area	Overall Performance Impact
Health and Wellness of Women	**Quality**—The results of the PMV activity demonstrated that many of **Blue Cross Complete of Michigan**'s female members were receiving the recommended cervical cytology and/or high-risk HPV testing and that many sexually active women were being appropriately tested for chlamydia. The rate for the *Cervical Cancer Screening* performance measure and all three indicator rates for the *Chlamydia Screening in Women* performance measure ranked between the 50th and 75th Medicaid Quality Compass percentile. Additionally, **Blue Cross Complete of Michigan** received a *Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of the compliance review activity, demonstrating the MHP had the necessary processes in place to notify MDHHS and ensure pregnant women were eligible for dental services. However, the *Breast Cancer Screening* performance measure rate ranked between the 25th and 49th Medicaid Quality Compass percentile and demonstrated a statistically significant decline from the previous year, indicating that some women are not receiving recommended mammograms. Further, the secret shopper survey identified a significant number of providers, including OB/GYN providers, who could not be reached. Overall, of the providers that could be reached and were accepting the MHP, Medicaid, and new patients, the appointment availability rate was low. **Blue Cross Complete of Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for recommended women's health management or may be experiencing other barriers in scheduling timely appointments.

HAP Empowered

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **HAP Empowered**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-29 displays the overall validation status and the baseline results for the performance indicator. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-29—Overall Validation Rating for HAP

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Improving the Timeliness of Prenatal Care	*Met*	Measuring the percentage of Black/African-American pregnant women who have a prenatal visit within 42 days of enrollment or within the first trimester	72.4%		

R1 = Remeasurement 1
R2 = Remeasurement 2

Due to its small population size and lack of an identified disparity, **HAP Empowered** determined through data analysis that the focus for the PIP should be improving timeliness of prenatal care for Black/African-American pregnant women as this population was the lowest-performing subgroup. The goal for **HAP Empowered**'s PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as the result of an intervention. Table 3-30 displays the interventions, as available, initiated by the MHP to support achievement of the PIP goal and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-30—Baseline Interventions for HAP

Intervention Descriptions	
Outreached to engage members in the internal case management program for maternity utilizing monthly pregnancy reports.	Implemented a maternity-focused care management program powered by ProgenyHealth. Progeny also outreaches to engage members and refer to Maternal Infant Health Program (MIHP).
Increased member incentive amount for prenatal care in 2021. Continued outreach strategies to engage members and educate on incentive program.	

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HAP Empowered designed a methodologically sound PIP. The MHP collected and reported accurate performance indicator results using a systematic data collection process. [**Quality**]

Strength #2: HAP Empowered used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. Interventions were implemented in a timely manner, were reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **HAP Empowered** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.

Performance Measure Validation

Performance Results

HAP Empowered was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **HAP Empowered** was fully compliant with all seven IS standards.

According to the auditor's review, **HAP Empowered** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-31 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-18] for **HAP Empowered**.

[3-18] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Table 3-31—HEDIS MY 2021 Performance Measure Results for HAP

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	36.06%	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	46.05%	★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	45.80%	★★
Ages 12 to 17 Years	34.35%	★
Ages 18 to 21 Years	19.18%	★★
Total	36.69%	★
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	55.87%	★★★
Ages 21 to 24 Years	60.48%	★★
Total	58.96%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	43.80%	★
Breast Cancer Screening		
Breast Cancer Screening	56.75%	★★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	82.97%	★★★
*HbA1c Poor Control (>9.0%)**	50.12%	★★
HbA1c Control (<8.0%)	44.28%	★★
Eye Exam (Retinal) Performed	49.88%	★★
Blood Pressure Control (<140/90 mm Hg)	53.28%	★★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	31.20%	★★★
Ages 65 to 74 Years	33.55%	★★★
Ages 75 to 85 Years	32.35%	★★★
Total	31.83%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	57.32%	★★★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HAP Empowered demonstrated overall strength in its HEDIS data reporting, as **HAP Empowered** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered's performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators ranked below the 25th percentile, indicating children who turned 15 months old during the measurement year were not always getting at least six well-child visits with a PCP during their first 15 months of life. Additionally, children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-19] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for both *Well-Child Visits in the First 30 Months of Life* measure indicators ranked below the 25th percentile, suggesting barriers exist for children to receive timely well-child visits.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life* measure.

Weakness #2: HAP Empowered's performance for the *Cervical Cancer Screening* measure ranked below the 25th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer was one of the most common causes of cancer death for American women; effective

[3-19] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-20] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Cervical Cancer Screening* measure ranked below the 25th percentile, suggesting barriers exist for women to be screened for cervical cancer.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure.

Weakness #3: HAP Empowered's performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Total* measure indicators ranked below the 25th percentile, and *Ages 3 to 11 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th percentile and 49th percentile, indicating some children were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-21] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Total* measure indicators ranked below the 25th percentile, and the *Ages 3 to 11 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some children to receive timely well-child visits.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure.

Weakness #4: HAP Empowered's performance for the *Chlamydia Screening in Women—Ages 21 to 24 Years* measure indicator ranked between the 25th percentile and 49th percentile, indicating some women 21 to 24 years of age identified as sexually active did not receive at least one test for chlamydia during the measurement year. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-22] [**Quality**]

Why the weakness exists: The rate for the *Chlamydia Screening in Women—Ages 21 to 24 Years* measure indicator ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some women identified as sexually active to receive testing for chlamydia.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some women identified as sexually active did not receive testing for chlamydia. Upon identification of a root cause, **HAP Empowered** should implement appropriate

3-20 National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2023.
3-21 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.
3-22 National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Jan 30, 2023.

interventions to improve the performance related to the *Chlamydia Screening in Women—Ages 21 to 24 Years* measure indicator.

Weakness #5: HAP Empowered's performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-23] [**Quality** and **Access**]

Why the weakness exists: The rates for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some members with diabetes to have controlled HbA1c levels.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled HbA1c levels. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators.

Weakness #6: HAP Empowered's performance for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have an eye exam to screen or monitor for diabetic retinal disease. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-24] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some members with diabetes to have an eye exam to screen or monitor for diabetic retinal disease.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some members with diabetes did not have an eye exam performed. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator.

Weakness #7: HAP Empowered's performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have controlled blood pressure. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension,

[3-23] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
[3-24] Ibid.

blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-25] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked between the 25th percentile and 49th percentile, suggesting that barriers exist for some members with diabetes to have controlled blood pressure.

Recommendation: HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled blood pressure. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator.

Compliance Review

Performance Results

Table 3-32 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-32 also presents **HAP Empowered**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **HAP Empowered** was subject to a corrective action review process outlined in Appendix A.

Table 3-32—Compliance Review Results for HAP

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	HAP	Statewide[1]
1	Administrative	5	0	100%	95.6%
2	Providers	18	3	86%	88.9%
3	Members	26	0	100%	98.7%
4	Quality	20	1	95%	98.9%
5	MIS/Financial	34	2	94%	95.7%
6	OIG/Program Integrity	31	2	94%	96.3%
Overall		**134**	**8**	**94%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

[3-25] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HAP Empowered achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: HAP Empowered achieved full compliance in the Member standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; collaboration with LHDs for members with special health care needs; care coordination; a fair grievance and appeal system; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered scored below the statewide average in the Provider standard. The MHP received a *Not Met* score for elements *2.7 Provider Network–MHP Demonstrates that Covered Services are Available and Accessible*, *2.20 Credentialing and Recredentialing Policies*, and *2.21 Secret Shopper Calls*. [**Quality** and **Access**]

Why the weakness exists: HAP Empowered's provider network did not meet the required ratio standard for pediatric PCPs in two counties; and the MHP did not submit to MDHHS an exception request for provider types/counties not meeting time, distance, or ratio standards due to staff turnover. Additionally, numerous gaps were identified in **HAP Empowered**'s network access plan and, overall, the network access plan was not comprehensive. **HAP Empowered** incorrectly believed the network access plan contained sufficient information. Further, **HAP Empowered** did not initially highlight or reference the page numbers of where relevant information could be found within the MHP's credentialing and recredentialing policies. Lastly, through secret shopper calls to PCPs to assess the accuracy of **HAP Empowered**'s provider directory, discrepancies were identified in the location and phone number of providers and with providers being listed as accepting new patients. **HAP Empowered** reported that the issue was caused by various process improvements implemented by former leadership and there was a lack of a clear initial planning process for updating demographic information for providers, along with providers and staff being unaware of the requirement.

Recommendation: As **HAP Empowered** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **HAP Empowered** ensure its CAP is fully implemented to mitigate the deficiencies.

Weakness #2: HAP Empowered scored below the statewide average in the Quality standard. The MHP received a *Not Met* score for element *4.9 PRM* [Performance Measure Report]. [**Quality**]

Why the weakness exists: HAP Empowered's submission of unachieved standards did not include the live birth weight performance measure. The MHP reported that it had mistakenly excluded this measure from the Performance Monitoring Report (PMR) Improvement Plan for the July 2022 compliance review submission. The measure was previously reviewed during the April 2022 PMR; however, there was an oversight in including it with the original submission.

Recommendation: As **HAP Empowered** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **HAP Empowered** ensure its CAP is fully implemented to mitigate the deficiencies.

Weakness #3: HAP Empowered scored below the statewide average in the MIS standard. The MHP receive *Not Met* score for elements *5.10 Provider Data Accuracy* and *5.11 Claims Processing (Non-Pharmacy)*. [**Quality**]

Why the weakness exists: HAP Empowered did not initially highlight or reference the page numbers of where relevant information could be found within the MHP's provider data accuracy policies and procedures. Additionally, **HAP Empowered** did not submit the claims processing report for December 2021, and three of the reports (for October 2021, November 2021, and May 2022) had inaccurate calculations. The MHP reported that errors were found on the reports prior to the original submission to MDHHS; however, the reports were not saved properly.

Recommendation: As **HAP Empowered** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **HAP Empowered** ensure its CAP is fully implemented to mitigate the deficiencies.

Weakness #4: HAP Empowered scored below the statewide average in the Program Integrity standard. The MHP received a *Not Met* score for *6.1 Quarterly Program Integrity Forms–Tips and Grievances* and *6.9 OIG Program Integrity–Compliance Program*.

Why the weakness exists: HAP Empowered did not correct the discrepancies identified on the tips and grievances reporting form during the final submission. The MHP reported that staff were not fully aware of the reporting protocol and an incorrect desk-level procedure was used. Additionally, **HAP Empowered** did not provide documentation confirming that all staff were given exit interviews and that those interviews included compliance and code of conduct related questions. The MHP had various active versions of an exit survey and demonstrated an opportunity to consolidate and streamline activities surrounding employee offboarding for both efficiency and effectiveness.

Recommendation: As **HAP Empowered** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **HAP Empowered** ensure its CAP is fully implemented to mitigate the deficiencies.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 354 cases by comparing provider data that **HAP Empowered** submitted to HSAG against **HAP Empowered**'s online provider directory. The sample included 118 PCPs, 118 pediatric providers, and 118 OB/GYN providers (Table 3-33). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 98.6 percent (n=349) of the reviews. The sampled providers were not found in the online provider directory in 1.4 percent of the reviewed cases.

Table 3-33—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	118	114	96.6%	4	3.4%
Pediatric Providers	118	118	100%	0	0.0%
OB/GYN Providers	118	117	99.2%	1	0.8%
HAP Total	**354**	**349**	**98.6%**	**5**	**1.4%**

Table 3-34 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **HAP Empowered**'s provider data submission to HSAG and **HAP Empowered**'s online provider directory.

Table 3-34—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	114	100%	118	100%	115	98.3%	347	99.4%
Provider Address	112	98.2%	115	97.5%	116	99.1%	343	98.3%
Provider City	114	100%	116	98.3%	116	99.1%	346	99.1%
Provider State	114	100%	116	98.3%	116	99.1%	346	99.1%
Provider Zip Code	114	100%	116	98.3%	116	99.1%	346	99.1%

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider Telephone Number	113	99.1%	116	98.3%	115	98.3%	344	98.6%
Provider Type/Specialty	114	100%	115	97.5%	115	98.3%	344	98.6%
Provider Gender	113	99.1%	116	98.3%	116	99.1%	345	98.9%
Provider Accepting New Patients	114	100%	116	98.3%	116	99.1%	346	99.1%
Non-English Language Speaking Provider (including American Sign Language)	104	91.2%	111	94.1%	45	38.5%	260	74.5%
Provider Primary Language	19	16.7%	62	52.5%	5	4.3%	86	24.6%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 342 sampled provider locations (i.e., "cases") for **HAP Empowered**, with an overall response rate of 70.2 percent (n=240). Table 3-35 summarizes the secret shopper survey results for **HAP Empowered**.

Table 3-35—Summary of HAP Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	112	74	66.1%	54	73.0%	45	83.3%	35	77.8%	34	97.1%
Pediatric Providers	115	98	85.2%	88	89.8%	69	78.4%	62	89.9%	60	96.8%
OB/GYN Providers	115	68	59.1%	46	67.6%	34	73.9%	27	79.4%	26	96.3%
HAP Total	**342**	**240**	**70.2%**	**188**	**78.3%**	**148**	**78.7%**	**124**	**83.8%**	**120**	**96.8%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-36 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **HAP Empowered**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-36—Appointment Availability Results

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)[1]	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	118	26	76.5%	22	18.6%	84.6%	0	212	28	8
Pediatric Providers	118	56	93.3%	49	41.5%	87.5%	0	72	14	7
OB/GYN Providers	118	25	96.2%	14	11.9%	56.0%	5	69	19	14
HAP Total	**354**	**107**	**89.2%**	**85**	**24.0%**	**79.4%**	**0**	**212**	**18**	**8**

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Reviewers located over 98 percent of the sampled providers in **HAP Empowered**'s online provider directory. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 70.2 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **HAP Empowered**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **HAP Empowered** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of cases in which the survey respondent reported that the provider location accepted **HAP Empowered**, Medicaid, and new patients, only 79.4 percent of cases offered the caller an appointment date. OB/GYN provider locations had an appointment availability rate of 56 percent. [**Access**]

Why the weakness exists: For new **HAP Empowered** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **HAP Empowered** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **HAP Empowered** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-37 presents **HAP Empowered**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-37—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for HAP

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	64.2%	71.3%
Rating of All Health Care	59.3%	64.2%+
Rating of Personal Doctor	72.7%	71.7%+
Rating of Specialist Seen Most Often	67.8%+	76.7%+
Composite Measures		
Getting Needed Care	80.9%	82.7%+
Getting Care Quickly	85.2%+	86.9%+
How Well Doctors Communicate	95.4% ↑	93.3%+
Customer Service	91.6%	90.5%+
Individual Item Measure		
Coordination of Care	84.9%+	87.1%+
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	70.7%	
Discussing Cessation Medications	51.6%	
Discussing Cessation Strategies	44.4%	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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

Strengths

Strength #1: HAP Empowered's 2022 top-box score was statistically significantly higher than the 2021 NCQA adult Medicaid national average for one measure, *How Well Doctors Communicate*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult and child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **HAP Empowered** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-38 presents **HAP Empowered**'s 2022 CSHCS CAHPS survey top-box scores. The following measures could not be displayed in the table because these measures had fewer than 11 responses and were suppressed: *Rating of Specialist Seen Most Often*, *Rating of CMDS Clinic*, *Customer Service*, *Access to Specialized Services*, *Transportation*, *CSHCS Family Center*, *CMDS Clinic*, and *Local Health Department Services*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-38—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for HAP

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	61.5%+
Rating of Health Care	50.0%* NA
Composite Measures	
How Well Doctors Communicate	95.8%+ NA
Individual Item Measures	
Access to Prescription Medicines	90.9%+
Not Felt Treated Unfairly: Race and Ethnicity	100.0%+ NA
Not Felt Treated Unfairly: Health Insurance Type	100.0%+NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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

Strengths

Strength #1: HAP Empowered's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: HAP Empowered's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **HAP Empowered** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-39 presents **HAP Empowered**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-39—Summary of 2022 HMP CAHPS Top-Box Scores for HAP

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	56.4%
Rating of All Health Care	54.5%$^{+}$
Rating of Personal Doctor	68.1%$^{+}$
Rating of Specialist Seen Most Often	63.0%$^{+}$
Composite Measures	
Getting Needed Care	82.8%$^{+}$
Getting Care Quickly	78.2%$^{+}$
How Well Doctors Communicate	94.0%$^{+}$
Customer Service	85.5%$^{+}$

	2022 Top-Box Score
Individual Item Measure	
Coordination of Care	90.5%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	63.6%+ ↓
Discussing Cessation Medications	45.5%+
Discussing Cessation Strategies	36.8%+ ↓

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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

Strengths

Strength #1: HAP Empowered's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: HAP Empowered's 2022 top-box scores were statistically significantly lower than the 2021 NCQA adult Medicaid national averages for two measures: *Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Strategies*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that **HAP Empowered**'s providers may not be advising members who smoke or use tobacco to quit or discuss cessation strategies as often as other providers. Further, the MHP reported that member engagement/enrollment in its Tobacco Quitline program is a continued barrier and, as a result, ongoing outreach continues to eligible members.

Recommendation: HSAG recommends that **HAP Empowered** explore drivers of lower experience scores and continue to develop initiatives designed to improve quality of care, including a focus on improving the provision of medical assistance with smoking and tobacco use cessation to members and reducing barriers to engagement. **HAP Empowered** should provide training and resources to providers to promote smoking cessation with their members.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **HAP Empowered**'s performance.

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

HSAG performed a comprehensive assessment of **HAP Empowered**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **HAP Empowered** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **HAP Empowered**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-40 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to **HAP Empowered**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-40—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **HAP Empowered** did not identify an existing disparity but focused its PIP on improving timeliness of prenatal care for Black/African-American women as this population was the lowest-performing subgroup. **HAP Empowered** designed a methodologically sound PIP and timely implemented interventions that were reasonably linked to their corresponding barriers. Future interventions should increase the number of Black/African-American women who receive a timely prenatal care appointment. The interventions implemented through the PIP activity should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator rate. While the rate for this measure indicator demonstrated a statistically significant improvement from the previous year, it ranked below the 25th Medicaid Quality Compass percentile. Further, as demonstrated through the compliance review activity, **HAP Empowered** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare

Performance Area	Overall Performance Impact
	conditions and reduce disparities in care. **HAP Empowered** also achieved 95 percent in the Quality standard, indicating that it had a sufficient QAPI program in which various initiatives can be implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—Overall, as demonstrated through the PMV activity, access to child and adolescent preventive services was a weakness of **HAP Empowered**'s program. Both indicator rates under the *Well-Child Visits in the First 30 Months of Life* performance measure ranked below the 25th Medicaid Quality Compass percentile and declined from the previous year. While all *Child and Adolescent Well-Care Visits* measure indicator rates demonstrated an increase in performance from the previous year, two age subgroup measure indicator rates ranked between the 25th and 49th Medicaid Quality Compass percentile, with the total rate and the rate for one age subgroup ranking below the 25th percentile, indicating continued opportunities for improvement. **HAP Empowered** was among the lowest-performing MHPs for these measures. Additionally, the secret shopper survey identified multiple providers, including pediatric providers, who could not be reached. Overall, of the providers that could be reached and were accepting the MHP, Medicaid, and new patients, the appointment availability rate was low; however, pediatric providers had the highest appointment availability rate amount the provider types reviewed. **HAP Empowered** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for appropriate child and adolescent preventive services or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—**HAP Empowered** performed well in the *Kidney Health Evaluation for Patients With Diabetes* and *Controlling High Blood Pressure* performance measures. All rates ranked between the 50th and 74th Medicaid Quality Compass percentile. Additionally, **HAP Empowered** received a *Met* score for element *3.10 CSHCS PCP Requirements* through the compliance review activity, demonstrating that the MHP had the necessary processes in place to ensure CSHCS members are assigned to a CSHCS-attested PCP who is willing to accept new CSHCS members with potentially complex chronic health conditions, regularly serve children or youth with complex chronic conditions, and has mechanisms to identify children or youth with chronic health conditions. However, while the rate for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator ranked between the 50th and 74th Medicaid Quality Compass percentile, the remaining four indicator rates under the *Comprehensive Diabetes Care* performance measure ranked between the 25th and 49th percentile. These results indicate there are continued opportunities to promote

Performance Area	Overall Performance Impact
	proper diabetes management. Further, the secret shopper survey identified a significant number of providers who could not be reached. Overall, of the providers that could be reached and were accepting the MHP, Medicaid, and new patients, the appointment availability rate was low. **HAP Empowered** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for recommended chronic care management or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Health and Wellness of Women	**Quality**—The results of the PMV activity demonstrated that many of **HAP Empowered**'s female members were receiving recommended mammograms, and sexually active women 16 to 20 years of age were being appropriately tested for chlamydia, as indicated by rates for the *Breast Cancer Screening* and *Chlamydia Screening in Women (ages 16 to 20 years* and *total* rates) performance measures, which ranked between the 50th and 74th Medicaid Quality Compass percentile. Additionally, **HAP Empowered** received a *Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of the compliance review activity, demonstrating the MHP had the necessary processes in place to notify MDHHS and ensure pregnant women were eligible for dental services. However, the rate for the *Cervical Cancer Screening* measure ranked below the 25th percentile and was the lowest-performing rate among the MHPs, indicating that many women did not receive the recommended cervical cytology and/or high-risk HPV testing. The *Chlamydia Screening in Women—Ages 21 to 24 Years* measure indicator ranked between the 25th and 49th Medicaid Quality Compass percentile, indicating many sexually active women of this age group were not being appropriately tested for chlamydia. Further, the secret shopper survey identified a significant number of providers, including OB/GYN providers, who could not be reached. Overall, of the providers, and particularly OB/GYN providers, that could be reached and were accepting the MHP, Medicaid, and new patients, the appointment availability rate was low. **HAP Empowered** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for recommended women's health screenings or may be experiencing other barriers in scheduling timely appointments.

McLaren Health Plan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **McLaren Health Plan**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-41 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-41—Overall Validation Rating for MCL

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities in Timeliness of Prenatal Care	*Met*	1. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for Black members.	60.8%			Yes
		2. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for White members.	71.7%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **McLaren Health Plan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-42 displays the interventions, as available, initiated by the MHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-42—Baseline Interventions for MCL

Intervention Descriptions	
Targeted outreach to members in regions 6 and 7 (highest population and disparate areas) upon notification of pregnancy to facilitate timeliness of prenatal care.	Providers received a $100 incentive for completing timely prenatal and postpartum care.
Providers received monthly gaps-in-care reports with disparity information for this measure.	Members received a $10 gift card incentive upon notification of pregnancy to the MHP.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: McLaren Health Plan designed a methodologically sound PIP. The MHP collected and reported accurate performance indicator results using a systematic data collection process and conducted appropriate statistical testing between subgroups. [**Quality**]

Strength #2: McLaren Health Plan used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. The MHP implemented timely interventions that were reasonably linked to the barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **McLaren Health Plan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.

Performance Measure Validation

Performance Results

McLaren Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **McLaren Health Plan** was fully compliant with all seven IS standards.

According to the auditor's review, **McLaren Health Plan** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-43 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-26] for **McLaren Health Plan**.

Table 3-43—HEDIS MY 2021 Performance Measure Results for MCL

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.66%	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	59.04%	★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	54.63%	★★★
Ages 12 to 17 Years	44.47%	★★
Ages 18 to 21 Years	23.41%	★★
Total	45.88%	★★★
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	53.84%	★★★
Ages 21 to 24 Years	61.89%	★★★
Total	57.84%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	56.69%	★★
Breast Cancer Screening		
Breast Cancer Screening	53.67%	★★

[3-26] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	86.13%	★★★★
*HbA1c Poor Control (>9.0%)**	54.74%	★
HbA1c Control (<8.0%)	38.20%	★
Eye Exam (Retinal) Performed	50.61%	★★
Blood Pressure Control (<140/90 mm Hg)	43.31%	★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	29.11%	★★
Ages 65 to 74 Years	42.42%	★★★
Ages 75 to 85 Years	NA	NC
Total	29.22%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	45.26%	★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.
NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.
NC indicates that a comparison is not appropriate.
MY 2021 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: McLaren Health Plan's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator, indicating members with diabetes were having an HbA1c test performed during the measurement year most of

the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-27] [**Quality** and **Access**]

Strength #2: McLaren Health Plan demonstrated overall strength in its HEDIS data reporting, as **McLaren Health Plan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-28] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, suggesting barriers exist for children to receive timely well-child visits.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

Weakness #2: McLaren Health Plan's performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators ranked below the 25th percentile, indicating that members with diabetes did not aways have controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-29] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators ranked below the 25th percentile, suggesting barriers exist for members with diabetes to have controlled HbA1c levels.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled HbA1c levels.

3-27 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

3-28 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

3-29 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators.

Weakness #3: McLaren Health Plan's performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked below the 25th percentile, indicating some members with diabetes did not have controlled blood pressure. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-30] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked below the 25th percentile, suggesting that barriers exist for members with diabetes to have controlled blood pressure.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled blood pressure. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator.

Weakness #4: McLaren Health Plan's performance for the *Controlling High Blood Pressure* measure ranked below the 25th percentile, indicating that some members with a diagnosis of hypertension did not have controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-31] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Controlling High Blood Pressure* measure ranked below the 25th percentile, suggesting that barriers exist for members with a diagnosis of hypertension to have controlled blood pressure.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with hypertension did not have controlled blood pressure. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Controlling High Blood Pressure* measure.

Weakness #5: McLaren Health Plan's performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th percentile and 49th percentile, indicating some children were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to

[3-30] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

[3-31] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.

influence health and development, and they are a critical opportunity for screening and counseling.[3-32] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some children to receive timely well-child visits.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure.

Weakness #6: McLaren Health Plan's performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer was one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-33] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for women to be screened for cervical cancer.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure.

Weakness #7: McLaren Health Plan's performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3-34] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some women to be screened for breast cancer.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure.

3-32 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

3-33 National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2023.

3-34 National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.

Weakness #8: McLaren Health Plan's performance for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have an eye exam to screen or monitor for diabetic retinal disease. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-35] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some members with diabetes to have an eye exam to screen or monitor for diabetic retinal disease.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have an eye exam performed. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator.

Weakness #9: McLaren Health Plan's performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure indicators ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-36] [**Quality** and **Access**]

Why the weakness exists: The rates for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure indicators ranked between the 25th percentile and 49th percentile, suggesting that barriers exist for some members with diabetes to receive kidney health evaluations.

Recommendation: HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.

[3-35] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

[3-36] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Jan 30, 2023.

Compliance Review

Performance Results

Table 3-44 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-44 also presents **McLaren Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **McLaren Health Plan** was subject to a corrective action review process outlined in Appendix A.

Table 3-44—Compliance Review Results for MCL

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	MCL	Statewide[1]
1	Administrative	3	2	60%	95.6%
2	Providers	19	2	90%	88.9%
3	Members	26	0	100%	98.7%
4	Quality	21	0	100%	98.9%
5	MIS/Financial	35	1	97%	95.7%
6	OIG/Program Integrity	32	1	97%	96.3%
Overall		**136**	**6**	**96%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

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: McLaren Health Plan achieved full compliance in the Member standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; collaboration with LHDs for members with special health care needs; care coordination; a fair grievance and appeal system; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Strength #2: McLaren Health Plan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs, QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan scored below the statewide average in the Administrative standard. The MHP received a *Not Met* score for elements *1.1 Organizational Chart* and *1.2 Administrative Position Descriptions*. [**Quality**]

Why the weakness exists: While **McLaren Health Plan** submitted its organizational chart, it listed a new QI director whose credentials have yet to be submitted for verification; while the organizational chart included representation for the Medicaid product line, the credentials of the individual listed had not been approved by MDHHS. The MHP's Medicaid Liaison stated that the new QI director was in training, and MDHHS should communicate with the previous person that held the position; however, that individual was no longer listed on the organizational chart.

Recommendation: As MDHHS previously informed **McLaren Health Plan** that, in future compliance reviews, the MHP must follow through with the expectations of elements *1.1 Organizational Chart* and *1.2 Administrative Position Descriptions* and have the proper credential review of positions that have training, education, certification, and licensure requirements, HSAG recommends **McLaren Health Plan** implement action plans to ensure it mitigates the deficiencies in future submissions to MDHHS.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 342 cases by comparing provider data that **McLaren Health Plan** submitted to HSAG against **McLaren Health Plan**'s online provider directory. The sample included 114 PCPs, 114 pediatric providers, and 114 OB/GYN providers (Table 3-45). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 97.4 percent (n=333) of the reviews. The sampled providers were not found in the online provider directory in 2.6 percent of the reviewed cases.

Table 3-45—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	114	107	93.9%	7	6.1%
Pediatric Providers	114	114	100%	0	0.0%
OB/GYN Providers	114	112	98.2%	2	1.8%
MCL Total	**342**	**333**	**97.4%**	**9**	**2.6%**

Table 3-46 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **McLaren Health Plan**'s provider data submission to HSAG and **McLaren Health Plan**'s online provider directory.

Table 3-46—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	107	100%	114	100%	112	100%	333	100%
Provider Address	107	100%	113	99.1%	108	96.4%	328	98.5%
Provider City	104	97.2%	110	96.5%	103	92.0%	317	95.2%
Provider State	107	100%	113	99.1%	109	97.3%	329	98.8%
Provider Zip Code	107	100%	113	99.1%	108	96.4%	328	98.5%
Provider Telephone Number	107	100%	113	99.1%	106	94.6%	326	97.9%
Provider Type/Specialty	107	100%	113	99.1%	109	97.3%	329	98.8%
Provider Gender	106	99.1%	113	99.1%	109	97.3%	328	98.5%
Provider Accepting New Patients	107	100%	113	99.1%	109	97.3%	329	98.8%
Non-English Language Speaking Provider (including American Sign Language)	107	100%	111	97.4%	107	95.5%	325	97.6%
Provider Primary Language	107	100%	111	97.4%	107	95.5%	325	97.6%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 314 sampled provider locations (i.e., "cases") for **McLaren Health Plan**, with an overall response rate of 71.0 percent (n=223). Table 3-47 summarizes the secret shopper survey results for **McLaren Health Plan**.

Table 3-47—Summary of MCL Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	104	66	63.5%	40	60.6%	24	60.0%	22	91.7%	20	90.9%
Pediatric Providers	110	95	86.4%	85	89.5%	69	81.2%	68	98.6%	62	91.2%
OB/GYN Providers	100	62	62.0%	47	75.8%	34	72.3%	30	88.2%	30	100%
MCL Total	**314**	**223**	**71.0%**	**172**	**77.1%**	**127**	**73.8%**	**120**	**94.5%**	**112**	**93.3%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-48 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **McLaren Health Plan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-48—Appointment Availability Results

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)[1]	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	114	18	90.0%	15	13.2%	83.3%	0	78	26	23
Pediatric Providers	114	56	90.3%	49	43.0%	87.5%	0	122	31	23

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)[1]	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
OB/GYN Providers	114	27	90.0%	20	17.5%	74.1%	3	61	15	8
MCL Total	**342**	**101**	**90.2%**	**84**	**24.6%**	**83.2%**	**0**	**122**	**26**	**20**

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Reviewers located over 97 percent of the sampled providers in **McLaren Health Plan**'s online provider directory. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 71.0 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **McLaren Health Plan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **McLaren Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of cases reached, only 77.1 percent indicated the office provided the specialty services requested, and of these only 73.8 percent indicated the sampled provider was affiliated with the location. [**Access**]

Why the weakness exists: **McLaren Health Plan**'s provider data included invalid specialty and provider information.

Recommendation: HSAG recommends that **McLaren Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-49 presents **McLaren Health Plan**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-49—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for MCL

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	59.6%	62.7% ↓
Rating of All Health Care	58.1%	70.7%
Rating of Personal Doctor	69.5%	71.7%
Rating of Specialist Seen Most Often	62.2%+	62.5%+
Composite Measures		
Getting Needed Care	85.3%	86.1%+
Getting Care Quickly	85.4%	90.7%+
How Well Doctors Communicate	94.1%	95.0%
Customer Service	87.1%*	94.3%+ ↑
Individual Item Measure		
Coordination of Care	85.1%+	76.4%+
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	70.7%	
Discussing Cessation Medications	50.0%	
Discussing Cessation Strategies	43.9%	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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: McLaren Health Plan's 2022 top-box score was statistically significantly higher than the 2021 NCQA child Medicaid national average for one measure, *Customer Service*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Rating of Health Plan*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that parents/caretakers of child members enrolled in **McLaren Health Plan** had less positive overall experiences with their child's health plan, since the score for this measure was statistically significantly lower than the 2021 NCQA child Medicaid national average. The MHP reported that the CAHPS surveys are de-identified and absent of any specific information to be able to assist members facing challenges with the MHP. Outreach efforts are provided to the general population based on results; however, responses may be an individual experience or concern that the MHP is unable to directly impact. The MHP is hopeful that the possible addition of member-specific surveys completed at the time of interaction will help drill down to specific areas or concerns that currently CAHPS does not allow.

Recommendation: HSAG recommends that **McLaren Health Plan** continue to explore what may be driving lower experience scores and develop initiatives designed to improve quality of care. HSAG further recommends the MHP continue to explore the option of conducting other MHP-specific member experience surveys that allow the MHP to impact negative member-specific experiences.

Performance Results—CSHCS

Table 3-50 presents **McLaren Health Plan**'s 2022 CSHCS CAHPS survey top-box scores. The following measures could not be displayed in the table because these measures had fewer than 11 responses and were suppressed: *Transportation* and *CSHCS Family Center*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-50—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for MCL

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	69.7%
Rating of Health Care	73.5% NA
Rating of Specialist Seen Most Often	75.8%
Rating of CMDS Clinic	63.2%+ NA
Composite Measures	
Customer Service	87.9%+
How Well Doctors Communicate	95.5% NA
Access to Specialized Services	76.5%+ NA
Transportation	78.6%+ NA
Individual Item Measures	
Access to Prescription Medicines	94.0%
CMDS Clinic	79.5%+ NA
Local Health Department Services	77.2%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	96.7% NA
Not Felt Treated Unfairly: Health Insurance Type	92.4% NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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: McLaren Health Plan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **McLaren Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-51 presents **McLaren Health Plan**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-51—Summary of 2022 HMP CAHPS Top-Box Scores for MCL

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	62.0%
Rating of All Health Care	50.0%
Rating of Personal Doctor	63.6%
Rating of Specialist Seen Most Often	58.0%+ ↓
Composite Measures	
Getting Needed Care	84.9%
Getting Care Quickly	76.4%+
How Well Doctors Communicate	91.9%
Customer Service	89.3%+
Individual Item Measure	
Coordination of Care	76.9%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	73.0%
Discussing Cessation Medications	50.3%
Discussing Cessation Strategies	42.5%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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: McLaren Health Plan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan's 2021 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Rating of Specialist Seen Most Often*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that **McLaren Health Plan**'s members are reporting a more negative experience with their specialist. The MHP reported that the CAHPS surveys are de-identified and absent of any specific information to be able to assist members facing challenges with the MHP. Outreach efforts are provided to the general population based on results; however, responses may be an individual experience or concern that the MHP is unable to directly impact. The MHP is hopeful that the possible addition of member-specific surveys completed at the time of interaction will help drill down to specific areas or concerns that currently CAHPS does not allow.

Recommendation: HSAG recommends that **McLaren Health Plan** determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the plan that could be contributing to a lack of network adequacy and access issues. HSAG further recommends the MHP continue to explore the option of conducting other MHP-specific member experience surveys that allow the MHP to impact negative member-specific experiences.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **McLaren Health Plan**'s performance.

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

HSAG performed a comprehensive assessment of **McLaren Health Plan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **McLaren Health Plan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **McLaren Health Plan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-52 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to **McLaren Health Plan**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-52—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **McLaren Health Plan** identified through its data analysis a disparity between Black women and White women in the timeliness of prenatal care. **McLaren Health Plan** designed a methodologically sound PIP and timely implemented interventions that were reasonably linked to their corresponding barriers and have the potential of reducing/eliminating the disparity. The interventions implemented through the PIP activity should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator rate; the rate for this measure ranked below the 25th Medicaid Quality Compass percentile. Further, as demonstrated through the compliance review activity, **McLaren Health Plan** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare conditions and reduce disparities in care. **McLaren Health Plan** also achieved full compliance in the Quality standard, indicating that it had a sufficient QAPI

Performance Area	Overall Performance Impact
	program in which various initiatives can be implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—**McLaren Health Plan** demonstrated mixed results as it related to preventive services provided to children and adolescents. The total rate, and the rate of one age subgroup, under the *Child and Adolescent Well-Care Visits* performance measure ranked between the 50th and 74th Medicaid Quality Compass percentile and demonstrated a statistically significant improvement from the previous year. While rates for the other two age subgroups ranked between the 25th and 49th Medicaid Quality Compass percentile, both rates also demonstrated a statistically significant improvement from the previous year. While the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator ranked between the 50th and 74th Medicaid Quality Compass percentile, the rate for the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile and both indicator rates demonstrated a statistically significant decline from the previous year. Additionally, the secret shopper survey identified multiple providers, including pediatric providers, who could not be reached. Multiple providers also reported the location either did not offer services for the requested specialty, or offered the correct specialty but the provider was not affiliated with the location, demonstrating inaccurate information in the MHP's provider data and/or the online provider directory. Further, **McLaren Health Plan** was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a pediatric provider for appropriate preventive services. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—Many of **McLaren Health Plan**'s members diagnosed with diabetes received recommended HbA1c testing as demonstrated through the PMV activity. The *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator rate ranked between the 75th and 89th Medicaid Quality Compass percentile and demonstrated a statistically significant improvement from the previous year. However, the remaining four rates fell below the 50th Medicaid Quality Compass percentile, with three of those rates below the 25th percentile. Further, the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator rate demonstrated a statistically significant decline from the previous year. The *Controlling High Blood Pressure* performance measure rate also ranked below the 25th percentile. **McLaren Health Plan** was among the lowest-performing MHPs for the *Comprehensive Diabetes Care* and *Controlling High Blood Pressure* performance measures. These results indicate there are continued opportunities to promote proper diabetes

Performance Area	Overall Performance Impact
	management and blood pressure control. Additionally, the secret shopper survey identified multiple providers who could not be reached. Multiple providers also reported their location either did not offer services for the requested specialty, or offered the correct specialty but the provider was not affiliated with the location, demonstrating inaccurate information in the MHP's provider data and/or the online provider directory. Further, **McLaren Health Plan** was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for appropriate management of chronic conditions. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care. However, **McLaren Health Plan** demonstrated improvement in the *Kidney Health Evaluation for Patients With Diabetes* performance measure. The rate for one age subgroup ranked between the 50th and 74th Medicaid Quality Compass percentile. While the total rate and the rate for one age subgroup only ranked between the 25th and 50th Medicaid Quality Compass percentile, all reportable rates under this performance measure increased from the previous year, with two rates demonstrating statistically significant improvement. Additionally, **McLaren Health Plan** receive a *Met* score for element *3.10 CSHCS PCP Requirements* through the compliance review activity, demonstrating that the MHP had the necessary processes in place to ensure CSHCS members are assigned to a CSHCS-attested PCP who is willing to accept new CSHCS members with potentially complex chronic health conditions, regularly serve children or youth with complex chronic conditions, and has mechanisms to identify children or youth with chronic health conditions.
Health and Wellness of Women	**Quality**—The results of the PMV activity demonstrated that many sexually active women were being appropriately tested for chlamydia as indicated by *Chlamydia Screening in Women* performance measure rates that ranked between the 50th and 74th Medicaid Quality Compass percentile. Additionally, **McLaren Health Plan** received a *Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of the compliance review activity, demonstrating the MHP had the necessary processes in place to notify MDHHS and ensure pregnant women were eligible for dental services. However, the rates for the *Cervical Cancer Screening* and *Breast Cancer Screening* performance measures ranked between the 25th and 49th Medicaid Quality Compass percentile, indicating that many of **McLaren Health Plan**'s female members were not receiving recommended cervical cytology and/or high-risk HPV testing, or recommended mammograms. The rate for the *Breast Cancer Screening* performance measure also demonstrated a statistically significant decline from the previous year. Further, the secret shopper survey identified multiple providers, including OB/GYN providers, who could not be reached. Multiple providers also reported their location either did not offer services for the requested specialty, or offered the correct specialty but the provider was not affiliated with the location, demonstrating

Performance Area	Overall Performance Impact
	inaccurate information in the MHP's provider data and/or the online provider directory. Further, **McLaren Health Plan** was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for recommended women's health screenings.

Meridian Health Plan of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Meridian Health Plan of Michigan**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-53 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-53—Overall Validation Rating for MER

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities	*Met*	1. Improve the PPC-Timeliness of Prenatal Care rate for the Black (non-Hispanic) population residing in Region 6 in order to reduce the disparity to the comparison subgroup.	61.9%			Yes
		2. Maintain the performance of the HEDIS PPC-Timeliness of Prenatal Care performance result for eligible White (non-Hispanic) members residing in Region 6.	70.1%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Meridian Health Plan of Michigan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-54 displays the interventions, as available, initiated by the MHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-54—Baseline Interventions for MER

Intervention Descriptions	
Meridian's Member Services department outreaches to members due for HEDIS PPC-Timeliness of Prenatal Care services telephonically to provide education and awareness, and to offer care coordination assistance. The Member Services department ensures members connect to care by helping members locate providers, schedule appointments, and [arrange for] transportation when needed or requested by members.	Start Smart for Baby maternity case management program (SSFB). SSFB is an evidenced-based program that leverages advanced analytics to identify and engage members to improve obstetrical and pediatric care services, reduce pregnancy-related complications, premature deliveries, low birth weight deliveries, and infant disease.
Providers are incentivized for successful completion of HEDIS PPC Timeliness of Prenatal Care measure. Meridian publishes PPC HEDIS care gap reports and education to the providers for any members due for measure completion.	Meridian to incentivize members for self-reporting pregnancies to plan for care coordination and social determinants of health (SDOH) needs assessment.
Meridian to refer Region 6 pregnant members due for prenatal care visits to CHWs for intensive outreach and engagement.	Meridian to refer pregnant members to a group-based care program. Group prenatal care aims to educate women about pregnancy and childbirth in a group setting, with the goal of empowering patients to take control of their own health.
Meridian to offer a member gift card incentive to members due for prenatal care visits after the member satisfactorily meets measure compliance.	

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Meridian Health Plan of Michigan designed a methodologically sound PIP. The MHP collected and reported accurate performance indicator results using a systematic data collection process and conducted appropriate statistical testing between subgroups. [**Quality**]

Strength #2: Meridian Health Plan of Michigan used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. The MHP implemented timely interventions that were reasonably linked to the barriers. [**Quality**, **Timeliness**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **Meridian Health Plan of Michigan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.

Performance Measure Validation

Performance Results

Meridian Health Plan of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **Meridian Health Plan of Michigan** was fully compliant with all seven IS standards.

According to the auditor's review, **Meridian Health Plan of Michigan** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-55 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-37] for **Meridian Health Plan of Michigan**.

Table 3-55—HEDIS MY 2021 Performance Measure Results for MER

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.85%	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	61.93%	★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	58.18%	★★★
Ages 12 to 17 Years	49.86%	★★★
Ages 18 to 21 Years	27.39%	★★★
Total	50.75%	★★★

[3-37] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	55.97%	★★★
Ages 21 to 24 Years	64.36%	★★★
Total	59.89%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	56.83%	★★
Breast Cancer Screening		
Breast Cancer Screening	50.97%	★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	83.45%	★★★
*HbA1c Poor Control (>9.0%)**	52.07%	★
HbA1c Control (<8.0%)	40.63%	★★
Eye Exam (Retinal) Performed	51.34%	★★
Blood Pressure Control (<140/90 mm Hg)	55.72%	★★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	30.15%	★★★
Ages 65 to 74 Years	23.50%	★
Ages 75 to 85 Years	23.60%	★
Total	29.61%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	48.91%	★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2021 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Meridian Health Plan of Michigan demonstrated overall strength in its HEDIS data reporting, as **Meridian Health Plan of Michigan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-38] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, suggesting barriers exist for children to receive timely well-child visits.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

Weakness #2: Meridian Health Plan of Michigan's performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicator ranked below the 25th percentile, and the *HbA1c Control (<8.0%)* measure indicator ranked between the 25th percentile and 49th percentile, indicating that members with diabetes did not aways have controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-39] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicator ranked below the 25th percentile, and the rate for the *HbA1c Control (<8.0%)* measure indicator ranked between the 25th percentile and 49th percentile, suggesting barriers exist for members with diabetes to have controlled HbA1c levels.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have

[3-38] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

[3-39] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

controlled HbA1c levels. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators.

Weakness #3: Meridian Health Plan of Michigan's performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Ages 75 to 85 Years* measure indicators ranked below the 25th percentile, and the *Total* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-40] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Ages 75 to 85 Years* measure indicators ranked below the 25th percentile, and the *Total* measure indicator ranked between the 25th percentile and 49th percentile, suggesting that barriers exist for some members with diabetes to receive kidney health evaluations.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.

Weakness #4: Meridian Health Plan of Michigan's performance for the *Controlling High Blood Pressure* measure ranked below the 25th percentile, indicating that some members with a diagnosis of hypertension did not have controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-41] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Controlling High Blood Pressure* measure ranked below the 25th percentile, suggesting that barriers exist for members with a diagnosis of hypertension to have controlled blood pressure.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with hypertension did not have controlled blood pressure. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Controlling High Blood Pressure* measure.

Weakness #5: Meridian Health Plan of Michigan's performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer was one of the most common causes

[3-40] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Jan 30, 2023.

[3-41] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.

of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-42] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for women to be screened for cervical cancer.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure.

Weakness #6: Meridian Health Plan of Michigan's performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3-43] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some women to be screened for breast cancer.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure.

Weakness #7: Meridian Health Plan of Michigan's performance for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have an eye exam to screen or monitor for diabetic retinal disease. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-44] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some members with diabetes to have an eye exam to screen or monitor for diabetic retinal disease.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have an eye

3-42 National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2023.
3-43 National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.
3-44 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

exam performed. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator.

Weakness #8: Meridian Health Plan of Michigan's performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have controlled blood pressure. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-45] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked between the 25th percentile and 49th percentile, suggesting that barriers exist for some members with diabetes to have controlled blood pressure.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled blood pressure. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator.

Compliance Review

Performance Results

Table 3-56 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-56 also presents **Meridian Health Plan of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Meridian Health Plan of Michigan** was subject to a corrective action review process outlined in Appendix A.

Table 3-56—Compliance Review Results for MER

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	MER	Statewide[1]
1	Administrative	5	0	100%	95.6%
2	Providers	19	2	90%	88.9%
3	Members	24	2	92%	98.7%
4	Quality	21	0	100%	98.9%
5	MIS/Financial	33	3	92%	95.7%

[3-45] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	MER	Statewide[1]
6	OIG/Program Integrity	32	1	97%	96.3%
Overall		**134**	**8**	**94%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Meridian Health Plan of Michigan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Meridian Health Plan of Michigan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs, QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan scored below the statewide average in the Member standard. The MHP received a *Not Met* score for elements *3.3 Member Newsletters* and *3.26 Diversity, Equity, and Inclusion (DEI) Assessment and Training*. [**Quality** and **Access**]

Why the weakness exists: Meridian Health Plan of Michigan's member newsletters did not inform members how to obtain copies of the newsletters in culturally or linguistically appropriate options (e.g., in non-English languages or alternative formats). The MHP acknowledged that its newsletters did not meet the culturally responsive Medicaid contract requirement for member education. Additionally, **Meridian Health Plan of Michigan** did not submit any documentation related to the completion of a DEI organizational assessment, a plan for DEI and/or policies and procedures targeting DEI, or the completion of staff training on implicit bias.

Recommendation: As **Meridian Health Plan of Michigan** previously submitted a CAP to address element 3.3, which was approved by MDHHS, HSAG recommends **Meridian Health Plan of Michigan** ensure its CAP is fully implemented to mitigate the deficiencies. MDHHS did not require the MHP to submit a CAP to address element 3.26; therefore, HSAG recommends that **Meridian Health Plan of Michigan** develop an action plan to fully address MDHHS' DEI assessment and training requirements and ensure timely submission during future compliance reviews.

Weakness #2: Meridian Health Plan of Michigan scored below the statewide average in the MIS standard. The MHP received a *Not Met* score for elements *5.11 Claims Processing (Non-Pharmacy)* and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS* (the MHP was cited twice for element 5.15). [**Quality** and **Access**]

Why the weakness exists: Meridian Health Plan of Michigan did not have accurate calculations in all monthly claims processing reports. The MHP reported that inaccurate data were mistakenly entered when transferring information from the MHP's internal tracker to the report submitted to MDHHS. An additional error was also noted upon **Meridian Health Plan of Michigan**'s review, which occurred due to human error. Additionally, **Meridian Health Plan of Michigan** did not meet the 95 percent encounter data acceptance rate standard for several months and did not provide a sufficient remediation plan. The MHP identified several encounter error codes contributing to the issue.

Recommendation: As **Meridian Health Plan of Michigan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **Meridian Health Plan of Michigan** ensure its CAP is fully implemented to mitigate the deficiencies. However, while **Meridian Health Plan of Michigan**'s CAP was approved, MDHHS requested several CAP revisions and previously expressed concerns that the MHP had not made sufficient improvements. To further enhance the MHP's efforts to improve the accuracy and consistency of encounter data reported to MDHHS, HSAG recommends that **Meridian Health Plan of Michigan** use the results of future encounter data validation activities to determine whether additional processes should be implemented to enhance the accuracy of data reported to MDHHS.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 363 cases by comparing provider data that **Meridian Health Plan of Michigan** submitted to HSAG against **Meridian Health Plan of Michigan**'s online provider directory. The sample included 121 PCPs, 121 pediatric providers, and 121 OB/GYN providers (Table 3-57). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 91.2 percent (n=331) of the reviews. The sampled providers were not found in the online provider directory in 8.8 percent of the reviewed cases.

Table 3-57—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	121	108	89.3%	13	10.7%
Pediatric Providers	121	107	88.4%	14	11.6%
OB/GYN Providers	121	116	95.9%	5	4.1%
MER Total	**363**	**331**	**91.2%**	**32**	**8.8%**

Table 3-58 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Meridian Health Plan of Michigan**'s provider data submission to HSAG and **Meridian Health Plan of Michigan**'s online provider directory.

Table 3-58—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	107	99.1%	106	99.1%	116	100%	329	99.4%
Provider Address	101	93.5%	95	88.8%	105	90.5%	301	90.9%
Provider City	102	94.4%	99	92.5%	106	91.4%	307	92.7%
Provider State	102	94.4%	102	95.3%	107	92.2%	311	94.0%
Provider Zip Code	102	94.4%	100	93.5%	107	92.2%	309	93.4%
Provider Telephone Number	80	74.1%	68	63.6%	78	67.2%	226	68.3%
Provider Type/Specialty	98	90.7%	89	83.2%	105	90.5%	292	88.2%
Provider Gender	102	94.4%	102	95.3%	107	92.2%	311	94.0%
Provider Accepting New Patients	102	94.4%	102	95.3%	107	92.2%	311	94.0%
Non-English Language Speaking Provider (including American Sign Language)	86	79.6%	86	80.4%	78	67.2%	250	75.5%
Provider Primary Language	8	7.4%	17	15.9%	24	20.7%	49	14.8%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 220 sampled provider locations (i.e., "cases") for **Meridian Health Plan of Michigan**, with an overall response rate of 75.5 percent (n=166). Table 3-59 summarizes the secret shopper survey results for **Meridian Health Plan of Michigan**.

Table 3-59—Summary of MER Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	80	63	78.8%	45	71.4%	43	95.6%	31	72.1%	31	100%
Pediatric Providers	65	48	73.8%	30	62.5%	24	80.0%	21	87.5%	20	95.2%
OB/GYN Providers	75	55	73.3%	38	69.1%	30	78.9%	24	80.0%	24	100%
MER Total	**220**	**166**	**75.5%**	**113**	**68.1%**	**97**	**85.8%**	**76**	**78.4%**	**75**	**98.7%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-60 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Meridian Health Plan of Michigan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-60—Appointment Availability Results

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients[1] (%)	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	121	25	80.6%	19	15.7%	76.0%	3	107	37	15
Pediatric Providers	121	15	75.0%	10	8.3%	66.7%	1	114	23	8

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients[1] (%)	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
OB/GYN Providers	121	21	87.5%	14	11.6%	66.7%	3	48	16	12
MER Total	**363**	**61**	**81.3%**	**43**	**11.8%**	**70.5%**	**1**	**114**	**27**	**13**

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Of the 91.2 percent of providers that reviewers located in **Meridian Health Plan of Michigan**'s online provider directory, the provider name and address indicators had match rates above 90 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Overall, 8.8 percent of the sampled providers listed in **Meridian Health Plan of Michigan**'s provider data could not be located in **Meridian Health Plan of Michigan**'s online provider directory. Among the provider categories, 11.6 percent of pediatric providers, 10.7 percent of PCP providers, and 4.1 percent of OB/GYN providers could not be located in the online directory. [**Access**]

Why the weakness exists: **Meridian Health Plan of Michigan**'s provider data included invalid provider information.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Only 75.5 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **Meridian Health Plan of Michigan**'s provider data included invalid telephone information. While HSAG only contacted phone numbers matching the online provider directory, the PDV review indicated only 68.3 percent of **Meridian Health Plan of Michigan**'s phone numbers in the provider data aligned with the online directory.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #3: Of cases in which the survey respondent reported that the provider location accepted **Meridian Health Plan of Michigan**, MI Medicaid, and new patients, 70.5 percent of cases offered an appointment date. PCP provider locations had an appointment availability rate of 76.0 percent. Both pediatric and OB/GYN provider locations had an appointment availability rate of 66.7 percent. [**Access**]

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Meridian Health Plan of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-61 presents **Meridian Health Plan of Michigan**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-61—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for MER

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	61.7%	68.8%
Rating of All Health Care	49.6% ↓	68.7%
Rating of Personal Doctor	63.2%	74.0%
Rating of Specialist Seen Most Often	61.6%+	69.6%+
Composite Measures		
Getting Needed Care	79.2%+	85.1%
Getting Care Quickly	78.8%+	88.7%+
How Well Doctors Communicate	89.0%	95.4%
Customer Service	90.6%+	86.5%+
Individual Item Measure		
Coordination of Care	72.7%+ ↓	85.9%+
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	74.1%	
Discussing Cessation Medications	54.9%	
Discussing Cessation Strategies	46.0%	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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

Strengths

Strength #1: Meridian Health Plan of Michigan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA adult and child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan's 2022 top-box scores were statistically significantly lower than the 2021 NCQA adult Medicaid national averages for two measures: *Rating of All Health Care* and *Coordination of Care*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that **Meridian Health Plan of Michigan** members are reporting more negative experiences with their child's healthcare and coordination of care. While not specific to these measures, the MHP reported that it experienced a decrease in CAHPS response rates, which may provide less insight into member satisfaction with their healthcare and the MHP.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** focus on improving members' overall experiences with their healthcare and identifying the root cause of the poorer experiences with their coordination of care.

Performance Results—CSHCS

Table 3-62 presents **Meridian Health Plan of Michigan**'s 2022 CSHCS CAHPS survey top-box scores. The following measure could not be displayed in the table because this measure had fewer than 11 responses and was suppressed: *CSHCS Family Center*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-62—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for MER

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	65.6%
Rating of Health Care	71.7% NA
Rating of Specialist Seen Most Often	73.6%
Rating of CMDS Clinic	77.8%+ NA
Composite Measures	
Customer Service	85.8%+ ↓
How Well Doctors Communicate	95.2% NA
Access to Specialized Services	70.5%+ NA
Transportation	74.3%+ NA

	2022 Top-Box Score
Individual Item Measures	
Access to Prescription Medicines	88.7%
CMDS Clinic	77.1%+ NA
Local Health Department Services	78.6% NA
Not Felt Treated Unfairly: Race and Ethnicity	99.2% NA
Not Felt Treated Unfairly: Health Insurance Type	93.3% NA

* Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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

Strengths

Strength #1: Meridian Health Plan of Michigan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Customer Service*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that parents/caretakers of child members enrolled in **Meridian Health Plan of Michigan** may not be receiving the information or help needed or may be dissatisfied with the level of courtesy and respect offered by customer service staff members. While not specific to this measure, the MHP reported that it experienced a decrease in CAHPS response rates, which may provide less insight into member satisfaction with their healthcare and the MHP.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** explore drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **Meridian Health Plan of Michigan** should consider obtaining direct patient feedback from members to drill down into areas that need improvement.

Performance Results—HMP

Table 3-63 presents **Meridian Health Plan of Michigan**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-63—Summary of 2022 HMP CAHPS Top-Box Scores for MER

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	64.4%
Rating of All Health Care	53.4%
Rating of Personal Doctor	70.4%
Rating of Specialist Seen Most Often	58.5%+
Composite Measures	
Getting Needed Care	75.7%+ ↓
Getting Care Quickly	79.0%+
How Well Doctors Communicate	89.8%
Customer Service	90.0%+
Individual Item Measure	
Coordination of Care	75.0%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	76.4%
Discussing Cessation Medications	57.0%
Discussing Cessation Strategies	45.9%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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

Strengths

Strength #1: Meridian Health Plan of Michigan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan's 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Getting Needed Care*. [**Quality** and **Access**]

Why the weakness exists: When compared to national benchmarks, the results indicate that **Meridian Health Plan of Michigan**'s members are reporting more negative experiences with getting the care, tests, treatment, or specialist appointment they need. While not specific to this measure, the MHP reported that it experienced a decrease in CAHPS response rates, which may provide less insight into member satisfaction with their healthcare and the MHP.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** explore the drivers of this lower experience score and develop initiatives designed to improve members' quality of care. In addition, **Meridian Health Plan of Michigan** should identify any barriers to accessing healthcare (e.g., transportation, geography) and work toward removing these barriers, so members have better access to care.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **Meridian Health Plan of Michigan**'s performance.

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

HSAG performed a comprehensive assessment of **Meridian Health Plan of Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Meridian Health Plan of Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Meridian Health Plan of Michigan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-64 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to **Meridian Health Plan of Michigan**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-64—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **Meridian Health Plan of Michigan** identified through its data analysis a disparity between Black women and White women in the timeliness of prenatal care. **Meridian Health Plan of Michigan** designed a methodologically sound PIP and timely implemented interventions that were reasonably linked to their corresponding barriers and have the potential of reducing/eliminating the disparity. The interventions implemented through the PIP activity should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator rate; the rate for this measure ranked below the 25th Medicaid Quality Compass percentile. Further, as demonstrated through the compliance review activity, **Meridian Health Plan of Michigan** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare conditions and reduce disparities in care. **Meridian Health Plan of Michigan** also achieved full compliance in the Quality standard, indicating that it had a sufficient QAPI program in which various initiatives can be implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—**Meridian Health Plan of Michigan** demonstrated mixed results as it related to preventive services provided to children and adolescents. All four *Child and Adolescent Well-Care Visits* measure indicator rates ranked between the 50th and 74th Medicaid Quality Compass percentile and demonstrated a statistically significant improvement from the previous year. However, while the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator rate also ranked between the 50th and 74th Medicaid Quality Compass percentile, it demonstrated a statistically significant decline from the previous year. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator rate also demonstrated a statistically significant decline from the previous year and ranked below the 25th Medicaid Quality Compass percentile, demonstrating continued opportunities for improvement. Additionally, the secret shopper survey identified multiple providers, including pediatric providers, who were not located in **Meridian Health Plan of Michigan**'s online provider directory or could not be reached, demonstrating inaccurate information in the MHP's provider data and/or the online provider directory. Further, of the providers who could be reached and were accepting the MHP, Medicaid, and new

Performance Area	Overall Performance Impact
	patients, appointment availability rates were low. **Meridian Health Plan of Michigan** was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a pediatric provider for appropriate preventive care or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity confirmed several opportunities to enhance proper management of chronic conditions. While one indicator rate under the *Comprehensive Diabetes Care* performance measure ranked between the 50th and 74th Medicaid Quality Compass percentile, three rates ranked between the 25th and 49th percentile, and one rate ranked below the 25th percentile. Two of the five indicator rates under the *Comprehensive Diabetes Care* performance measure also demonstrated a statistically significant decline from the previous year. While one age subgroup rate under the *Kidney Health Evaluation for Patients With Diabetes* performance measure ranked between the 50th and 74th Medicaid Quality Compass percentile, the total rate ranked between the 25th and 49th percentile, and the two remaining age subgroups ranked below the 25th percentile. All indicator rates under the *Kidney Health Evaluation for Patients With Diabetes* performance measure demonstrated a statistically significant decline from the previous year. The rate for the *Controlling High Blood Pressure* performance measure also ranked below the 25the Medicaid Quality Compass percentile. These results suggest that some of **Meridian Health Plan of Michigan**'s members diagnosed with diabetes did not receive proper diabetes management or a kidney health evaluation, and some members diagnosed with hypertension did not have adequate blood pressure control. Additionally, the secret shopper survey identified multiple providers who were not located in **Meridian Health Plan of Michigan**'s online provider directory or could not be reached, demonstrating inaccurate information in the MHP's provider data and/or the online provider directory. Further, of the providers who could be reached and were accepting the MHP, Medicaid, and new patients, appointment availability rates were low. **Meridian Health Plan of Michigan** was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for management of chronic care conditions or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing care to manage chronic conditions.

Performance Area	Overall Performance Impact
Health and Wellness of Women	**Quality**—The results of the PMV activity demonstrated that many sexually active women were being appropriately tested for chlamydia as indicated by the *Chlamydia Screening in Women* measure indicator rates that ranked between the 50th and 74th Medicaid Quality Compass percentile. The *total* rate and the rate of one age subgroup also demonstrated a statistically significant improvement from the previous year. Additionally, **Meridian Health Plan of Michigan** received a *Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of the compliance review activity, demonstrating the MHP had the necessary processes in place to notify MDHHS and ensure pregnant women were eligible for dental services. However, the rates for the *Cervical Cancer Screening* and *Breast Cancer Screening* performance measures ranked between the 25th and 49th Medicaid Quality Compass percentile, indicating that many of **Meridian Health Plan of Michigan**'s female members were not receiving recommended cervical cytology and/or high-risk HPV testing, or recommended mammograms. The rates for the *Cervical Cancer Screening* and *Breast Cancer Screening* performance measures also demonstrated a statistically significant decline from the previous year. Further, the secret shopper survey identified multiple providers, including OB/GYN providers, who were not located in **Meridian Health Plan of Michigan**'s online provider directory or could not be reached, demonstrating inaccurate information in the MHP's provider data and/or the online provider directory. Further, of the providers who could be reached and were accepting the MHP, Medicaid, and new patients, appointment availability rates were low. **Meridian Health Plan of Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate an OB/GYN provider for appropriate women health screenings or may be experiencing other barriers in scheduling timely appointments.

Molina Healthcare of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Molina Healthcare of Michigan**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*).Table 3-65 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-65—Overall Validation Rating for MOL

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities for Timeliness of Prenatal Care	*Met*	1. Timeliness of Prenatal Care—Black	66.2%			Yes
		2. Timeliness of Prenatal Care—White	71.1%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Molina Healthcare of Michigan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-66 displays the interventions, as available, initiated by the MHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-66—Baseline Interventions for MOL

Intervention Descriptions
Molina Healthcare of Michigan had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina Healthcare of Michigan designed a methodologically sound PIP. The MHP collected and reported accurate performance indicator results using a systematic data collection process and conducted appropriate statistical testing for comparison between the two subgroups to determine a disparity. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although no weaknesses were identified, HSAG recommends **Molina Healthcare of Michigan** use appropriate causal/barrier analysis methods to identify barriers to care and implement interventions to address those barriers in a timely manner.

Performance Measure Validation

Performance Results

Molina Healthcare of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **Molina Healthcare of Michigan** was fully compliant with all seven IS standards.

According to the auditor's review, **Molina Healthcare of Michigan** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-67 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-46] for **Molina Healthcare of Michigan**.

Table 3-67—HEDIS MY 2021 Performance Measure Results for MOL

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	55.95%	★★★

[3-46] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.53%	★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	59.60%	★★★
Ages 12 to 17 Years	52.34%	★★★
Ages 18 to 21 Years	31.90%	★★★
Total	52.26%	★★★
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	62.05%	★★★★
Ages 21 to 24 Years	65.63%	★★★★
Total	63.67%	★★★★
Cervical Cancer Screening		
Cervical Cancer Screening	57.21%	★★
Breast Cancer Screening		
Breast Cancer Screening	51.37%	★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	87.10%	★★★★
*HbA1c Poor Control (>9.0%)**	39.90%	★★★
HbA1c Control (<8.0%)	51.82%	★★★★
Eye Exam (Retinal) Performed	57.18%	★★★
Blood Pressure Control (<140/90 mm Hg)	62.77%	★★★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	27.62%	★★
Ages 65 to 74 Years	30.61%	★★
Ages 75 to 85 Years	31.92%	★★
Total	27.91%	★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	55.96%	★★★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2021 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina Healthcare of Michigan's performance ranked between the 75th and 89th percentile for all *Chlamydia Screening in Women* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-47] [**Quality**]

Strength #2: Molina Healthcare of Michigan's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator, indicating members with diabetes were having an HbA1c test performed during the measurement year most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-48] [**Quality** and **Access**]

Strength #3: Molina Healthcare of Michigan's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Control—HbA1c Control (<8.0%)* measure indicator, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-49] [**Quality** and **Access**]

Strength #4: Molina Healthcare of Michigan demonstrated overall strength in its HEDIS data reporting, as **Molina Healthcare of Michigan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and

3-47 National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Jan 30, 2023.
3-48 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
3-49 Ibid.

development, and they are a critical opportunity for screening and counseling.[3-50] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, suggesting barriers exist for children to receive timely well-child visits.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

Weakness #2: Molina Healthcare of Michigan's performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer was one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-51] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for women to be screened for cervical cancer.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure.

Weakness #3: Molina Healthcare of Michigan's performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3-52] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some women to be screened for breast cancer.

3-50 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

3-51 National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2023.

3-52 National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure.

Weakness #4: Molina Healthcare of Michigan's performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-53] [**Quality** and **Access**]

Why the weakness exists: The rates for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked between the 25th percentile and 49th percentile, suggesting that barriers exist for some members with diabetes to receive kidney health evaluations.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.

Compliance Review

Performance Results

Table 3-68 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-68 also presents **Molina Healthcare of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Molina Healthcare of Michigan** was subject to a corrective action review process outlined in Appendix A.

Table 3-68—Compliance Review Results for MOL

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	MOL	Statewide[1]
1	Administrative	5	0	100%	95.6%
2	Providers	19	2	90%	88.9%
3	Members	26	0	100%	98.7%
4	Quality	21	0	100%	98.9%
5	MIS/Financial	34	2	94%	95.7%

[3-53] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Jan 30, 2023.

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	MOL	Statewide[1]
6	OIG/Program Integrity	32	1	97%	96.3%
Overall		**137**	**5**	**96%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina Healthcare of Michigan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Molina Healthcare of Michigan achieved full compliance in the Member standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; collaboration with LHDs for members with special health care needs, and care coordination; a fair grievance and appeal system; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Molina Healthcare of Michigan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs, QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan scored below the statewide average in the MIS standard. The MHP received a *Not Met* score for elements *5.8 Third Party Subrogation Requests* and *5.11 Claims Processing (Non-Pharmacy)*. [**Quality** and **Access**]

Why the weakness exists: **Molina Healthcare of Michigan** did not complete the claims processing forms as instructed and the MHP did not supply any reasoning for deviations identified in the individual reports.

Recommendation: As **Molina Healthcare of Michigan** previously submitted a CAP, or was on an existing CAP, to address these findings which were approved by MDHHS, HSAG recommends **Molina Healthcare of Michigan** ensure its CAP is fully implemented to mitigate the deficiencies.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 324 cases by comparing provider data that **Molina Healthcare of Michigan** submitted to HSAG against **Molina Healthcare of Michigan**'s online provider directory. The sample included 108 PCPs, 108 pediatric providers, and 108 OB/GYN providers (Table 3-69). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 96.3 percent (n=312) of the reviews. The sampled providers were not found in the online provider directory in 3.7 percent of the reviewed cases.

Table 3-69—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	108	105	97.2%	3	2.8%
Pediatric Providers	108	101	93.5%	7	6.5%
OB/GYN Providers	108	106	98.1%	2	1.9%
MOL Total	**324**	**312**	**96.3%**	**12**	**3.7%**

Table 3-70 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Molina Healthcare of Michigan**'s provider data submission to HSAG and **Molina Healthcare of Michigan**'s online provider directory.

Table 3-70—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	105	100%	101	100%	106	100%	312	100%
Provider Address	103	98.1%	97	96.0%	104	98.1%	304	97.4%

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider City	104	99.0%	97	96.0%	103	97.2%	304	97.4%
Provider State	104	99.0%	97	96.0%	104	98.1%	305	97.8%
Provider Zip Code	104	99.0%	97	96.0%	104	98.1%	305	97.8%
Provider Telephone Number	104	99.0%	96	95.0%	99	93.4%	299	95.8%
Provider Type/Specialty	101	96.2%	96	95.0%	104	98.1%	301	96.5%
Provider Gender	98	93.3%	97	96.0%	62	58.5%	257	82.4%
Provider Accepting New Patients	98	93.3%	94	93.1%	100	94.3%	292	93.6%
Non-English Language Speaking Provider (including American Sign Language)	103	98.1%	97	96.0%	103	97.2%	303	97.1%
Provider Primary Language	103	98.1%	97	96.0%	104	98.1%	304	97.4%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 285 sampled provider locations (i.e., "cases") for **Molina Healthcare of Michigan**, with an overall response rate of 68.4 percent (n=195). Table 3-71 summarizes the secret shopper survey results for **Molina Healthcare of Michigan**.

Table 3-71—Summary of MOL Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	97	64	66.0%	34	53.1%	27	79.4%	19	70.4%	19	100%
Pediatric Providers	94	76	80.9%	50	65.8%	33	66.0%	30	90.9%	30	100%
OB/GYN Providers	94	55	58.5%	16	29.1%	8	50.0%	7	87.5%	7	100%
MOL Total	**285**	**195**	**68.4%**	**100**	**51.3%**	**68**	**68.0%**	**56**	**82.4%**	**56**	**100%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-72 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Molina Healthcare of Michigan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-72—Appointment Availability Results

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients[1] (%)	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	108	19	100%	14	13.0%	73.7%	0	118	21	13
Pediatric Providers	108	27	90.0%	24	22.2%	88.9%	0	88	22	13
OB/GYN Providers	108	7	100%	0	0.0%	0.0%	NA*	NA*	NA*	NA*
MOL Total	**324**	**53**	**94.6%**	**38**	**11.7%**	**71.7%**	**0**	**118**	**22**	**13**

[1] The denominator includes cases responding to the survey that accept the MHP and MI Medicaid.
[2] The denominator includes all cases included in the sample.
[3] The denominator includes cases responding to the survey that accept the MHP, accept MI Medicaid, and accept new patients.
* NA indicates no appointment dates were offered by the office staff.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Of the 96.3 percent of providers that reviewers located in **Molina Healthcare of Michigan**'s online provider directory, the provider's name, address, and telephone indicators had match rates above 95 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 68.4 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **Molina Healthcare of Michigan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Only 51.3 percent of the responsive cases reported that the location offered services for the requested specialty. Among these cases, 65.8 percent of the pediatric provider locations offered the specialty services indicated in the online provider directory, 53.1 percent of the PCP provider locations offered the requested specialty services, and 29.1 percent of OB/GYN provider locations offered the requested specialty services. [**Access**]

Why the weakness exists: **Molina Healthcare of Michigan**'s provider data matched the online provider directory; however, the directory information was not confirmed by the provider's office staff members. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory as it relates to the location's specialty.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect specialty information) to address the provider data deficiencies.

Weakness #3: Of cases in which the survey respondent reported that the provider location accepted **Molina Healthcare of Michigan**, MI Medicaid, and new patients, 71.7 percent of cases offered the caller an appointment date. [**Access**]

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations. Additionally, the low rate of locations offering OB/GYN services (i.e., 29.1 percent) inhibited the callers' ability to survey appointment availability, with only seven OB/GYN cases reaching the appointment availability question within the survey.

Recommendation: In addition to using the case-level analytic data files to correct provider data deficiencies, HSAG recommends that **Molina Healthcare of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Molina Healthcare of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-73 presents **Molina Healthcare of Michigan**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-73—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for MOL

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	62.0%	63.3% ↓
Rating of All Health Care	55.7%	65.9% ↓
Rating of Personal Doctor	64.7%	68.5% ↓
Rating of Specialist Seen Most Often	67.0%	57.4%+ ↓
Composite Measures		
Getting Needed Care	87.0%	83.7%+
Getting Care Quickly	83.8%	87.3%+
How Well Doctors Communicate	88.6%	94.6%
Customer Service	94.9%+ ↑	93.3%+
Individual Item Measure		
Coordination of Care	83.8%+	81.5%+
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	79.0%	
Discussing Cessation Medications	61.8% ↑	
Discussing Cessation Strategies	54.8% ↑	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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

Strengths

Strength #1: Molina Healthcare of Michigan's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult and child Medicaid national averages for three measures: *Customer Service*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often.* [**Quality**]

Why the weakness exists: When compared to national benchmarks, parents/caretakers of child members enrolled in **Molina Healthcare of Michigan** had less positive overall experiences with their child's health plan, health care, personal doctor, and specialist. The MHP reported that its CAHPS report is reviewed by the CAHPS Taskforce to identify low-performing measures, rate trends, and to identify the questions that are the key drivers for impacting the rate. This information is used to develop initiatives to improve the rate of each key driver question. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting key drivers for these measures based on the information provided through this EQR.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** continue to explore what may be impacting the drivers of these lower experience scores, develop initiatives designed to improve quality of care, and focus on improving members' overall experiences with their healthcare. **Molina Healthcare of Michigan** should determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the plan that could be contributing to a lack of network adequacy and access issues.

Performance Results—CSHCS

Table 3-74 presents **Molina Healthcare of Michigan**'s 2022 CSHCS CAHPS survey top-box scores. The following measure could not be displayed in the table because the measure had fewer than 11 responses and was suppressed: *CSHCS Family Services*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-74—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for MOL

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	64.2%
Rating of Health Care	69.2% NA
Rating of Specialist Seen Most Often	68.8%
Rating of CMDS Clinic	81.0%+ NA
Composite Measures	
Customer Service	86.1%+
How Well Doctors Communicate	93.4% NA
Access to Specialized Services	73.4%+ NA
Transportation	82.4%+ NA
Individual Item Measures	
Access to Prescription Medicines	92.0%
CMDS Clinic	87.2%+ NA
Local Health Department Services	76.6%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	95.8% NA
Not Felt Treated Unfairly: Health Insurance Type	95.8% NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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

Strengths

Strength #1: Molina Healthcare of Michigan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-75 presents **Molina Healthcare of Michigan**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-75—Summary of 2022 HMP CAHPS Top-Box Scores for MOL

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	67.0%
Rating of All Health Care	58.3%
Rating of Personal Doctor	71.2%
Rating of Specialist Seen Most Often	68.8%+
Composite Measures	
Getting Needed Care	76.9%+ ↓
Getting Care Quickly	80.5%+
How Well Doctors Communicate	91.2%
Customer Service	81.7%+
Individual Item Measure	
Coordination of Care	82.8%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	82.1% ↑

	2022 Top-Box Score
Discussing Cessation Medications	58.8%
Discussing Cessation Strategies	48.3%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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: Molina Healthcare of Michigan's 2022 top-box score was statistically significantly higher than the 2021 NCQA adult Medicaid national average for one measure, *Advising Smokers and Tobacco Users to Quit*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan's 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Getting Needed Care*. [**Quality** and **Access**]

Why the weakness exists: When compared to national benchmarks, the results indicate that **Molina Healthcare of Michigan**'s members are reporting more negative experiences with getting the care, tests, treatment, and specialist appointments they need. In addition to the review of the quarterly PMRs for the reported rate of each measure, the MHP runs monthly internal reports which provide up-to-date monitoring of each measure. Each measure is assigned to the appropriate MHP department to develop initiatives to improve the rate and provide monthly updates to the workgroup which oversees the performance of the HMP measures. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting key drivers for these measures based on the information provided through this EQR.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** continue to explore what may be the drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **Molina Healthcare of Michigan** should identify any barriers to accessing healthcare (e.g., transportation, geography) and work toward removing these barriers, so members have better access to care.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **Molina Healthcare of Michigan**'s performance.

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

HSAG performed a comprehensive assessment of **Molina Healthcare of Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Molina Healthcare of Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Molina Healthcare of Michigan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-76 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to **Molina Healthcare of Michigan**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-76—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **Molina Healthcare of Michigan** identified through its data analysis a disparity between Black women and White women in the timeliness of prenatal care. While **Molina Healthcare of Michigan** designed a methodologically sound PIP, the MHP had not yet progressed to initiating interventions. Future interventions implemented through the PIP activity have the potential to reduce/eliminate the disparity. Future interventions should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator rate, which ranked below the 25th Medicaid Quality Compass percentile. Further, as demonstrated through the compliance review activity, **Molina Healthcare of Michigan** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare conditions and reduce disparities in care. **Molina Healthcare of Michigan** also achieved full compliance in the Quality standard, indicating that it had a sufficient

Performance Area	Overall Performance Impact
	QAPI program in which various initiatives can be implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—**Molina Healthcare of Michigan** demonstrated mixed results related to preventive services provided to children and adolescents. All *Child and Adolescent Well-Care Visits* measure indicator rates ranked between the 50th and 74th Medicaid Quality Compass percentile and demonstrated a statistically significant improvement from the previous year. However, while the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator rate also ranked between the 50th and 74th Medicaid Quality Compass percentile, it demonstrated a statistically significant decline from the previous year. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rate also demonstrated a statistically significant decline from the prior year and ranked below the 25th Medicaid Quality Compass percentile, demonstrating continued opportunities for improvement. Additionally, the secret shopper survey identified multiple providers, including pediatric providers, who could not be reached or reported that the location did not offer the requested specialty, demonstrating inaccurate information in **Molina Healthcare of Michigan**'s provider data and/or the online provider directory. Further, of the providers who could be reached and were accepting the MHP, Medicaid, and new patients, appointment availability rates were low, including the rate for pediatric provider types. **Molina Healthcare of Michigan** was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a pediatric provider for appropriate preventive care or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity demonstrated mixed results as it related to the management of chronic conditions. Three of the five indicator rates under the *Comprehensive Diabetes Care* performance measure ranked between the 50th and 74th Medicaid Quality Compass percentile, and the two remaining rates ranked between the 74th and 89th percentile with one of these rates demonstrating a statistically significant improvement from the previous year. The *Controlling High Blood Pressure* performance measure rate also ranked between the 50th and 74th Medicaid Quality Compass percentile. These results indicate that many of **Molina Healthcare of Michigan**'s members diagnosed with diabetes are receiving appropriate diabetes management and that many members diagnosed with hypertension have their blood pressure controlled. However, all *Kidney Health Evaluation for Patients With Diabetes* measure indicator rates ranked between the 25th and 49th Medicaid Quality Compass percentile,

Performance Area	Overall Performance Impact
	with two rates demonstrating a statistically significant decline from the previous year, suggesting that many of **Molina Healthcare of Michigan**'s members diagnosed with diabetes did not receive the recommended testing for kidney disease. Additionally, the secret shopper survey identified multiple providers who could not be reached, or reported that the location did not offer the requested specialty, demonstrating inaccurate information in **Molina Healthcare of Michigan**'s provider data and/or the online provider directory. Further, of the providers who could be reached and were accepting the MHP, Medicaid, and new patients, appointment availability rates were low. **Molina Healthcare of Michigan** was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for proper management of chronic conditions or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing services.
Health and Wellness of Women	**Quality**—The results of the PMV activity demonstrated that many sexually active women were being appropriately tested for chlamydia as indicated by *Chlamydia Screening in Women* measure indicator rates that ranked between the 75th and 89th Medicaid Quality Compass percentile. The total rate and the rate of one age subgroup also demonstrated a statistically significant improvement from the previous year. Additionally, **Molina Healthcare of Michigan** received a *Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of the compliance review activity, demonstrating the MHP had the necessary processes in place to notify MDHHS and ensure pregnant women were eligible for dental services. However, the rates for the *Cervical Cancer Screening* and *Breast Cancer Screening* performance measures ranked between the 25th and 49th Medicaid Quality Compass percentile, indicating that many of **Molina Healthcare of Michigan**'s female members were not receiving recommended cervical cytology and/or high-risk HPV testing, or recommended mammograms. The rate for the *Cervical Cancer Screening* and *Breast Cancer Screening* performance measures also demonstrated a statistically significant decline from the previous year. Further, the secret shopper survey identified multiple providers, including OB/GYN providers, who could not be reached or reported that the location did not offer the requested specialty, demonstrating inaccurate information in **Molina Healthcare of Michigan**'s provider data and/or the online provider directory. Further, of the providers who could be reached and were accepting the MHP, Medicaid, and new patients, appointment availability rates were low. **Molina Healthcare of Michigan** was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for proper management of women's health or may be experiencing other barriers in scheduling timely appointments.

Priority Health Choice

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Priority Health Choice**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-77 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-77—Overall Validation Rating for PRI

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Improving Timeliness of Prenatal Care for African-American Women	*Met*	1. The percentage of African-American women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health.	69.4%			Yes
		2. The percentage of Caucasian women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health.	86.1%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Priority Health Choice**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-American women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (Caucasian women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-78 displays the interventions, as available, initiated by the MHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-78—Baseline Interventions for PRI

Intervention Descriptions
Priority Health Choice had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Priority Health Choice designed a methodologically sound PIP. The MHP collected and reported accurate performance indicator results using a systematic data collection process and conducted appropriate statistical testing for comparison between subgroups. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **Priority Health Choice** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.

Performance Measure Validation

Performance Results

Priority Health Choice was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **Priority Health Choice** was fully compliant with all seven IS standards.

According to the auditor's review, **Priority Health Choice** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-79 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-54] for **Priority Health Choice**.

Table 3-79—HEDIS MY 2021 Performance Measure Results for PRI

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	59.18%	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	65.58%	★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	60.53%	★★★★
Ages 12 to 17 Years	51.89%	★★★
Ages 18 to 21 Years	30.06%	★★★
Total	52.67%	★★★
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	60.52%	★★★★
Ages 21 to 24 Years	66.59%	★★★★
Total	63.39%	★★★★
Cervical Cancer Screening		
Cervical Cancer Screening	63.99%	★★★★
Breast Cancer Screening		
Breast Cancer Screening	56.52%	★★★

[3-54] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	86.37%	★★★★
*HbA1c Poor Control (>9.0%)**	34.31%	★★★★
HbA1c Control (<8.0%)	55.72%	★★★★★
Eye Exam (Retinal) Performed	61.31%	★★★★
Blood Pressure Control (<140/90 mm Hg)	69.59%	★★★★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	34.91%	★★★
Ages 65 to 74 Years	34.09%	★★★
Ages 75 to 85 Years	29.77%	★★
Total	34.79%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	66.42%	★★★★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2021 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Priority Health Choice's performance ranked between the 75th and 89th percentile for the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years* measure indicator, indicating children ages 3 to 11 years were receiving one or more well-child visit during the measurement year most of the time. Well-care visits provide an opportunity for providers to influence health and

development, and they are a critical opportunity for screening and counseling.[3-55] [**Quality**, **Timeliness**, and **Access**]

Strength #2: Priority Health Choice's performance ranked between the 75th and 89th percentile for all *Chlamydia Screening in Women* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-56] [**Quality**]

Strength #3: Priority Health Choice's performance ranked between the 75th and 89th percentile for the *Cervical Cancer Screening* measure indicator, indicating women were being screened for cervical cancer most of the time. Cervical cancer was one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-57] [**Quality** and **Access**]

Strength #4: Priority Health Choice's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator, indicating members with diabetes were having an HbA1c test performed during the measurement year most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-58] [**Quality** and **Access**]

Strength #5: Priority Health Choice's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Control—HbA1c Poor Control (>9.0%)* measure indicator, and at or above the 90th percentile for the *HbA1c Control (<8.0%)* measure indicator, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-59] [**Quality** and **Access**]

Strength #6: Priority Health Choice's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator, indicating that members with diabetes had an eye exam to screen or monitor for diabetic retinal disease most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-60] [**Quality** and **Access**]

[3-55] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.
[3-56] National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Jan 30, 2023.
[3-57] National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2023.
[3-58] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
[3-59] Ibid.
[3-60] Ibid.

Strength #7: Priority Health Choice's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator, indicating that members with diabetes had controlled blood pressure most of the time. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-61] [**Quality** and **Access**]

Strength #8: Priority Health Choice's performance ranked between the 75th and 89th percentile for the *Controlling High Blood Pressure* measure, indicating that members with a diagnosis of hypertension had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-62] [**Quality** and **Access**]

Strength #9: Priority Health Choice demonstrated overall strength in its HEDIS data reporting, as **Priority Health Choice** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Priority Health Choice's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-63] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, suggesting barriers exist for children to receive timely well-child visits.

Recommendation: HSAG recommends that **Priority Health Choice** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Priority Health Choice** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

3-61 Ibid.
3-62 National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.
3-63 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

Weakness #2: Priority Health Choice's performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-64] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator ranked between the 25th percentile and 49th percentile, suggesting that barriers exist for some members with diabetes to receive kidney health evaluations.

Recommendation: HSAG recommends that **Priority Health Choice** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Priority Health Choice** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.

Compliance Review

Performance Results

Table 3-80 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-80 also presents **Priority Health Choice**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Priority Health Choice** was subject to a corrective action review process outlined in Appendix A.

Table 3-80—Compliance Review Results for PRI

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	PRI	Statewide[1]
1	Administrative	5	0	100%	95.6%
2	Providers	19	2	90%	88.9%
3	Members	25	1	96%	98.7%
4	Quality	21	0	100%	98.9%
5	MIS/Financial	36	0	100%	95.7%
6	OIG/Program Integrity	32	1	97%	96.3%
Overall		**138**	**4**	**97%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

[3-64] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Jan 30, 2023.

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: Priority Health Choice achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Priority Health Choice achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs, QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Strength #3 Priority Health Choice achieved full compliance in the MIS standard, demonstrating the MHP maintained an HIS that collected, analyzed, integrated, and reported data in various program areas and functions, including but not limited to, provider data; member enrollment and disenrollment; financial statements and reports; third-party recovery and subrogation requests; the common formulary; provider enrollment; claims payment; grievance and appeal tracking; and quality reporting. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Priority Health Choice scored below the statewide average in the Member standard. The MHP received a *Not Met* score for element *3.12 Pregnant Women Dental Policies and Procedures*. [**Quality** and **Access**]

Why the weakness exists: Priority Health Choice did not update its policy to specify that dental benefits will continue until the last day of the 12th calendar month after the end of the member's pregnancy. **Priority Health Choice** indicated that it had operationalized this eligibility change as directed by MDHHS but was unable to update its policy due to the receipt of the updated compliance review timeline occurring on the same day as the MHP's compliance review documentation submission. However, **Priority Health Choice** was initially notified of the required policy change 45 days prior to the compliance review documentation submission due date, which was sufficient time for the MHP to update policy to reflect the change.

Recommendation: As **Priority Health Choice** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **Priority Health Choice** ensure its CAP is fully implemented to mitigate the deficiencies.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 324 cases by comparing provider data that **Priority Health Choice** submitted to HSAG against **Priority Health Choice**'s online provider directory. The sample included 108 PCPs, 108 pediatric providers, and 108 OB/GYN providers (Table 3-81). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 94.4 percent (n=306) of the reviews. The sampled providers were not found in the online provider directory in 5.6 percent of the reviewed cases.

Table 3-81—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	108	102	94.4%	6	5.6%
Pediatric Providers	108	102	94.4%	6	5.6%
OB/GYN Providers	108	102	94.4%	6	5.6%
PRI Total	**324**	**306**	**94.4%**	**18**	**5.6%**

Table 3-82 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Priority Health Choice**'s provider data submission to HSAG and **Priority Health Choice**'s online provider directory.

Table 3-82—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	101	99.0%	102	100%	101	99.0%	304	99.3%
Provider Address	98	96.1%	98	96.1%	99	97.1%	295	96.4%
Provider City	98	96.1%	96	94.1%	99	97.1%	293	95.8%
Provider State	98	96.1%	98	96.1%	100	98.0%	296	96.7%
Provider Zip Code	98	96.1%	98	96.1%	100	98.0%	296	96.7%
Provider Telephone Number	55	53.9%	71	69.6%	59	57.8%	185	60.5%
Provider Type/Specialty	97	95.1%	95	93.1%	99	97.1%	291	95.1%

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider Gender	98	96.1%	98	96.1%	100	98.0%	296	96.7%
Provider Accepting New Patients	98	96.1%	98	96.1%	100	98.0%	296	96.7%
Non-English Language Speaking Provider (including American Sign Language)	95	93.1%	95	93.1%	100	98.0%	290	94.8%
Provider Primary Language	98	96.1%	97	95.1%	100	98.0%	295	96.4%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 182 sampled provider locations (i.e., "cases") for **Priority Health Choice**, with an overall response rate of 52.7 percent (n=96). Table 3-83 summarizes the secret shopper survey results for **Priority Health Choice**.

Table 3-83—Summary of PRI Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	55	28	50.9%	22	78.6%	19	86.4%	18	94.7%	12	66.7%
Pediatric Providers	69	32	46.4%	17	53.1%	10	58.8%	6	60.0%	4	66.7%
OB/GYN Providers	58	36	62.1%	16	44.4%	8	50.0%	5	62.5%	5	100%
PRI Total	**182**	**96**	**52.7%**	**55**	**57.3%**	**37**	**67.3%**	**29**	**78.4%**	**21**	**72.4%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-84 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Priority Health Choice**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-84—Appointment Availability Results

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients[1] (%)	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	108	11	91.7%	10	9.3%	90.9%	1	70	27	18
Pediatric Providers	108	3	75.0%	2	1.9%	66.7%	0	8	4	4
OB/GYN Providers	108	5	100%	3	2.8%	60.0%	13	14	14	14
PRI Total	**324**	**19**	**90.5%**	**15**	**4.6%**	**78.9%**	**0**	**70**	**22**	**14**

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Of the 94.4 percent of providers that reviewers located in **Priority Health Choice**'s online provider directory, the provider's name and address indicators had match rates over 95 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 60.5 percent of the sampled provider locations had a matching telephone number when conducting the PDV component of the NVS. [**Quality** and **Access**]

Why the weakness exists: **Priority Health Choice**'s provider data included invalid telephone information.

Recommendation: HSAG recommends that **Priority Health Choice** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Only 52.7 percent of the sampled provider locations were able to be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **Priority Health Choice**'s provider data included invalid telephone information. While HSAG only contacted locations with matching phone numbers in the online provider directory, the PDV review indicated only 60.5 percent of **Priority Health Choice**'s provider phone numbers provided in the provider data were a match to the online directory.

Recommendation: HSAG recommends that **Priority Health Choice** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #3: Of cases reached, only 57.3 percent indicated the office provided the specialty services requested. [**Access**]

Why the weakness exists: **Priority Health Choice**'s provider data included invalid specialty information.

Recommendation: HSAG recommends that **Priority Health Choice** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty information) to address the provider data deficiencies.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-85 presents **Priority Health Choice**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-85—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for PRI

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	66.7%	70.7%
Rating of All Health Care	61.8%	73.0%
Rating of Personal Doctor	65.5%	78.0%
Rating of Specialist Seen Most Often	75.5%	72.5%+
Composite Measures		
Getting Needed Care	84.8%	86.6%+
Getting Care Quickly	85.8%	89.6%+
How Well Doctors Communicate	92.9%	95.3%
Customer Service	90.4%+	86.8%+
Individual Item Measure		
Coordination of Care	92.1%+ ↑	87.8%+
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	76.9%	
Discussing Cessation Medications	49.4%	
Discussing Cessation Strategies	44.7%	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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

Strengths

Strength #1: Priority Health Choice's 2022 top-box score was statistically significantly higher than the 2021 NCQA adult Medicaid national average for one measure, *Coordination of Care*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Priority Health Choice's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult or child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Priority Health Choice** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-86 presents **Priority Health Choice**'s 2022 CSHCS CAHPS survey top-box scores. The following measure could not be displayed in the table because this measure had fewer than 11 responses and was suppressed: *CSHCS Family Center*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-86—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for PRI

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	73.1%
Rating of Health Care	72.2% NA
Rating of Specialist Seen Most Often	78.1%
Rating of CMDS Clinic	88.0%+ NA
Composite Measures	
Customer Service	98.0%+ ↑
How Well Doctors Communicate	96.3% NA
Access to Specialized Services	70.2%+ NA
Transportation	87.1%+ NA
Individual Item Measures	
Access to Prescription Medicines	93.4%
CMDS Clinic	96.0%+ NA
Local Health Department Services	78.8%+ NA

	2022 Top-Box Score
Not Felt Treated Unfairly: Race and Ethnicity	97.2% NA
Not Felt Treated Unfairly: Health Insurance Type	96.0% NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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

Strengths

Strength #1: Priority Health Choice's 2022 top-box score was statistically significantly higher than the 2021 NCQA child Medicaid national average for one measure, *Customer Service*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Priority Health Choice's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Priority Health Choice** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-87 presents **Priority Health Choice**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-87—Summary of 2022 HMP CAHPS Top-Box Scores for PRI

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	59.9%
Rating of All Health Care	57.1%
Rating of Personal Doctor	67.4%

	2022 Top-Box Score
Rating of Specialist Seen Most Often	69.8%+
Composite Measures	
Getting Needed Care	83.7%
Getting Care Quickly	80.1%
How Well Doctors Communicate	91.6%
Customer Service	83.8%+
Individual Item Measure	
Coordination of Care	86.7%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	75.7%
Discussing Cessation Medications	56.8%
Discussing Cessation Strategies	47.9%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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

Strengths

Strength #1: Priority Health Choice's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Priority Health Choice's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Priority Health Choice** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **Priority Health Choice**'s performance.

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

HSAG performed a comprehensive assessment of **Priority Health Choice**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Priority Health Choice** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Priority Health Choice**'s overall performance contributed to the CHCP'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 healthcare services provided to **Priority Health Choice**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-88—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **Priority Health Choice** identified through its data analysis a disparity between African-American women and Caucasian women in the timeliness of prenatal care. While **Priority Health Choice** designed a methodologically sound PIP, the MHP had not yet progressed to initiating interventions. Future interventions implemented through the PIP activity have the potential to reduce/eliminate the disparity. Future interventions should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator rate, which ranked between the 25th and 49th Medicaid Quality Compass percentile and demonstrated a statistically significant decline from the previous year. Further, as demonstrated through the compliance review activity, **Priority Health Choice** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare conditions and reduce disparities in care. **Priority Health Choice** also achieved full compliance in the Quality standard, indicating that it had a sufficient QAPI program in which various initiatives can be

Performance Area	Overall Performance Impact
	implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—**Priority Health Choice Michigan** demonstrated strengths of its program related to preventive services provided to children and adolescents. The total rate and the rates for two age subgroups for the *Child and Adolescent Well-Care Visits* performance measure ranked between the 50th and 74th Medicaid Quality Compass percentile, and the remaining age subgroup ranked between the 75th and 89th percentile. The total rate and the rates for two age subgroups also demonstrated a statistically significant improvement from the previous year. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator rate also ranked between the 50th and 74th Medicaid Quality Compass percentile; however, it demonstrated a statistically significant decline from the previous year. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator rate also demonstrated a statistically significant decline from the prior year and ranked below the 25th Medicaid Quality Compass percentile, demonstrating continued opportunities for improvement. Additionally, the secret shopper survey identified multiple providers, including pediatric providers, who could not be reached or reported that the location did not offer the requested specialty, demonstrating inaccurate information in **Priority Health Choice Michigan**'s provider data and/or the online provider directory. **Priority Health Choice Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a pediatric provider for appropriate preventive care. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity demonstrated strong performance as it related to the management of diabetes and hypertension. Four of the five indicator rates under the *Comprehensive Diabetes Care* performance measure ranked between the 75th and 89th Medicaid Quality Compass percentile, and the remaining indicator rate ranked above the 90th percentile. The *Controlling High Blood Pressure* performance measure rate also ranked between the 75th and 89th Medicaid Quality Compass percentile. These results indicate that many of **Priority Health Choice Michigan**'s members diagnosed with diabetes are receiving appropriate diabetes management and that many members diagnosed with hypertension have their blood pressure controlled. While the rate for one age subgroup under the *Kidney Health Evaluation for Patients With Diabetes* performance measure ranked between the 25th and 49th Medicaid Quality Compass percentile, the total rate and the rates for the remaining two age subgroups ranked between the 50th and 74th percentile. Overall, when compared to national percentiles, **Priority Health Choice Michigan**

Performance Area	Overall Performance Impact
	performed well in these measures. However, it should be noted that the rates for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator, *Controlling High Blood Pressure* performance measure, and the total rate and the rate for one age subgroup under the *Kidney Health Evaluation for Patients With Diabetes* performance measure demonstrated a statistically significant decline from the previous year. Additionally, the secret shopper survey identified multiple providers who could not be reached or reported that the location did not offer the requested specialty, demonstrating inaccurate information in **Priority Health Choice Michigan**'s provider data and/or the online provider directory. **Priority Health Choice Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for proper management of chronic conditions. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing care to manage chronic conditions.
Health and Wellness of Women	**Quality**—The results of the PMV activity demonstrated that many sexually active women were being appropriately tested for chlamydia and many women members were receiving recommended cervical cytology and/or high-risk HPV testing or recommended mammograms as indicated by *Chlamydia Screening in Women* and *Cervical Cancer Screening* performance measure rates that ranked between the 75th and 89th Medicaid Quality Compass percentile. The total rate and the rate of one age subgroup under the *Chlamydia Screening in Women* performance measure also demonstrated a statistically significant improvement from the previous year. While the *Breast Cancer Screening* performance measure rate ranked between the 50th and 75th Medicaid Quality Compass percentile, the rate demonstrated a statistically significant decline from the prior year, demonstrating continued opportunities to ensure **Priority Health Choice Michigan**'s female measures continue to receive recommended mammograms. Additionally, **Priority Health Choice Michigan** received a *Not Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of the compliance review activity. While the MHP operationalized eligibility changes of dental benefits for pregnant women, its policies and procedures did not reflect these updates. Further, the secret shopper survey identified multiple providers, including OB/GYN providers, who could not be reached or reported that the location did not offer the requested specialty, demonstrating inaccurate information in **Priority Health Choice Michigan**'s provider data and/or the online provider directory. **Priority Health Choice Michigan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate an OB/GYN provider for recommended women's health screenings.

UnitedHealthcare Community Plan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **UnitedHealthcare Community Plan**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-89 displays the overall validation status and the baseline results for the performance indicator. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-89—Overall Validation Rating for UNI

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Addressing Disparities in Timeliness of Prenatal Care	*Met*	Timeliness of prenatal care for African-American/Black members in Region 10	61.5%		

R1 = Remeasurement 1
R2 = Remeasurement 2

Due to its lack of an identified disparity, **UnitedHealthcare Community Plan** determined through data analysis that the focus for the PIP should be improving timeliness of prenatal care for its African-American/Black members who reside in Region 10, as this population was the lowest-performing subgroup. The overall goal is to achieve statistically significant improvement over the baseline performance for the subsequent remeasurement periods or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-90 displays the interventions initiated, as available, by the MHP to support achievement of the PIP goal and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-90—Baseline Interventions for UNI

Intervention Descriptions
UnitedHealthcare Community Plan had not progressed to initiating improvement strategies and interventions for the PIP. Interventions will be reported in the next annual EQR technical report.

Strengths, Weaknesses, and Recommendations

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

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

Strengths

Strength #1: UnitedHealthcare Community Plan designed a methodologically sound PIP. The MHP collected and reported accurate performance indicator results using a systematic data collection process. The causal/barrier analysis process included the use of appropriate QI tools in the identification and prioritization of barriers. [**Quality**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although no weaknesses were identified, HSAG recommends **UnitedHealthcare Community Plan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.

Performance Measure Validation

Performance Results

UnitedHealthcare Community Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **UnitedHealthcare Community Plan** was fully compliant with all seven IS standards.

According to the auditor's review, **UnitedHealthcare Community Plan** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-91 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-65] for **UnitedHealthcare Community Plan**.

[3-65] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Table 3-91—HEDIS MY 2021 Performance Measure Results for UNI

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	57.52%	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	58.08%	★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	57.53%	★★★
Ages 12 to 17 Years	50.23%	★★★
Ages 18 to 21 Years	32.09%	★★★
Total	50.60%	★★★
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	60.01%	★★★★
Ages 21 to 24 Years	65.18%	★★★
Total	62.36%	★★★★
Cervical Cancer Screening		
Cervical Cancer Screening	58.88%	★★
Breast Cancer Screening		
Breast Cancer Screening	51.15%	★★
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	89.78%	★★★★★
*HbA1c Poor Control (>9.0%)**	33.09%	★★★★★
HbA1c Control (<8.0%)	56.93%	★★★★★
Eye Exam (Retinal) Performed	55.47%	★★★
Blood Pressure Control (<140/90 mm Hg)	67.15%	★★★★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	37.55%	★★★★
Ages 65 to 74 Years	43.35%	★★★★
Ages 75 to 85 Years	47.69%	★★★★
Total	37.87%	★★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	64.72%	★★★★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.

MY 2021 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: UnitedHealthcare Community Plan's performance ranked between the 75th and 89th percentile for the *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Total* measure indicators, indicating women identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-66] [**Quality**]

Strength #2: UnitedHealthcare Community Plan's performance ranked at or above the 90th percentile for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator, indicating members with diabetes were having an HbA1c test performed during the measurement year most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-67] [**Quality** and **Access**]

Strength #3: UnitedHealthcare Community Plan's performance ranked at or above the 90th percentile for the *Comprehensive Diabetes Control—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-68] [**Quality** and **Access**]

Strength #4: UnitedHealthcare Community Plan's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator, indicating that members with diabetes had controlled blood pressure most of the time. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke,

3-66 National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Jan 30, 2023.
3-67 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
3-68 Ibid.

hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-69] [**Quality** and **Access**]

Strength #5: UnitedHealthcare Community Plan's performance ranked between the 75th and 89th percentile for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators, indicating that members with diabetes received kidney health evaluations most of the time. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-70] [**Quality** and **Access**]

Strength #6: UnitedHealthcare Community Plan's performance ranked between the 75th and 89th percentile for the *Controlling High Blood Pressure* measure, indicating that members with a diagnosis of hypertension had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-71] [**Quality** and **Access**]

Strength #7: UnitedHealthcare Community Plan demonstrated overall strength in its HEDIS data reporting, as **UnitedHealthcare Community Plan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-72] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, suggesting barriers exist for children to receive timely well-child visits.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30*

3-69 Ibid.
3-70 Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Jan 30, 2023.
3-71 National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.
3-72 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits measure indicator.

Weakness #2: UnitedHealthcare Community Plan's performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer was one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-73] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for women to be screened for cervical cancer.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure.

Weakness #3: UnitedHealthcare Community Plan's performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3-74] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some women to be screened for breast cancer.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure.

[3-73] National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Jan 30, 2023.

[3-74] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.

Compliance Review

Performance Results

Table 3-92 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-92 also presents **UnitedHealthcare Community Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **UnitedHealthcare Community Plan** was subject to a corrective action review process outlined in Appendix A.

Table 3-92—Compliance Review Results for UNI

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	UNI	Statewide[1]
1	Administrative	5	0	100%	95.6%
2	Providers	18	3	86%	88.9%
3	Members	26	0	100%	98.7%
4	Quality	20	1	95%	98.9%
5	MIS/Financial	33	3	92%	95.7%
6	OIG/Program Integrity	29	4	88%	96.3%
Overall		**131**	**11**	**92%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

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: UnitedHealthcare Community Plan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight, which are necessary to effectively carry out managed care functions. [**Quality**]

Strength #2: UnitedHealthcare Community Plan achieved full compliance in the Member standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; collaboration with LHDs for members with special health care needs, and care coordination; a fair grievance and appeal system; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan scored below the statewide average in the Provider standard. The MHP received a *Not Met* score for elements *2.7 Provider Network–MHP Demonstrates that Covered Services are Available and Accessible*, *2.20 Credentialing and Recredentialing Policies*, and *2.21 Secret Shopper Calls*. [**Quality** and **Access**]

Why the weakness exists: UnitedHealthcare Community Plan did not meet ratio standards for general dentistry in three counties and several counties lacked OB/GYN providers, cardiologists, and behavioral health providers. The network access plan was also missing several requirements such as GeoAccess summaries (e.g., time/distance and ratio standards); exception requests; network development activities and results from the past year; corrective actions taken for provider non-compliance; non-emergency medical transportation (NEMT) services; and how the MHP monitors, tracks, and reports to MDHHS the delivery of covered services to members potentially affected by exceptions. Additionally, **UnitedHealthcare Community Plan** did not submit its credentialing policies and procedures timely. The MHP reported that it neglected to include them in its submission in error. Further, through secret shopper calls to PCPs to assess the accuracy of **UnitedHealthcare Community Plan**'s provider directory, discrepancies were identified in the location and phone number of providers and with providers being listed as accepting new patients. Some providers also had conditions on which patients they would accept. The MHP reported the coronavirus disease 2019 (COVID-19) public health emergency (PHE) as a barrier, and that many providers do not share demographic updates with the MHP timely or provide conflicting information. **UnitedHealthcare Community Plan** also reported that its delegates were not submitting provider updates to the MHP.

Recommendation: As **UnitedHealthcare Community Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **UnitedHealthcare Community Plan** ensure its CAP is fully implemented to mitigate the deficiencies.

Weakness #2: UnitedHealthcare Community Plan scored below the statewide average in the Quality standard. The MHP received a *Not Met* score for element *4.9 PMR Review*. [**Quality**]

Why the weakness exists: UnitedHealthcare Community Plan did not provide an improvement plan for four of the eight performance measures that did not meet the minimum standard related to live birth weights, developmental screening, breast cancer screening, and blood lead testing. The MHP reported the following barriers or underlying causes for not meeting these four performance measure standards:

- Live birth weight—disparities by race and ethnicity, biological risk factors, individual risk factors, lifestyle risk behaviors, and community factors.

- Developmental screening—network providers may not consistently perform developmental screenings on members during preventive or sick visits, and potential incorrect coding.
- Breast cancer screening—mobile mammography clinics not being available in 2021 and available appointments in 2022 booking quickly.
- Blood lead testing—recent changes to the blood lead screening reference range and, as a result, providers were no longer able to use filter paper; the Women, Infants and Children (WIC) program no longer completes lead screening for children, to which some providers and members were accustomed; and recalls with point of care lead testing machines.

Recommendation: As **UnitedHealthcare Community Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **UnitedHealthcare Community Plan** ensure its CAP is fully implemented to mitigate the deficiencies.

Weakness #3: UnitedHealthcare Community Plan scored below the statewide average in the MIS standard. The MHP received a *Not Met* score for elements *5.6 Pharmacy/MCO Common Formulary* and *5.8 Third Party Subrogation Requests* (the MHP was cited twice for element 5.8). [**Quality** and **Access**]

Why the weakness exists: UnitedHealthcare Community Plan did not meet the claims standard (less than 0.1 percent noncompliant claims) for products covered on the common formulary. The MHP was improperly using the National Council for Prescription Drug Programs' (NCPDP's) rejection codes and its claims logic preferred generic products when both the brand and generic are on the common formulary. Additionally, **UnitedHealthcare Community Plan** violated the 30-day response time for subrogation requests. The MHP reported that for one case, the subrogation team was awaiting a response from an attorney before an itemization could be sent; and for a second case, the delay occurred due to holidays and staffing challenges.

Recommendation: As **UnitedHealthcare Community Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **UnitedHealthcare Community Plan** ensure its CAP is fully implemented to mitigate the deficiencies.

Weakness #4: UnitedHealthcare Community Plan scored below the statewide average in the Program Integrity standard. The MHP received a *Not Met* score for elements *6.1 Quarterly Program Integrity Forms–Tips and Grievances*, *6.2 Quarterly Program Integrity Forms–Data Mining*, *6.3 Quarterly Program Integrity Forms–Audits*, and *6.4 Quarterly Program Integrity Forms–Provider Disenrollments*. [**Quality**]

Why the weakness exists: Multiple errors were identified on the program integrity reporting forms. **UnitedHealthcare Community Plan** reported that human error was to blame for the reporting deficiencies, such as data input and data output errors.

Recommendation: As **UnitedHealthcare Community Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **UnitedHealthcare Community Plan** ensure its CAP is fully implemented to mitigate the deficiencies.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 333 cases by comparing provider data that **UnitedHealthcare Community Plan** submitted to HSAG against **UnitedHealthcare Community Plan**'s online provider directory. The sample included 111 PCPs, 111 pediatric providers, and 111 OB/GYN providers (Table 3-93). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 96.7 percent (n=322) of the reviews. The sampled providers were not found in the online provider directory in 3.3 percent of the reviewed cases.

Table 3-93—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	111	106	95.5%	5	4.5%
Pediatric Providers	111	107	96.4%	4	3.6%
OB/GYN Providers	111	109	98.2%	2	1.8%
UNI Total	**333**	**322**	**96.7%**	**11**	**3.3%**

Table 3-94 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **UnitedHealthcare Community Plan**'s provider data submission to HSAG and **UnitedHealthcare Community Plan**'s online provider directory.

Table 3-94—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	106	100%	106	99.1%	109	100%	321	99.7%
Provider Address	102	96.2%	98	91.6%	103	94.5%	303	94.1%
Provider City	103	97.2%	103	96.3%	107	98.2%	313	97.2%
Provider State	103	97.2%	103	96.3%	109	100%	315	97.8%
Provider Zip Code	103	97.2%	103	96.3%	105	96.3%	311	96.6%
Provider Telephone Number	99	93.4%	99	92.5%	103	94.5%	301	93.5%
Provider Type/Specialty	103	97.2%	103	96.3%	109	100%	315	97.8%

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider Gender	101	95.3%	98	91.6%	107	98.2%	306	95.0%
Provider Accepting New Patients	103	97.2%	103	96.3%	109	100%	315	97.8%
Non-English Language Speaking Provider (including American Sign Language)	86	81.1%	87	81.3%	100	91.7%	273	84.8%
Provider Primary Language	101	95.3%	101	94.4%	109	100%	311	96.6%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 297 sampled provider locations (i.e., "cases") for **UnitedHealthcare Community Plan**, with an overall response rate of 45.5 percent (n=135). Table 3-95 summarizes the secret shopper survey results for **UnitedHealthcare Community Plan**.

Table 3-95—Summary of UNI Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	99	44	44.4%	25	56.8%	17	68.0%	11	64.7%	10	90.9%
Pediatric Providers	95	56	58.9%	22	39.3%	15	68.2%	15	100%	13	86.7%
OB/GYN Providers	103	35	34.0%	15	42.9%	11	73.3%	10	90.9%	10	100%
UNI Total	**297**	**135**	**45.5%**	**62**	**45.9%**	**43**	**69.4%**	**36**	**83.7%**	**33**	**91.7%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-96 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **UnitedHealthcare Community Plan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-96—Appointment Availability Results

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)[1]	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	111	7	70.0%	6	5.4%	85.7%	1	41	16	9
Pediatric Providers	111	10	76.9%	8	7.2%	80.0%	0	61	24	14
OB/GYN Providers	111	10	100%	4	3.6%	40.0%	0	12	6	6
UNI Total	**333**	**27**	**81.8%**	**18**	**5.4%**	**66.7%**	**0**	**61**	**17**	**8**

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Of the 96.7 percent of providers that reviewers located in **UnitedHealthcare Community Plan**'s online provider directory, the provider's name, address, and telephone indicators had match rates above 93 percent. [**Access**]

Strength #2: Of the 96.7 percent of providers that reviewers located in **UnitedHealthcare Community Plan**'s online provider directory, the new patient acceptance indicator had a match rate of 97.8 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 45.5 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **UnitedHealthcare Community Plan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of cases in which the survey respondent reported that the provider location accepted **UnitedHealthcare Community Plan**, MI Medicaid, and new patients, 66.7 percent of cases offered the caller an appointment. [**Access**]

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, HSAG noted that these considerations may represent common processes among providers' offices to facilitate practice operations. Additionally, the low rates of locations offering the requested specialty; being affiliated with the sampled provider; and accepting MHP, MI Medicaid, and new patients inhibited callers' ability to survey appointment availability. Only 27 cases reached the appointment availability question within the survey.

Recommendation: In addition to correcting provider data deficiencies, HSAG recommends that **UnitedHealthcare Community Plan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **UnitedHealthcare Community Plan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-97 presents **UnitedHealthcare Community Plan**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-97—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for UNI

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	63.3%	68.3%
Rating of All Health Care	60.9%	63.9% ↓
Rating of Personal Doctor	72.3%	76.0%
Rating of Specialist Seen Most Often	64.0%+	76.6%+
Composite Measures		
Getting Needed Care	79.8%+	80.9%+
Getting Care Quickly	79.5%+	79.8%* ↓
How Well Doctors Communicate	93.1%	94.0%
Customer Service	91.7%+	82.8%+
Individual Item Measure		
Coordination of Care	88.1%+	89.6%+
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	79.2%	
Discussing Cessation Medications	56.8%	
Discussing Cessation Strategies	47.6%	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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

Strengths

Strength #1: UnitedHealthcare Community Plan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA adult or child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures: *Rating of All Health Care* and *Getting Care Quickly*. [**Quality** and **Timeliness**]

Why the weakness exists: UnitedHealthcare Community Plan's providers may not be providing care to child members as quickly as other providers and parents/caretakers of child members are reporting lower overall experience scores with their child's healthcare. The MHP reported that it includes parents/caretakers in invites to the Member Advisory Group where it discusses the results of CAHPS and solicits identification of improvement opportunities. However, HSAG is unable to identify the MHP-specific barriers or other factors as reported through the Member Advisory Group that may be impacting key drivers for these measures. The MHP also reported that it was a challenge to monitor the impact of process improvement activities with annual survey data.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** continue to explore the drivers of these lower experience scores and develop initiatives designed to improve quality of care and timeliness of care.

Performance Results—CSHCS

Table 3-98 presents **UnitedHealthcare Community Plan**'s 2022 CSHCS CAHPS survey top-box scores. The following measure could not be displayed in the table because this measure had fewer than 11 responses and was suppressed: *CSHCS Family Center*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-98—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for UNI

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	65.1%
Rating of Health Care	66.3% NA
Rating of Specialist Seen Most Often	70.5%
Rating of CMDS Clinic	72.7%+ NA
Composite Measures	
Customer Service	84.0%+
How Well Doctors Communicate	95.2% NA

	2022 Top-Box Score
Access to Specialized Services	70.0%+ NA
Transportation	61.1%+ NA
Individual Item Measures	
Access to Prescription Medicines	90.2%
CMDS Clinics	91.3%+ NA
Local Health Department Services	74.5%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	95.7% NA
Not Felt Treated Unfairly: Health Insurance Type	96.7% NA

+ These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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

Strengths

Strength #1: UnitedHealthcare Community Plan's 2022 top-box scores were not statistically significantly higher than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-99 presents **UnitedHealthcare Community Plan**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-99—Summary of 2022 HMP CAHPS Top-Box Scores for UNI

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	58.9%
Rating of All Health Care	65.5%
Rating of Personal Doctor	71.3%
Rating of Specialist Seen Most Often	76.9%+
Composite Measures	
Getting Needed Care	89.3%+ ↑
Getting Care Quickly	84.0%+
How Well Doctors Communicate	95.6% ↑
Customer Service	89.5%+
Individual Item Measure	
Coordination of Care	80.4%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	74.2%
Discussing Cessation Medications	56.0%
Discussing Cessation Strategies	45.3%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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

Strengths

Strength #1: UnitedHealthcare Community Plan's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for two measures: *Getting Needed Care* and *How Well Doctors Communicate*. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **UnitedHealthcare Community Plan**'s performance.

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

HSAG performed a comprehensive assessment of **UnitedHealthcare Community Plan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **UnitedHealthcare Community Plan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **UnitedHealthcare Community Plan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-100 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to **UnitedHealthcare Community Plan**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-100—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **UnitedHealthcare Community Plan** did not identify an existing disparity but focused its PIP on improving timeliness of prenatal care for African-American/Black women as this population was the lowest-performing subgroup. While **UnitedHealthcare Community Plan** designed a methodologically sound PIP, the MHP had not yet progressed to initiating interventions. Future interventions should increase the number of African-American/Black women who receive a timely prenatal care appointment. Future interventions should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator rate, which ranked between the 25th and 49th Medicaid Quality Compass percentile. Additionally, as demonstrated through the compliance review activity, **UnitedHealthcare Community Plan** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare conditions and reduce disparities in care. **UnitedHealthcare Community Plan** also achieved a 95 percent compliance rate in the Quality standard, indicating that it had a sufficient QAPI program in which various initiatives can be implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—**UnitedHealthcare Community Plan** demonstrated strengths of its program related to preventive services provided to children and adolescents. All four *Child and Adolescent Well-Care Visits* measure indicator rates ranked between the 50th and 74th Medicaid Quality Compass percentile with all rates demonstrating a statistically significant improvement from the previous year. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator rate also ranked between the 50th and 74th Medicaid Quality Compass percentile; however, it demonstrated a statistically significant decline from the previous year. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator rate also demonstrated a statistically significant decline from the prior year and ranked below the 25th Medicaid Quality Compass percentile, demonstrating continued opportunities for improvement. Additionally, the secret shopper survey identified multiple providers, including pediatric providers, who could not be reached. Further, of the providers who could be reached and were accepting the MHP, Medicaid, and new patients, appointment availability rates were low. **UnitedHealthcare**

Performance Area	Overall Performance Impact
	Community Plan was placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a pediatric provider for appropriate preventive care or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity demonstrated overall strong performance as it related to the management of chronic conditions, including diabetes and hypertension. One indicator rate under the *Comprehensive Diabetes Care* performance measure ranked between the 50th and 74th Medicaid Quality Compass percentile, one indicator rate ranked between the 75th and 89th percentile, and the three remaining indicator rates ranked above the 90th percentile. The *Controlling High Blood Pressure* performance measure rate and all indicator rates under the *Kidney Health Evaluation for Patients With Diabetes* performance measure ranked between the 75th and 89th Medicaid Quality Compass percentile. One rate under the *Comprehensive Diabetes Care* performance measure, and the total rate and the rates for two age subgroups under the *Kidney Health Evaluation for Patients With Diabetes* performance measure also demonstrated a statistically significant improvement from the previous year. However, the secret shopper survey identified multiple providers who could not be reached. Further, of the providers who could be reached and were accepting the MHP, Medicaid, and new patients, appointment availability rates were low. **UnitedHealthcare Community Plan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider for proper management of chronic conditions or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing care to manage chronic conditions.
Health and Wellness of Women	**Quality**—The results of the PMV activity demonstrated that many sexually active women were being appropriately tested for chlamydia as indicated by the *Chlamydia Screening in Women* performance measure rates. The rate for one age subgroup ranked between the 50th and 74th Medicaid Quality Compass percentile, while the total rate, and the rate for the remaining one age subgroup, ranked between the 75th and 89th percentile. Additionally, **UnitedHealthcare Community Plan** received a *Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of the compliance review activity, demonstrating the MHP had the necessary processes in place to notify MDHHS and ensure pregnant women were eligible for dental services. However, the rates for the *Cervical Cancer Screening* and *Breast Cancer Screening* performance measures ranked between the 25th and 49th Medicaid Quality Compass percentile, indicating that many of **UnitedHealthcare**

Performance Area	Overall Performance Impact
	Community Plan's female members were not receiving recommended cervical cytology and/or high-risk HPV testing or recommended mammograms. The rate for the *Breast Cancer Screening* performance measure also demonstrated a statistically significant decline from the previous year. Further, the secret shopper survey identified multiple providers, including OB/GYN providers, who could not be reached. Of the providers who could be reached and were accepting the MHP, Medicaid, and new patients, appointment availability rates were low. **UnitedHealthcare Community Plan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider or may be experiencing other barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing care to recommended women's health screenings.

Upper Peninsula Health Plan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **Upper Peninsula Health Plan**'s PIP (i.e., the PIP Design and Implementation stages). Based on its technical review, HSAG determined the overall methodological validity of the PIP and assigned an overall validation status (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-101 displays the overall validation status and the baseline results for the performance indicators. The PIP had not progressed to reporting remeasurement outcomes for this validation cycle. The first remeasurement will be assessed and validated in SFY 2023.

Table 3-101—Overall Validation Rating for UPP

PIP Topic	Validation Rating	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members ages 20-44	*Met*	1. Annual Ambulatory or Preventative Visit for UPP Black members.	64.7%			Yes
		2. Annual Ambulatory or Preventative Visit for UPP White members.	77.4%			

R1 = Remeasurement 1
R2 = Remeasurement 2

The goals for **Upper Peninsula Health Plan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black members) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White members), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-102 displays the interventions, as available, initiated by the MHP to support achievement of the PIP goals and address the barriers identified through QI and causal/barrier analysis processes.

Table 3-102—Baseline Interventions for UPP

Intervention Descriptions	
The MHP outreached members of the target population to perform a survey to identify barriers to completing care, along with education and coordination of care as needed.	The MHP offered an alternative payment method to select provider clinic systems to address and eliminate existing racial disparities for the performance indicator.
The MHP worked with provider relations staff to increase provider reported race.	

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Upper Peninsula Health Plan designed a methodologically sound PIP. The MHP collected and reported accurate performance indicator results using a systematic data collection process and conducted appropriate statistical testing between subgroups. [**Quality**]

Strength #2: Upper Peninsula Health Plan used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers. The MHP implemented timely interventions that were reasonably linked to the barriers. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: There were no identified weaknesses.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **Upper Peninsula Health Plan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.

Performance Measure Validation

Performance Results

Upper Peninsula Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2021 Compliance Audit Report findings, **Upper Peninsula Health Plan** was fully compliant with all seven IS standards.

According to the auditor's review, **Upper Peninsula Health Plan** followed the NCQA HEDIS MY 2021 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-103 displays the HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles[3-75] for **Upper Peninsula Health Plan**.

Table 3-103—HEDIS MY 2021 Performance Measure Results for UPP

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Child & Adolescent Care		
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	67.53%	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	67.43%	★★
Child and Adolescent Well-Care Visits		
Ages 3 to 11 Years	57.85%	★★★
Ages 12 to 17 Years	51.87%	★★★
Ages 18 to 21 Years	23.44%	★★
Total	49.99%	★★★
Women—Adult Care		
Chlamydia Screening in Women		
Ages 16 to 20 Years	41.06%	★
Ages 21 to 24 Years	51.13%	★
Total	45.73%	★
Cervical Cancer Screening		
Cervical Cancer Screening	61.31%	★★★
Breast Cancer Screening		
Breast Cancer Screening	59.29%	★★★★

[3-75] HEDIS MY 2021 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	MY 2021 Performance Level[1]
Living With Illness		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	90.51%	★★★★★
*HbA1c Poor Control (>9.0%)**	33.33%	★★★★★
HbA1c Control (<8.0%)	55.47%	★★★★★
Eye Exam (Retinal) Performed	59.61%	★★★★
Blood Pressure Control (<140/90 mm Hg)	82.48%	★★★★★
Kidney Health Evaluation for Patients With Diabetes		
Ages 18 to 64 Years	34.50%	★★★
Ages 65 to 74 Years	39.38%	★★★
Ages 75 to 85 Years	35.06%	★★★
Total	34.98%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	79.08%	★★★★★

[1]Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2021 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Upper Peninsula Health Plan's performance ranked between the 75th and 89th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, indicating children who turned 15 months old during the measurement year were getting at least six well-child visits with a PCP during their first 15 months of life most of the time. Well-care visits provide an opportunity for providers to

influence health and development, and they are a critical opportunity for screening and counseling.[3-76] [**Quality**, **Timeliness**, and **Access**]

Strength #2: Upper Peninsula Health Plan's performance ranked between the 75th and 89th percentile for the *Breast Cancer Screening* measure, indicating women 50 to 74 years of age were being screened for breast cancer most of the time. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3-77] [**Quality** and **Access**]

Strength #3: Upper Peninsula Health Plan's performance ranked at or above the 90th percentile for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator, indicating members with diabetes were having an HbA1c test performed during the measurement year most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-78] [**Quality** and **Access**]

Strength #4: Upper Peninsula Health Plan's performance ranked at or above the 90th percentile for the *Comprehensive Diabetes Control—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-79] [**Quality** and **Access**]

Strength #5: Upper Peninsula Health Plan's performance ranked between the 75th and 89th percentile for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator, indicating that members with diabetes had an eye exam to screen or monitor for diabetic retinal disease most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-80] [**Quality** and **Access**]

Strength #6: Upper Peninsula Health Plan's performance ranked at or above the 90th percentile for the *Comprehensive Diabetes Control—Blood Pressure Control (<140/90 mm Hg)* measure indicator, indicating that members with diabetes had controlled blood pressure most of the time. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-81] [**Quality** and **Access**]

3-76 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.
3-77 National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 30, 2023.
3-78 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Jan 30, 2023.
3-79 Ibid.
3-80 Ibid.
3-81 Ibid.

Strength #7: Upper Peninsula Health Plan's performance ranked at or above the 90th percentile for the *Controlling High Blood Pressure* measure, indicating that members with a diagnosis of hypertension had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-82] [**Quality** and **Access**]

Strength #8: Upper Peninsula Health Plan demonstrated overall strength in its HEDIS data reporting, as **Upper Peninsula Health Plan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan's performance for all *Chlamydia Screening in Women* measure indicators ranked below the 25th percentile, indicating that women identified as sexually active were not always receiving at least one test for chlamydia during the measurement year. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-83] [**Quality**]

Why the weakness exists: The rates for all *Chlamydia Screening in Women* measure indicators ranked below the 25th percentile, suggesting barriers exist for some women identified as sexually active to receive testing for chlamydia.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** conduct a root cause analysis or focused study to determine why some women identified as sexually active did not receive testing for chlamydia. Upon identification of a root cause, **Upper Peninsula Health Plan** should implement appropriate interventions to improve the performance related to the *Chlamydia Screening in Women* measure.

Weakness #2: Upper Peninsula Health Plan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th percentile and 49th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-84] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator

[3-82] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 30, 2023.
[3-83] National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Jan 30, 2023.
[3-84] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some children to receive timely well-child visits.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Upper Peninsula Health Plan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

Weakness #3: Upper Peninsula Health Plan's performance for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* measure indicator ranked between the 25th percentile and 49th percentile, indicating some children ages 18 to 21 years were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-85] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* measure indicator ranked between the 25th percentile and 49th percentile, suggesting barriers exist for some children to receive timely well-child visits.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Upper Peninsula Health Plan** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure.

Compliance Review

Performance Results

Table 3-104 presents the total number of criteria for each standard that received a score of *Met* or *Not Met*. Table 3-104 also presents **Upper Peninsula Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Upper Peninsula Health Plan** was subject to a corrective action review process outlined in Appendix A.

Table 3-104—Compliance Review Results for UPP

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	UPP	Statewide[1]
1	Administrative	5	0	100%	95.6%
2	Providers	17	4	81%	88.9%

[3-85] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 30, 2023.

Standard		Number of Scores		Compliance Scores	
		Met	*Not Met*	UPP	Statewide[1]
3	Members	26	0	100%	98.7%
4	Quality	21	0	100%	98.9%
5	MIS/Financial	35	1	97%	95.7%
6	OIG/Program Integrity	33	0	100%	96.3%
Overall		**137**	**5**	**96%**	**95.9%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Upper Peninsula Health Plan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight, which are necessary to effectively carry out managed care functions. [**Quality**]

Strength #2: Upper Peninsula Health Plan achieved full compliance in the Member standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; collaboration with LHDs for members with special health care needs; care coordination; a fair grievance and appeal system; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Upper Peninsula Health Plan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs, QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Strength #4: Upper Peninsula Health Plan achieved full compliance in the Program Integrity standard, demonstrating a sufficient compliance program, including adequate policies and procedures; adequate staffing and employee training; communication between internal and external partners; and internal monitoring, auditing, and investigation practices. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan scored below the statewide average in the Provider standard. The MHP received a *Not Met* score for elements *2.7 Provider Network–MHP Demonstrates that Covered Services are Available and Accessible*, *2.10 Provider Wait Times*, *2.16 PBM* [Pharmacy Benefit Manager] *Service Organization Controls Report*, and *2.21 Secret Shopper Calls*. [**Quality** and **Access**]

Why the weakness exists: Upper Peninsula Health Plan did not meet ratio standards for adult PCPs and pediatric PCPs for several counties, and did not meet ratio standards for general dentistry for all but three counties. The MHP also did not meet time/distance standards for adult PCPs, pediatric PCPs, OB/GYN providers, cardiology, outpatient behavioral health, hospitals, pharmacy, and general dentistry. Additionally, the network access plan did not detail all required information, instead the information was included in attached policies and procedures. **Upper Peninsula Health Plan** reported that its service area does not have the number of provider types to meet MDHHS' network adequacy standards and that it contracts with all providers in its service area. The MHP also confirmed that it did not include all required elements within the network access plan. Further, **Upper Peninsula Health Plan** did not provide full data reports or monitoring results for assessing provider wait times for appointments, and submitted the incorrect service organization control report for its PBM. Lastly, through secret shopper calls to PCPs to assess the accuracy of **Upper Peninsula Health Plan**'s provider directory, discrepancies were identified with providers being listed as accepting new patients. Some providers also had conditions on which patients they would accept. The MHP reported that a complex form and facsimile process for communicating changes in provider demographics, staff shortages and turnover at provider offices, and an unclear definition of "restrictions" were the underlying causes of the issues identified.

Recommendation: As **Upper Peninsula Health Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **Upper Peninsula Health Plan** ensure its CAP is fully implemented to mitigate the deficiencies.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 103 cases by comparing provider data that **Upper Peninsula Health Plan** submitted to HSAG against **Upper Peninsula Health Plan**'s online provider directory. The sample included 73 PCPs, 17 pediatric providers, and 13 OB/GYN providers (Table 3-105). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 94.2 percent (n=97) of the reviews. The sampled providers were not found in the online provider directory in 5.8 percent of the reviewed cases.

Table 3-105—Summary of Providers Present in the Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in the Directory		Providers Not Found in Directory	
		Count	%	Count	%
PCPs	73	70	95.9%	3	4.1%
Pediatric Providers	17	16	94.1%	1	5.9%
OB/GYN Providers	13	11	84.6%	2	15.4%
UPP Total	**103**	**97**	**94.2%**	**6**	**5.8%**

Table 3-106 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Upper Peninsula Health Plan**'s provider data submission to HSAG and **Upper Peninsula Health Plan**'s online provider directory.

Table 3-106—Provider Demographic Indicators Matching Online Provider Directory

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider's Name	70	100%	15	93.8%	11	100%	96	99.0%
Provider Address	68	97.1%	16	100%	11	100%	95	97.9%
Provider City	68	97.1%	16	100%	11	100%	95	97.9%
Provider State	68	97.1%	16	100%	11	100%	95	97.9%
Provider Zip Code	68	97.1%	16	100%	11	100%	95	97.9%
Provider Telephone Number	67	95.7%	16	100%	11	100%	94	96.9%
Provider Type/Specialty	67	95.7%	16	100%	11	100%	94	96.9%

Indicator	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
	Count	% Match*	Count	% Match*	Count	% Match*	Count	% Match*
Provider Gender	68	97.1%	16	100%	11	100%	95	97.9%
Provider Accepting New Patients	65	92.9%	16	100%	11	100%	92	94.8%
Non-English Language Speaking Provider (including American Sign Language)	62	88.6%	15	93.8%	8	72.7%	85	87.6%
Provider Primary Language	68	97.1%	16	100%	11	100%	95	97.9%

*The denominator for each study indicator includes the number of cases in which the provider location was found in the directory and was relevant to the provider category.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 91 sampled provider locations (i.e., "cases") for **Upper Peninsula Health Plan**, with an overall response rate of 95.6 percent (n=87). Table 3-107 summarizes the secret shopper survey results for **Upper Peninsula Health Plan**.

Table 3-107—Summary of UPP Secret Shopper Survey Results

Provider Category	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)[1]	Confirmed Provider	Rate (%)[2]	Accepting MHP	Rate (%)[3]	Accepting MI Medicaid	Rate (%)[4]
PCPs	64	60	93.8%	60	100%	55	91.7%	54	98.2%	52	96.3%
Pediatric Providers	16	16	100%	16	100%	16	100%	16	100%	16	100%
OB/GYN Providers	11	11	100%	10	90.9%	10	100%	10	100%	10	100%
UPP Total	**91**	**87**	**95.6%**	**86**	**98.9%**	**81**	**94.2%**	**80**	**98.8%**	**78**	**97.5%**

[1] The denominator includes cases responding to the survey.
[2] The denominator includes cases responding to the survey and offering the requested specialty services.
[3] The denominator includes cases responding to the survey, offering the requested specialty services, and affiliated with the correct provider.
[4] The denominator includes cases responding to the survey, offering the requested specialty services, affiliated with the correct provider, and accepting the MHP.

Table 3-108 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Upper Peninsula Health Plan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-108—Appointment Availability Results

Provider Category	Total Survey Cases	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)[1]	Cases Offered an Appointment			Appointment Wait Time (Days)			
				Number	Rate Among All Surveyed Cases[2] (%)	Rate Among Cases Accepting New Patients[3] (%)	Min	Max	Average	Median
PCPs	73	47	90.4%	35	47.9%	74.5%	2	189	26	15
Pediatric Providers	17	13	81.3%	9	52.9%	69.2%	1	22	9	7
OB/GYN Providers	13	10	100%	8	61.5%	80.0%	4	27	16	17
UPP Total	**103**	**70**	**89.7%**	**52**	**50.5%**	**74.3%**	**1**	**189**	**22**	**15**

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV 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: Of the 94.2 percent of providers that reviewers located in **Upper Peninsula Health Plan**'s online provider directory, the provider's name, address, and telephone indicators had match rates above 96 percent. [**Access**]

Strength #2: Overall, **Upper Peninsula Health Plan** had a response rate of 95.6 percent (i.e., HSAG was able to contact providers during the telephone survey). Pediatric providers and OB/GYN providers had a response rate of 100 percent, while PCP providers had a response rate of 93.8 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Of cases in which the survey respondent reported that the provider location accepted **Upper Peninsula Health Plan**, MI Medicaid, and new patients, 74.3 percent of cases offered the caller an appointment date. [**Access**]

Why the weakness exists: For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent

limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: In addition to using the case-level analytic data files to correct provider data deficiencies, HSAG recommends that **Upper Peninsula Health Plan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Upper Peninsula Health Plan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-109 presents **Upper Peninsula Health Plan**'s 2022 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-109—Summary of 2022 Adult and Child Medicaid CAHPS Top-Box Scores for UPP

	2022 Adult Medicaid	2022 Child Medicaid
Global Ratings		
Rating of Health Plan	71.1% ↑	67.5%
Rating of All Health Care	56.1%	70.2%
Rating of Personal Doctor	71.9%	76.7%
Rating of Specialist Seen Most Often	62.8%	75.0%+
Composite Measures		
Getting Needed Care	84.4%	87.4%
Getting Care Quickly	87.1% ↑	94.2% ↑
How Well Doctors Communicate	95.4% ↑	97.1% ↑
Customer Service	94.8% ↑	90.6%+
Individual Item Measure		
Coordination of Care	83.7%	84.7%+
Effectiveness of Care Measures*		
Advising Smokers and Tobacco Users to Quit	76.4%	

	2022 Adult Medicaid	2022 Child Medicaid
Discussing Cessation Medications	58.9% ↑	
Discussing Cessation Strategies	52.7%	

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

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

Strengths

Strength #1: Upper Peninsula Health Plan's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Discussing Cessation Medications*. [**Quality** and **Timeliness**]

Strength #2: Upper Peninsula Health Plan's 2022 top-box scores were statistically significantly higher than the 2021 NCQA child Medicaid national averages for two measures: *Getting Care Quickly* and *How Well Doctors Communicate*. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan 's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA adult and child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-110 presents **Upper Peninsula Health Plan**'s 2022 CSHCS CAHPS survey top-box scores. The following measure could not be displayed in the table because this measure had fewer than 11 responses and was suppressed: *CHSCS Family Center*. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-110—Summary of 2022 CSHCS CAHPS Survey Top-Box Scores for UPP

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	67.4%+
Rating of Health Care	73.7%* NA
Rating of Specialist Seen Most Often	83.6%+ ↑
Rating of CMDS Clinic	88.2%+ NA
Composite Measures	
Customer Service	91.2%+
How Well Doctors Communicate	98.0%+ NA
Access to Specialized Services	70.1%+ NA
Transportation	97.2%+ NA
Individual Item Measures	
Access to Prescription Medicines	90.4%+
CMDS Clinic	94.1%+ NA
Local Health Department Services	81.8%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	96.1%+ NA
Not Felt Treated Unfairly: Health Insurance Type	97.4%+ NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

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

Strengths

Strength #1: Upper Peninsula Health Plan's 2022 top-box score was statistically significantly higher than the 2021 NCQA child Medicaid national average for one measure, *Rating of Specialist Seen Most Often*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan's 2022 top-box scores were not statistically significantly lower than the 2021 NCQA child Medicaid national averages for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-111 presents **Upper Peninsula Health Plan**'s 2022 CAHPS top-box scores for HMP. Arrows (↑ or ↓) indicate 2022 scores were statistically significantly higher or lower than the 2021 national average.

Table 3-111—Summary of 2022 HMP CAHPS Top-Box Scores for UPP

	2022 Top-Box Score
Global Ratings	
Rating of Health Plan	67.2%
Rating of All Health Care	51.6% ↓
Rating of Personal Doctor	65.6%
Rating of Specialist Seen Most Often	72.4%
Composite Measures	
Getting Needed Care	84.9%
Getting Care Quickly	86.0%
How Well Doctors Communicate	95.3% ↑
Customer Service	90.0%+
Individual Item Measure	
Coordination of Care	86.0%+
Effectiveness of Care Measures*	
Advising Smokers and Tobacco Users to Quit	69.7%

	2022 Top-Box Score
Discussing Cessation Medications	50.4%
Discussing Cessation Strategies	45.0%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating the results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.
↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

Strengths, Weaknesses, and Recommendations—HMP

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

Strengths

Strength #1: Upper Peninsula Health Plan's 2022 top-box score was statistically significantly higher than the 2021 NCQA adult Medicaid national average for one measure, *How Well Doctors Communicate*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan's 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that **Upper Peninsula Health Plan** members are reporting a more negative experience with their overall healthcare.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** explore drivers of this lower experience score and develop initiatives designed to improve quality of care, including a focus on improving members' overall experiences with their healthcare.

Quality Rating

The 2022 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2022 Michigan Consumer Guide, which is inclusive of **Upper Peninsula Health Plan**'s performance.

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

HSAG performed a comprehensive assessment of **Upper Peninsula Health Plan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Upper Peninsula Health Plan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Upper Peninsula Health Plan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-112 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of healthcare services provided to **Upper Peninsula Health Plan**'s Medicaid members.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess year-over-year trending and to further determine overall conclusions.

Table 3-112—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Health Disparities	**Quality** and **Timeliness**—Through MDHHS' mandated PIP, **Upper Peninsula Health Plan** identified through its data analysis a disparity between Black women and White women in the timeliness of prenatal care. **Upper Peninsula Health Plan** designed a methodologically sound PIP and timely implemented interventions that were reasonably linked to their corresponding barriers and have the potential of reducing/eliminating the disparity. The interventions implemented through the PIP activity should also have an impact on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator rate, which ranked above the 90th Medicaid Quality Compass percentile. Additionally, as demonstrated through the compliance review activity, **Upper Peninsula Health Plan** received a *Met* score for element *4.10 Addressing Health Disparities—Population Health Mgmt (PHM)*, indicating that the MHP had adequate policies and procedures for providing population health management services where telephonic and mail-based care management was not sufficient or appropriate, including in adult and family shelters for members who are homeless, a member's home, and a member's place of employment or school. Care coordination, member engagement, and other initiatives implemented through population health management programs/services can target specific populations and healthcare conditions and reduce disparities in care. **Upper Peninsula Health Plan** also

Performance Area	Overall Performance Impact
	achieved full compliance in the Quality standard, indicating that it had a sufficient QAPI program in which various initiatives can be implemented and focused on, eliminating healthcare disparities identified within the MHP's CHCP population.
Child and Adolescent Preventive Services	**Quality**, **Timeliness** and **Access**—**Upper Peninsula Health Plan** demonstrated some performance strengths as it related to preventive services provided to children and adolescents. The total rate, and the rates for two age subgroups, for the *Child and Adolescent Well-Care Visits* performance measure ranked between the 50th and 74th Medicaid Quality Compass percentile with these rates also demonstrating a statistically significant improvement from the previous year. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator rate also ranked between the 75th and 89th Medicaid Quality Compass percentile. The results of the secret shopper survey suggest that members can easily contact a provider as demonstrated through high response rates, including a 100 percent response rate for pediatric providers. However, the rate for one age subgroup under the *Child and Adolescent Well-Care Visits* performance measure and the rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th Medicaid Quality Compass percentile. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rate also demonstrated a statistically significant decline from the previous year. Additionally, the secret shopper survey identified multiple providers, including pediatric providers, who were accepting the MHP, Medicaid, and new patients, but appointment availability rates were low. **Upper Peninsula Health Plan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may be experiencing barriers in scheduling timely appointments. The results of the CAHPS activity indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing preventive care.
Chronic Conditions	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity demonstrate **Upper Peninsula Health Plan**'s overall strong performance as it related to the management of chronic conditions, including diabetes and hypertension. One indicator rate under the *Comprehensive Diabetes Care* performance measure ranked between the 75th and 89th Medicaid Quality Compass percentile, and the four remaining indicator rates ranked above the 90th percentile. The *Controlling High Blood Pressure* performance measure rate also ranked above the 90th Medicaid Quality Compass percentile and demonstrated a statistically significant improvement from the previous year, and all indicator rates under the *Kidney Health Evaluation for Patients With Diabetes* performance measure ranked between the 50th and 74th percentile. These results indicate that many of MHP's members diagnosed with hypertension had adequate blood pressure control and many members

Performance Area	Overall Performance Impact
	diagnosed with diabetes received proper diabetes management, including a kidney health evaluation. The results of the secret shopper survey suggest that members can easily contact a provider as demonstrated through high response rates. However, the secret shopper survey also identified multiple providers who were accepting the MHP, Medicaid, and new patients, but appointment availability rates were low. **Upper Peninsula Health Plan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. The results of the CAHPS activity also indicate some members have negative perceptions of their personal doctors, which may also be a barrier to accessing care to manage chronic conditions. While these results suggest that members may not always have access to accurate information to locate a provider and may be experiencing barriers in scheduling timely appointments and negative perceptions of their personal care, they do not appear to have impacted member access to care for members diagnosed with diabetes and hypertension as demonstrated through **Upper Peninsula Health Plan**'s strong performance of the chronic care measures of the PMV activity.
Health and Wellness of Women	**Quality**—The results of the PMV activity demonstrated that many of **Upper Peninsula Health Plan**'s female members were receiving recommended cervical cytology and/or high-risk HPV testing and mammograms, as indicated by the *Cervical Cancer Screening* performance measure rate, which ranked between the 50th and 74th Medicaid Quality Compass percentile, and the *Breast Cancer Screening* performance measure rate, which ranked between the 75th and 89th percentile. However, it should be noted that the *Breast Cancer Screening* performance measure rate also demonstrated a statistically significant decline from the previous year. Additionally, **Upper Peninsula Health Plan** received a *Met* score for element *3.12 Pregnant Women Dental Policies and Procedures* of the compliance review activity, demonstrating the MHP had the necessary processes in place to ensure pregnant women receive dental eligibility and services. The results of the secret shopper survey also suggest that members can easily contact a provider as demonstrated through high response rates, including a 100 percent response rate for OB/GYN providers. However, many sexually active women were not being appropriately tested for chlamydia as all *Chlamydia Screening in Women* measure indicator rates ranked below the 25th Medicaid Quality Compass percentile. Additionally, the secret shopper survey identified multiple providers, including OB/GYN providers, who were accepting the MHP, Medicaid, and new patients, but appointment availability rates were low. **Upper Peninsula Health Plan** was also placed on a compliance review CAP due to provider data discrepancies in the provider directory. These results suggest that members may not always have access to accurate information to locate a provider and may be experiencing other barriers in scheduling timely appointments.

4. Follow-Up on Prior External Quality Review Recommendations for Medicaid Health Plans

From the findings of each MHP's performance for the SFY 2021 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the CHCP. The recommendations provided to each MHP for the EQR activities in the *State Fiscal Year 2021 External Quality Review Technical Report for Medicaid Health Plans* are summarized in Table 4-1 through Table 4-9. The MHP'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 4-9.

Additional performance measures and performance measure results are included in Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess the degree to which each MHP addressed the prior year's recommendations.

Aetna Better Health of Michigan

Table 4-1—Prior Year Recommendations and Responses for AET

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no identified weaknesses, **Aetna Better Health of Michigan** should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The MHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Addressing Disparities in Timeliness of Prenatal Care in Rural Communities NEW INTERVENTIONS • Racial and culturally concordant mailings and Secure Messaging System (SMS) campaigns were deployed to our pregnant mothers that include quick response (QR) codes on the mailings and links in the SMS to take members to 'Every Mother Counts: Choices in Childbirth' resources and videos on the importance of advocating for themselves during appointments, asking questions at every visit and that mothers have the right to make informed choices in their pregnancy, birth and as a parent with physicians.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
• Execution of contract with Health Intelligence Platform to offer pregnant members solutions to improve their quality of care and engagement in the healthcare system. The Health Intelligence platform will allow women pregnant access to the Baby Smart coaching program that supports appointment and transportation scheduling, pregnancy and parenting education, pregnancy monitoring and postpartum health goals, quick connections to any needed critical resources for social risks/Social Determinants of Health (SDoH) as well as virtual doula pairing for high-risk pregnant women. • Health Intelligence platform solution leveraging multimodal communication methods including text, outreach calls, mailings, dashboard access, pregnancy "pals", birthing support and advocacy as well as education resources CONTINUED INTERVENTIONS • Enhanced member education materials by emphasizing importance of early prenatal care. Send member mailers to all female members aged 18-40 years old. Inclusion of prenatal care Text and Interactive Voice Response (IVR) campaign for all confirmed pregnant members on importance of prenatal care. • Continue to educate members on appropriate timeline to seek OB/GYN/PCP's and push ER [emergency room]/Urgent visits as a last resort of care. • Multimodal communication leveraging combination of IVR, text, email, and mailers to send educational messages to engage members in completing prenatal/postpartum care. • Healthy behavior rewards $50 gift card for completion of 1st prenatal care visit within 1st trimester or 42 days of enrollment, $50 gift card for completion of 6 or more prenatal care visits and a $50 gift card for timely completion of the postpartum care visit.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Timeliness of Prenatal Care (TOPC) and Postpartum Care (PPC) measure increased year over year as a result of initiatives implemented. A 1.21 percentage point rate lift was seen year over year in the TOPC measure and a 4.63 percentage point rate lift was seen year over year in the PPC measure. o Prenatal and Postpartum Care ▪ PN 68.86% PP 54.01% MY2020 ▪ PN 70.07% PP 58.64% MY2021
c. Identify any barriers to implementing initiatives: • There are several factors that are challenging to overcome when trying to improve the timeliness of prenatal and postpartum care measure through interventions. Several of our OB offices and primary care offices have reported being short-staffed since the pandemic began and therefore addressing gaps in care has not been priority as they navigate handling fully booked schedules on a weekly basis. This is evident in our rural communities as well as urban communities. Majority of our OB offices still do not allow the mother to bring her other children or family to their appointments, when historically prenatal care has been a shared experience. Transportation remains a barrier to rural women accessing health services even when offered transportation through our vendor, at times the pick-up time from an appointment can take up to over an hour resulting in less return visits for the member. One of our largest providers will not schedule the initial OB visit prior to 12 weeks gestation (when they determined the fetus is viable), leaving the member to self-report via a telehealth triage call, using estimated gestation periods based on last menstrual period recalled by member.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** addressed the prior year's recommendation. The MHP reassessed its causal/barrier analysis and developed new interventions to address barriers to care and continued interventions that demonstrated effectiveness.

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

HSAG recommended the following:

- Due to continued low performance for the *Childhood Immunization Status* measure indicators, **Aetna Better Health of Michigan** should monitor performance improvement interventions currently in place and continue to expand upon or implement additional interventions, when necessary, to improve the performance related to the *Childhood Immunization Status* measure. The Center for Disease Control and Prevention (CDC) recommends continued administration of routine immunization during the pandemic to prevent transmission of other preventable infectious diseases. According to the American Academy of Pediatrics (AAP), while telehealth visits are recommended, in-person visits, especially for vaccination, should not be discontinued unless community circumstances require the limitation of in-person visits, in which case curbside or drive-through vaccination can be implemented by clinics to limit patient-provider contact.
- Due to continued low performance for the *Asthma Medication Ratio* measure, **Aetna Better Health of Michigan** should monitor and target its efforts toward those with asthma medication ratios less than 50 percent to improve upon performance related to the *Asthma Medication Ratio* measure. Appropriate medication management for those with persistent asthma is especially important during the COVID-19 pandemic, as those with moderate-to-severe or uncontrolled asthma are more likely to be hospitalized from COVID-19.
- **Aetna Better Health of Michigan** should conduct a root cause analysis or focused study to determine why some women did not receive prenatal and postpartum care. If it is determined that COVID-19 impacted performance for the *Prenatal and Postpartum Care* measure indicators, **Aetna Better Health of Michigan** should proactively alter its approach to prenatal and postpartum care through methods such as telemedicine, when possible, to improve upon performance related to the *Prenatal and Postpartum Care* measure. Additionally, if member mistrust in the healthcare system and providers is identified as a root cause that impacted the rates for both *Prenatal and Postpartum Care* measure indicators, **Aetna Better Health of Michigan** should work toward strengthening patient-provider relationships in an effort to improve upon the rate for the *Prenatal and Postpartum Care* measure. The American Medical Association (AMA) has discussed ways to strengthen trusting patient-physician relationships and reduce health inequities: the medical profession should hear and amplify the voices of patients and families; partner with communities where disproportionate rates of maternal mortality exist; have greater collaboration with non-clinical community organizations with close ties to minoritized and marginalized groups to identify opportunities to best support pregnant persons and new families; and engage in funding and development of outreach initiatives to promote comprehensive pre-pregnancy, prenatal, peripartum, and postpartum care.
- **Aetna Better Health of Michigan should** conduct a root cause analysis or focused study to determine why members were not always receiving appropriate testing for pharyngitis to warrant antibiotic treatment. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Appropriate Testing for Pharyngitis* measure.
- **Aetna Better Health of Michigan** should conduct a root cause analysis or focused study to determine why some children did not receive lead blood tests by their second birthday. If it is determined that COVID-19 impacted performance for *Lead Screening in Children*, **Aetna Better Health of Michigan** should take a

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
proactive approach in ensuring young children are receiving appropriate lead testing and care management. During the pandemic, the AAP recommended that well-child examinations occur in person whenever possible and within the child's medical home where continuity of care can be established. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Lead Screening in Children* measure.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

Childhood Immunizations

- Community Based Organization (CBO) partnerships with entities whose Community Health Workers (CHWs) offer face to face engagement to educate on safety and efficacy of immunizations, importance of adhering to immunization schedule, and appointment scheduling for administration of vaccines.
- $25 healthy behaviors reward for completion of vaccine series
- Live outreach calls, text campaigns, health education mailings
- Health Intelligence platform solution to support outreach and engagement to member parents/guardians due for immunizations through their responsive portal, access to quick push notifications, outbound call campaigns, text, email, and direct mailings.

Asthma Medication Ratio

- Aetna meets and works with Kids Health Connection monthly to focus efforts on outreach to and connection to families with children 17 years of age and younger in Wayne, Oakland, and Macomb counties with a diagnosis of asthma. Kids Health Connection outreaches Aetna members diagnosed with asthma via live calls and in-home visits to provide members with the tools they need to improve their ability to self-manage their asthma (education, spacers, rescue inhaler proper usage, asthma attack triggers etc.)
- Next Best Action outreach campaign targets members with a diagnosis of asthma who have had an Multi-Dose Inhaler (MDI) prescription claim in a rolling 3-month period with the goal to decrease asthma related Emergency Department (ED) visits. The campaign provides links to resources on how to appropriately use a spacer, appropriate use of an inhaler and the importance of ensuring providers prescribe a spacer with an inhaler. Our Community Outreach Workers are assigned members to perform targeted outreach and inhaler use education to members that have had an Inpatient (IP)/ED visit with a diagnosis of asthma.

Prenatal and Postpartum Care

- Care Management (CM) hosts quarterly joint meetings with participating Maternal Infant Health Program (MIHP). Weekly Region 10 Medicaid Health Plan (MHP) collaborative meetings to identify interventions that reduce stress, reduce the risk of preterm labor and low birth weight with focus on increasing health equity for African American mothers. Monthly MHP/Maternal Infant Health Program (MIHP) joint meeting to data share, identify trends and offer supports and services.
- Executed outreach initiatives for Prenatal Care including health education mailings including our Aetna Baby Book when pregnancy is identified, live call outreach campaigns for all identified pregnant mothers to encourage prenatal vitamins, coordinate care with OB/GYN (appt scheduling and

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

transportation arrangement), referrals to MIHP, oral health benefit and coordinating connection to CBO if social determinant of health is identified during call.

- $150 healthy behavior rewards ($50 for Timely prenatal Care visit, $50 for 6 or more prenatal care visits in pregnancy and $50 for timely postpartum visit completion)
- Racial and culturally concordant mailings and SMS campaigns were deployed to our pregnant mothers that include QR codes on the mailings and links in the SMS to take members to 'Every Mother Counts: Choices in Childbirth' resources and videos on the importance of advocating for themselves during appointments, asking questions at every visit and that mothers have the right to make informed choices in their pregnancy, birth and as a parent with physicians.
- Encouraging and educating providers and members on leveraging telehealth services to complete their first OB intake visit within the first trimester.
- All pregnant members are enrolled into our population health program called Maternity Matters. The members are offered care coordination services and receive education materials frequently by mail throughout pregnancy and following delivery. Education materials include information on pregnancy wellness, diet and activity, prenatal and postpartum care, postpartum depression, and resources such as WIC. Information on member incentives for completing prenatal and post-partum care, reaching the care team, and accessing Aetna's afterhours nurse service or the ED for needed care is also incorporated. This education also details the schedule for well child visits, including lead screening, and connection to a pediatrician. Our Care Management team outreaches all pregnant members and offers to provide Care Management for 18 months as part of our newly implemented Maternity Matters program. Through this program, case managers are able to identify pregnant members much earlier in their pregnancy than in the past. This early identification allows us to engage and coordinate pre-natal care and reduce low birthweight outcomes. Additionally, by following members postpartum, case managers are able to address barriers to care, increase compliance with post-partum measures, and provide education and referrals to pediatricians for EPSDT services and childhood vaccinations.
- As part of our efforts to increase maternity and infant health, we have collaborated with several community-based organizations. Aetna is working in partnership to advance equity, increase personal engagement and improve outcomes for our maternity members by ensuring a continuous and frequent communication among the below entities, members, and providers to break down silos among a members care team so that one, holistic, plan of care follows the member.
  - City of Detroit Health Department – Monthly meetings minimum
  - Region 10 Low Birth Wight Health Plan Collaboration - Biweekly meetings
  - Region 8 SWMPQ [Southwest Michigan Perinatal Quality] Improvement Coalition – Monthly
  - Region 9 Perinatal Collaborative – BiWeekly
  - Region SEMPQIC [Southeast Michigan Perinatal Quality Improvement Coalition] Perinatal Quality Collaborative – Monthly
  - MIHP Black Mothers' Breastfeed Association BMBFA (Region 10 Collaborative) – Biweekly meetings
  - Center Pregnancy Program of Henry Ford – Ended June 2022

Appropriate Testing for Pharyngitis

- High volume low performing providers are targeted for outreach and health education on the importance of appropriate prescribing habits and completing a group A streptococcus test for viral pharyngitis episodes

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
Lead Screening • Collaborate with local health departments and PCPs notifying of elevated blood lead levels via our Care Management (CM) team. A CM Registered Nurse (RN) connects with members that have identified as having a blood lead level 4.5 or above (3.5 for Benton Harbor). CMs coordinate care as needed, provide referrals to lead-related resources, and educate and support members and their families. Members can also be referred to CHWs for additional support and referrals for renter laws, housing concerns, water filters and other lead-related community resources. A CM will coordinate with member's PCP for retesting until member is at the recommended lead level and lead-source(s) are removed • Health Education Outreach (Text, Health education mailers and live-outreach calls) • Healthy Behaviors promotion $25 • Coordinated Lead Health Fair Events in region 10, performed live outreach calls and deployed text campaigns to secure attendance, Aetna merchandise giveaways, $25 gift cards for completing lead test and continue to strengthen our partnership with Wayne Health mobile unit and MDHHS in priority zip codes for lead level testing
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Timeliness of Prenatal Care (TOPC) and Postpartum Care (PPC) measure increased year over year as a result of initiatives implemented. A 1.21 percentage point rate lift was seen year over year in the TOPC measure and a 4.63 percentage point rate lift was seen year over year in the PPC measure. • Prenatal and Postpartum Care • PN 68.86% PP 54.01% MY2020 • PN 70.07% PP 58.64% MY2021
c. Identify any barriers to implementing initiatives: Childhood Immunizations • Vaccine hesitant parents remains to be a significant challenge in increasing our Childhood Immunization Status (CIS) rates. In addition, to vaccine hesitancy, we see member parents reporting that they prefer to delay their child's vaccine schedule over a few years to which the series are simply not ever completed. We are also having member's report that their providers will not see more than 2 children in a day for well visits therefore families with 3 or more children are having a difficult time getting appointments for all of their children resulting in several days of doctors' visits. For families with transportation barriers, this is a big obstacle to overcome. • In our outreach efforts, vaccine hesitant families are educated on the efficacy and safety of vaccines and are instructed to direct concerns to their provider. We incentivize members $25 for completing all vaccines due prior to their second birthday and providers $25 for completion of each series in Combo 3 and an added $100 incentive in 2021 for completion of the combo 3 series to support higher vaccination rates however it has not impacted outcomes. Root Cause analysis with Quality, Care Management and other member facing departments will occur in Quarter 3 & Quarter 4 2022. Prenatal and Postpartum Care • There are several factors that are challenging to overcome when trying to improve the timeliness of prenatal and postpartum care measure through interventions. Several of our Obstetrician (OB) offices and primary care offices have reported being short-staffed since the pandemic began and therefore addressing gaps in care has not been priority as they navigate handling fully booked schedules on a weekly basis. Office Managers are answering phone calls and scheduling appointments as well as

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
taking patients back into their rooms. Short appointment times when a member is finally seen makes an expectant mother feel rushed and not cared for during their visit and can reduce the likelihood of that mother return for follow up postpartum care. Majority of our OB offices still do not allow the mother to bring her other children or family at their appointments when historically prenatal care has been a shared experience. Several instances where phone numbers are disconnected, or they decline our calls when performing outreach. Mothers with more than 1 child feel they don't need early prenatal care as they know what to expect or don't feel they have any concerns throughout pregnancy. Appropriate Testing for Pharyngitis • Physicians are unnecessarily prescribing antibiotics due to a multitude of factors such as decision fatigue, having patient pressure for prescription, being uncertain of the diagnosis (patients with similar symptoms and the risk of not prescribing them is greater than that from unnecessary antibiotic use), as well as having limited time with patients during outpatient appointments. Our doctor's offices have been experiencing very difficult challenges since the covid pandemic started. Staff shortages being a very prevalent factor in how standard protocols are overlooked to be able to see every patient in a given workday (time constraints, decision fatigue). Lead Screening • LeadCare II, LeadCare Plus and LeadCare Ultra testing kits were recalled by the Food and Drug Administration (FDA) for producing falsely low results in July 2021. Providers had to discontinue use of these kits in their offices leading to a capillary lead test shortage in our State and across the country. Several provider offices reported that their only option was to offer venous testing which parents refused to complete for their children under the age of 2. The covid pandemic has exacerbated the delay as supply shortages are evident for several lab supply products across the country. We at Aetna ensure that we make providers aware that blood lead tests should still be completed venously and the importance of not delaying lead testing for children exposed to lead.
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** has partially addressed the prior year's recommendations. **Aetna Better Health of Michigan** has put forth effort to address HSAG's prior year recommendation for the *Childhood Immunization Status* measure indicators by partnering with CBOs, offering rewards for completion of vaccine series, and working toward further engaging members by conducting outreach and providing education to members. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *Childhood Immunization Status* measure indicators. Significant barriers noted by **Aetna Better Health of Michigan** were vaccine hesitant parents, delay of child vaccine schedules over a few years, providers not willing to see more than two children during scheduled well-care visits, and transportation. HSAG recommends that **Aetna Better Health of Michigan** continue its efforts on improving childhood immunizations and monitor the impact of initiatives currently in place to ensure improved performance. The Centers for Disease Control and Prevention (CDC) offers provider resources related to vaccine conversations with parents that could potentially help address barriers related to vaccine hesitant parents and the delay of child vaccine schedules.[4-1] As it relates to the prior year's recommendation for the *Asthma Medication Ratio* measure, **Aetna Better Health of Michigan** has demonstrated efforts by outreaching to members with a diagnosis of asthma through

[4-1] Centers for Disease Control and Prevention. Talking with Parents about Vaccines for Infants, updated April 11, 2018. Available at: https://www.cdc.gov/vaccines/hcp/conversations/talking-with-parents.html. Accessed on: Feb 1, 2023.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
its partnership with Kids Health Connection and its Next Best Action internal campaign work. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *Asthma Medication Ratio* measure. As such, HSAG continues to recommend that **Aetna Better Health of Michigan** pursue further education and outreach to members with asthma, with a targeted focus on members with an asthma medication ratio less than 50 percent, to improve upon performance and asthma control for its members. As it relates to the prior year's recommendation for the *Prenatal and Postpartum Care* measure indicators, **Aetna Better Health of Michigan** has demonstrated efforts by hosting quarterly MHP/MIHP joint meetings, conducting outreach campaigns, providing health education to members and providers, encouraging the use of telehealth services among providers and members, and collaborating with CBOs. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *Prenatal and Postpartum Care* measure indicators. Significant barriers noted by **Aetna Better Health of Michigan** were staffing shortages, providers not allowing the mother to bring other children or family to appointments, difficulty outreaching to members, and mothers with more than one child feeling that prenatal care is unnecessary. HSAG recommends that **Aetna Better Health of Michigan** continue its efforts on improving access to prenatal and postpartum care and monitor the impact of initiatives currently in place to ensure improved performance. **Aetna Better Health of Michigan** could consider continuing to further encourage telehealth services among providers and patients to help address some of the noted barriers. As it relates to the prior year's recommendation for the *Appropriate Testing for Pharyngitis* measure, **Aetna Better Health of Michigan** has demonstrated efforts by outreaching to low-performing providers to provide health education on appropriate prescribing habits and completion of the streptococcus test for viral pharyngitis episodes. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *Appropriate Testing for Pharyngitis* measure. Significant barriers noted by **Aetna Better Health of Michigan** were staffing shortages, decision fatigue, appointment time constraints, and members pressuring providers for prescription. HSAG recommends that **Aetna Better Health of Michigan** continue its efforts on improving performance for the *Appropriate Testing for Pharyngitis* measure and monitor the impact of initiatives currently in place to ensure improved performance. **Aetna Better Health of Michigan** is encouraged to continue with educating and outreaching to low-performing providers to reinforce the importance of appropriate antibiotic prescribing habits. As it relates to the prior year's recommendation for the *Lead Screening in Children* measure, **Aetna Better Health of Michigan** has demonstrated efforts by collaborating with LHDs and PCPs, conducting outreach to provide health education to members, coordinating lead health fair events, and providing incentives to members for completing lead tests. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *Lead Screening in Children* measure. Significant barriers noted by **Aetna Better Health of Michigan** were lead test shortages due to the FDA recall on testing kits and parents refusal to have children under the age of 2 complete venous testing. HSAG recommends that **Aetna Better Health of Michigan** continue its efforts on improving lead screening for children and monitor the impact of initiatives currently in place to ensure improved performance. **Aetna Better Health of Michigan** is encouraged to continue educating providers on the use of other methods for lead testing and the importance of not delaying lead testing for children exposed to lead.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **Aetna Better Health of Michigan** previously submitted a CAP to address these findings [discrepancies in provider information were identified in the provider directory], which was accepted by MDHHS, **Aetna Better Health of Michigan** should ensure its CAP is fully implemented to mitigate the deficiencies. Additionally, **Aetna Better Health of Michigan** should conduct its own periodic secret shopper survey of a sample of its provider network and use the results of any future EQR-related network adequacy validation activity to further analyze the completeness and accuracy of its provider data. • As **Aetna Better Health of Michigan** previously submitted a CAP to address these findings [several appeals did not meet the 30-day time frame for resolution and no extensions were taken], which was accepted by MDHHS, **Aetna Better Health of Michigan** should ensure its CAP is fully implemented to mitigate the deficiencies. Additionally, **Aetna Better Health of Michigan** should implement a process to continuously monitor and track time frames in real time to ensure appeals are completed timely and a develop a formal auditing process to address timeliness concerns with individual staff members. • As **Aetna Better Health of Michigan** previously submitted a CAP to address these findings [the third-party subrogation report reflected response times over 30 days], **Aetna Better Health of Michigan** should ensure its CAP is fully implemented to mitigate the deficiencies. • As **Aetna Better Health of Michigan** previously submitted a CAP to address these findings [Several deficiencies were identified throughout the year regarding program integrity, specifically within the program integrity forms. **Aetna Better Health of Michigan**'s reporting structure did not comply with the requirement of the compliance officer to report directly to the chief executive officer and board of directors, documentation did not support that the compliance officer participated in code of conduct training, documentation did not reference process for system edit reviews, no documentation was provided that identified a process for suspending payment to a provider, **Aetna Better Health of Michigan**'s annual program integrity report contained inconsistencies compared to the quarterly report data, the annual Office of Inspector General (OIG) report did not compare the activities to the fiscal year (FY) 2020 plan, and **Aetna Better Health of Michigan** did not provide a narrative for provider exclusion and credentialing/disenrollment processes in the Quality Improvement Program Integrity Activities section of the Annual Program Integrity Plan], **Aetna Better Health of Michigan** should ensure its CAP is fully implemented to mitigate the deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Aetna submitted action plans to address all deficiencies identified in the FY2021 Compliance Review submissions. Actions taken include process updates, report revisions, and adding quality checks and internal monitoring processes to help improve process timeliness and accuracy. • Provider Directory/Data Accuracy: Aetna created a centralized email box for receipt of all provider changes and implemented a tracking tool that tracks provider changes from receipt until confirmation is received from the Provider Data Services team that the change is complete. Aetna started leveraging returned mail as a source to update provider information. We have added collaboration meetings between provider relations and provider data services teams to address outstanding issues with provider change requests. Aetna also added a 4275 file validation audit to scan and ensure no provider information is captured that does not have a positive participation status or other required information

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
for file inclusion. This will reduce passage of data to MDHHS for providers who should not be reflected as participating or accepting new patients. • Appeals Timeliness: A monitoring and escalation process was implemented. Cases drawing close to the due date timelines are escalated to ensure outstanding information is obtained to close cases within required timelines. Monthly review and internal audits were implemented and are ongoing to ensure management oversight of appeals case timeliness. • Third party subrogation report: A quality check oversight process for Aetna's vendor referral inbox was implemented to ensure subrogation response timeliness. Process enhancements that reduce handoffs and streamline the workflow were implemented to minimize processing and response times. Weekly reporting oversight was implemented to monitor aging of correspondence and response inventory. • Program Integrity: Policy updates and report revisions were implemented to ensure accuracy of submitted reports. Additionally, MDHHS OIG updated the report templates to help clarify and ease health plan reporting. • Subsequent to approval of action plans by MDHHS, implementation was confirmed by Compliance. Additionally, the implementations were validated by MDHHS with submission evidence for the FY2022 Compliance Review.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Aetna received Met scores for the FY2022 Compliance Review for three of the four recommendation areas. FY2022 results have not yet been received for one area – provider directory accuracy. Our efforts to improve provider data accuracy has resulted in improved tracking of data update work.
c. Identify any barriers to implementing initiatives: • A considerable, ongoing barrier is provider communication to Aetna – providers do not readily advise Aetna in advance of a demographic change. We have communicated with our Providers that they should allow at least 30 days for demographic changes. Providers have struggled with staffing issues due to Covid, so Aetna often does not get demographic changes until well after the provider demographic change has taken effect.
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** addressed the prior year's recommendations related to the provider directory, member appeals, third-party subrogation requests, and program integrity reports. The results of the SFY 2022 compliance review also confirmed that the MHP successfully remediated the deficiencies related to elements *5.8 Third Party Subrogation Requests*, *6.3 Quarterly Program Integrity Forms* (Audits), *6.5 Quarterly Program Integrity Forms* (Overpayments Collected), *6.9 OIG Program Integrity–Fraud Compliance Program, 6.10 OIG Annual Program Integrity Report*, and *6.11 OIG Program Integrity Plan*. However, HSAG was unable to confirm if **Aetna Better Health of Michigan** successfully remediated element *3.6 Written Member Appeal Decisions Rendered* (now referred to as *3.6-A Member Appeals* and *3.6-B Member Grievances*) as element 3.6 will be scored and included in the SFY 2023 compliance review. Therefore, HSAG recommends that **Aetna Better Health of Michigan** continue to monitor and implement actions to ensure member appeals are resolved timely. Additionally, while **Aetna Better Health of Michigan** implemented interventions to enhance the accuracy of its provider directory, the MHP received a *Not Met* score for element *2.21 Secret Shopper Calls* (previously referred to as *2.6 MHP Provider Directory*) during the SFY 2022 compliance review as discrepancies were identified in PCP locations and phone numbers, and with being listed as accepting new patients. However, **Aetna Better Health of Michigan** continues to work on strategies to enhance the accuracy of its provider directory through the SFY 2023 compliance review CAP which was approved by MDHHS. As such, HSAG has no additional recommendations at this time.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**Aetna Better Health of Michigan** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, timeliness of care, and access to care. **Aetna Better Health of Michigan** should identify any barriers to accessing healthcare (e.g., transportation, geography) and work toward removing these barriers, so members have better access to care. • CSHCS—**Aetna Better Health of Michigan** should monitor the measures to ensure significant decreases in scores over time do not occur. • Healthy Michigan—**Aetna Better Health of Michigan** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care. **Aetna Better Health of Michigan** should provide training and resources to providers to promote smoking cessation with their members.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Our Care Management team continues to increase our face-to-face presence in the community to provide education to members on chronic conditions. Community Health Workers (CHWs) are making unannounced home visits to members who have been unable to engage telephonically. If members are not home, a door knocker and business card with case management contact information encouraging them to call back. Currently we have completed 65 face-to-face visits and participated in 13 events. In 2022 we have completed 244 Chronic Condition specific assessments • Encourage providers to offer same day appointment scheduling. We are collaborating with providers to adopt same-day appointment scheduling in addition to traditional scheduling. • Promoting telehealth solutions beyond the pandemic instituted processes, to expand the access to care options to those reluctant to re-engage back into the provider office, and/or those that prefer to remain in the comfort of their own homes while seeking care. • We will continue to review the CAHPS scores and Year Over Year (YOY) analyses in our Quality Management/Utilization Management and Quality Management Oversite Committee meetings. • Design and implement an Iterative Improvement survey to assess dissatisfaction and to supplement CAHPS results. The questions will be centered around the experience of care, and composite section. • Add smoking cessation training materials, member incentive materials, Michigan Tobacco Quitline information, and approved smoking cessation products to monthly Quality Provider Liaison meetings with providers to ensure they have the resources needed to help members quit smoking. • To provide staff the most updated education, we have monthly trainings on the current CDC clinical guidelines and educational practices. This ensures our staff can provide the most accurate education to parents/members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • "Percentage of Current Smokers" rate improved in MY 2021 from MY 2020 by 4.8 percentage points YoY. • "Got Checkup Appointment/Routing Appt As Soon as Needed" slightly improved in MY 2021. • "Rating of Health Plan" improved by 6.83 percentage points in MY 2021.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
c. Identify any barriers to implementing initiatives: • Our CAHPS response rate has declined YoY despite providing prepaid postage and sending out a second survey with the 3rd reminder. • Decreased engagement in Healthy Behaviors since COVID: We are seeing hesitancy from members to return to provider offices due to COVID-19 or fear of getting sick. Additional feedback from members is that the long-term effects of boosters are unknown, and this deters members from seeking additional care. During outreach, Case Managers discuss the importance of reengaging with Primary, Preventative, and Specialty care as part of member engagement efforts. Discussions regarding telehealth, as appropriate, are also utilized to connect members to medical professionals who can address members concerns and increase healthy behaviors. Case managers and CHWs leverage motivational interviewing skills to understand members ambivalence and help them move into a state of action and engagement with providers. • Member's refusal to participate in Care Management: Families may already have access to care management services through community-based organizations. To increase coordination of services we have monthly touch points with large organizations including the Detroit Local Health Department to discuss members and partnerships opportunities. Members at times report a knowledge deficit regarding the objective of Care Management. Education is provided to members regarding services available through, and the benefits of Care Management.
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** has addressed the prior year's recommendations. The SFY 2022 CAHPS activity confirmed that **Aetna Better Health of Michigan**'s scores were comparable to national averages for all measures for the adult and child Medicaid, CSHCS, and HMP populations.

Blue Cross Complete of Michigan

Table 4-2—Prior Year Recommendations and Responses for BCC

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Blue Cross Complete of Michigan** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Blue Cross Complete (BCC) is conducting ongoing root cause and barrier analyses in regular meetings • between the Quality and Maternity teams, as well as monthly cross-departmental Maternity Workgroup • meetings. • BCC completed a survey of black women regarding access to prenatal care and care during COVID. • BCC completed a survey of OBGYN offices across its service areas regarding policies around access to prenatal care. • BCC continued previous Performance Improvement Project (PIP) strategies for black women in Wayne County, including use of improved Early Identification Report, stratification as high risk in order to conduct targeted outreach, and a care card incentive for black women in Wayne County.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Previous PIP data showed improvement over baseline rate for the disparate subgroup. • Prenatal rate improved 9.17 percentage points from MY 2020 to MY 2021. • The disparity between black women in Wayne County and white women in Wayne County decreased by 8.37 percentage points from MY 2020 to MY 2021.
c. Identify any barriers to implementing initiatives: • CDC COVID-19 Community Level in Wayne County remains High. • Structural racism is a noted cause of adverse maternal outcomes for disparate populations. • In-person outreach by Community Health Navigators was suspended during the COVID-19 Public Health Emergency.
HSAG Assessment: HSAG has determined that **Blue Cross Complete of Michigan** addressed the prior year's recommendations. The MHP revisited its causal/barrier analysis to capture barriers associated with the PHE.
2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Blue Cross Complete of Michigan** should conduct a root cause analysis or focused study to determine why members were not always receiving appropriate testing for pharyngitis to warrant antibiotic treatment. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Appropriate Testing for Pharyngitis* measure. • **Blue Cross Complete of Michigan** should conduct a root cause analysis or focused study to determine why some women did not receive prenatal and postpartum care. If it is determined that COVID-19 impacted performance for the *Prenatal and Postpartum Care* measure indicators, **Blue Cross Complete of**

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
Michigan should proactively alter its approach to prenatal and postpartum care through methods such as telemedicine, when possible, to improve upon performance related to the *Prenatal and Postpartum Care* measure. **Blue Cross Complete of Michigan** may also consider evaluating the potential to maximize telehealth (when possible and appropriate) to help alleviate staff shortages, optimize prenatal and postpartum care service delivery, as it can be utilized for triaging and to provide counseling to pregnant women, and reduce risk for severe illness from COVID-19 for pregnant women. • Due to continued low performance for the *Asthma Medication Ratio* measure, **Blue Cross Complete of Michigan** should monitor and target its efforts toward those with asthma medication ratios less than 50 percent to improve upon performance related to the *Asthma Medication Ratio* measure. Appropriate medication management for those with persistent asthma is especially important during the COVID-19 pandemic, as those with moderate-to-severe or uncontrolled asthma are more likely to be hospitalized from COVID-19.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • BCC conducted a root cause analysis for the below measures and implemented the following initiatives. Measure 1: Appropriate Testing for Pharyngitis: • The HEDIS team was asked to review HEDIS specifications and data sources for this measure and found no irregularities. The HEDIS team did report that similar declines were found across other affiliated Medicaid plans operating in other states. There was a significant decline in the eligible population during this time frame and the decline is understood to be a result of the COVID-19 pandemic. • BCC published educational articles for both providers and members. Measure 2: Prenatal and Postpartum Care • Member and provider communications including social media posts, texting campaigns and educational articles. • Member and provider incentives. • Surveyed black women regarding access to prenatal care and care during COVID. • Surveyed a sample of OBGYN offices across BCC's service areas regarding policies around access to prenatal care. • Year round HEDIS medical record review. • Exploring enhanced telehealth capability to increase access for all members. Measure 3: Asthma Medication Ratio (AMR) • BCC participates in a pilot program in Region 9 to provide educational materials on asthma symptom management to pediatric members who have been discharged with an asthma diagnosis. A Community Health Navigator (CHN) will complete an Asthma Environmental Survey and provides a home cleaning kit to the member. The BCC CHN can provide 1:1 personalized education and will also connect the member to resources for environmental trigger remediation. • BCC is launching a pilot with a vendor that focuses on identifying and outreaching to members who have high emergency department utilization for rescue asthma medication. Members will receive a

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
sensor to attach to their inhaler. The sensors then automatically track where, when, and how often the medication is used and the member's care team and health coach work with the member for better asthma control. • BCC's Pharmacy Benefit Manager (PBM) expanded communication with members who are non-adherent with their medications for asthma by performing outreach calls to members and providing educational mailings. • BCC runs an ongoing social media and texting campaign to educate members on the importance of controlled asthma and developing a treatment plan with a provider. • BCC Care Managers perform outreach to members with asthma to provide care coordination and education. • BCC's PBM Data mining to identify members for outreach with a lapse in refill or asthma medication concerns. • BCC supports a quality initiative with Michigan Medicine to increase asthma education during patient visits.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Measure 1: Appropriate Testing for Pharyngitis: BCC will continue to monitor this measure for improvement and revise initiatives as needed. • Measure 2: Prenatal and Postpartum Care: o Prenatal rate improved from MY2020 to MY 2021 o Postpartum rate improved from MY 2020 to MY 2021 o BCC has seen increase in telehealth services during the pandemic. • Measure 3: Asthma Medication Ratio: BCC will continue to monitor this measure for improvement and revise initiatives as needed.
c. Identify any barriers to implementing initiatives: • Measure 1: Appropriate Testing for Pharyngitis: Provider offices remain short-staffed • Measure 2: Prenatal and Postpartum Care: o Public Health Emergency (PHE) continues in Michigan. o Lack of awareness of availability of telehealth. o Outreach efforts to members are hindered by member unresponsiveness. • Measure 3: Asthma Medication Ratio: Awaiting finalization of contract with vendor, expected completion in the 4th quarter of 2022.
HSAG Assessment: HSAG has determined that **Blue Cross Complete of Michigan** has partially addressed the prior year's recommendations. **Blue Cross Complete of Michigan** has put forth effort to address HSAG's prior year recommendation for the *Appropriate Testing for Pharyngitis* measure by conducting a root cause analysis, which resulted in identification of the COVID-19 PHE as a factor for low performance for the measure, and providing education to members and providers. However, **Blue Cross Complete of Michigan** continues to demonstrate low performance for the *Appropriate Testing for Pharyngitis* measure. A significant barrier noted by **Blue Cross Complete of Michigan** was that provider offices remained short-staffed. HSAG recommends that **Blue Cross Complete of Michigan** continue its efforts on improving performance for the *Appropriate Testing for Pharyngitis* measure and monitor the impact of initiatives currently in place to ensure improved performance. **Blue Cross Complete of Michigan** is encouraged to continue educating members and providers.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
Blue Cross Complete of Michigan partially addressed the prior year's recommendation for the *Prenatal and Postpartum Care* measure indicators. **Blue Cross Complete of Michigan** demonstrated efforts by exploring enhanced telehealth capability, surveying a sample of OB/GYN provider offices regarding policies and prenatal care access, surveying black women on access to prenatal care, providing member and provider incentives, and conducting member and provider outreach and education. Additionally, **Blue Cross Complete of Michigan** demonstrated improved performance for the *Prenatal and Postpartum Care* measure indicators. Although **Blue Cross Complete of Michigan** demonstrated improved performance, significant barriers noted by **Blue Cross Complete of Michigan** were member unresponsiveness to outreach efforts, lack of awareness of telehealth availability, providers not allowing the mother to bring other children or family to appointments, and the COVID-19 PHE. As such, HSAG recommends that **Blue Cross Complete of Michigan** continue its efforts on improving access to prenatal and postpartum care and monitor the impact of initiatives currently in place to ensure continuous improved performance. **Blue Cross Complete of Michigan** could consider continuing to further encourage telehealth services among providers and patients to help address some of the noted barriers. As it relates to the prior year's recommendation for the *Asthma Medication Ratio* measure, **Blue Cross Complete of Michigan** has demonstrated efforts by participating in a pilot program to provide education on asthma symptom management to pediatric members, launching a pilot with a vendor that focuses on identification and outreach to members with high emergency department utilization for rescue asthma medication, member outreach via **Blue Cross Complete of Michigan**'s PBM and care managers, and participation in a quality initiative with Michigan Medicine for increasing asthma education during patient visits. However, **Blue Cross Complete of Michigan** continues to demonstrate low performance for the *Asthma Medication Ratio* measure. As such, HSAG continues to recommend that **Blue Cross Complete of Michigan** pursue continued further education and outreach to members with asthma, with a targeted focus on members with an asthma medication ratio less than 50 percent, to improve upon performance and asthma control for its members.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **Blue Cross Complete of Michigan** previously submitted a CAP to address these findings [discrepancies in provider information were identified in the provider directory, and multiple members did not have a dental provider identified], which was accepted by MDHHS, **Blue Cross Complete of Michigan** should ensure its CAP is fully implemented to mitigate the deficiencies. Additionally, **Blue Cross Complete of Michigan** should use other sources, such as the provider website, to verify and correct data included in the provider directory. **Blue Cross Complete of Michigan** should also use the results of any future EQR-related network adequacy validation activity to further analyze the completeness and accuracy of its provider data. • As **Blue Cross Complete of Michigan** previously submitted a CAP to address these findings [several appeals did not meet the 30-day time frame for resolution and the explanations did not meet the allowable reasons for an extension], which was accepted by MDHHS, **Blue Cross Complete of Michigan** should ensure its CAP is fully implemented to mitigate the deficiencies. Additionally, **Blue Cross Complete of Michigan** should implement a process to continuously monitor and track time frames in real time to ensure appeals are completed timely and develop a formal training and auditing process to address timeliness concerns and provide education on the appropriate uses of extensions with individual staff members.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Provider Directory • BCC Provider Data Management updates provider data received from network providers in provider directories (including the 4275 provider files) and provides quarterly monitoring of provider data accuracy via a survey sent to providers inquiring if they have had any demographic changes in the last quarter. • BCC Provider Network Management conducts secret shopper calls on a random sample of primary care and specialty providers. The outcome of the secret shopper calls are reviewed with the providers to educate them on the provider data change notification process. Providers who fail to confirm that they provided the required updates to demographic information and are identified as continuously "non-compliant" are placed on corrective action plans. Appeals • Appeals & Grievances (A&G) management provided retraining on the appeals process to Appeals Coordinators & Nurses. • Appeals & Grievances department has implemented a daily reconciliation process of the assigned cases to validate that appeals are assigned to the correct queues. • Appeals & Grievances department implemented additional monitoring through an automated, daily dashboard, which provides case information pulled directly from an appeal tracking system. The A&G team lead, and supervisor monitor the age of all cases to help ensure they are completed by the compliance date.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Provider Directory • BCC continues to monitor the impact of initiatives but has not seen continuous and consistent improvement. Appeals • Increase in compliance and quality Key Performance Indicators • Reduction in risk to compliance due to additional oversight and monitoring
c. Identify any barriers to implementing initiatives: Provider Directory • Administrative burdens and limited provider resources as a result of the COVID-19 pandemic have diminished the provider's ability to provide updated information and respond to BCC inquiries on a timely basis. Appeals • Timing of system changes to further automate processes and reduce manual reviews.
HSAG Assessment: HSAG has determined that **Blue Cross Complete of Michigan** did not address the prior year's recommendation related to the assignment of a dental provider. The MHP's narrative did not specifically address element *2.14 Dental Provider Directory*, and this element was not included in the SFY 2022

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
compliance review; therefore, HSAG was unable to confirm the deficiency was adequately addressed. As such, HSAG recommends that **Blue Cross Complete of Michigan** implement monitoring activities to ensure all members are assigned a dental provider. HSAG has determined that **Blue Cross Complete of Michigan** addressed the prior year's recommendations related to member appeals and the provider directory. However, HSAG was unable to confirm if **Blue Cross Complete of Michigan** successfully remediated element *3.6 Written Member Appeal Decisions Rendered* (now referred to as *3.6-A Member Appeals* and *3.6-B Member Grievances*) as element 3.6 will be scored and included in the SFY 2023 compliance review. Therefore, HSAG recommends that **Blue Cross Complete of Michigan** continue to monitor and implement actions to ensure member appeals are resolved timely. Additionally, while **Blue Cross Complete of Michigan** implemented interventions to enhance the accuracy of its provider directory, the MHP received a *Not Met* score for element *2.21 Secret Shopper Calls* (previously referred to as *2.6 MHP Provider Directory*) during the SFY 2022 compliance review as discrepancies were identified in PCP locations and phone numbers, and with being listed as accepting new patients. However, **Blue Cross Complete of Michigan** continues to work on strategies to resolve the deficiency through the SFY 2022 compliance review CAP which was approved by MDHHS. As such, HSAG has no additional recommendations at this time.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**Blue Cross Complete of Michigan** should focus on improving adult members' overall experiences with their personal doctor. **Blue Cross Complete of Michigan** should provide training and resources to providers to cultivate better relationships between providers and members, and to support improvement in providers' communication skills. • Adult and Child Medicaid—**Blue Cross Complete of Michigan** should explore what may be driving lower experience scores with their child's health plan and develop initiatives designed to improve quality of care, timeliness of care, and access to care. • CSHCS—**Blue Cross Complete of Michigan** should monitor the measures to ensure significant decreases in scores over time do not occur. • Healthy Michigan—**Blue Cross Complete of Michigan** should monitor the measures to ensure significant decreases in scores over time do not occur.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • BCC has included training and other resources to strengthen provider-patient relationships and improve communication in our provider newsletters, provider fax blasts, and provider meetings. • BCC care management and community health workers outreach to members to assist in connecting member with necessary services. • Member communication has been developed and shared in various texting campaigns and member newsletters to further educate on benefits, access standards and to provide support in navigating health care services, including telemedicine services.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
• BCC implemented a post appointment survey process to obtain feedback from members on their experience in the provider offices. This survey was implemented in summer 2022. BCC plans to share provider specific results with our provider groups to increase awareness of member feedback at the practice level and develop initiatives to address member concerns. • BCC began to share provider specific health equity data and performance at each provider's joint operating committee meetings to identify performance improvement opportunities to close health care gaps.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • BCC saw improvement in both the 2022 Adult and Child CAHPS report for "Rating of Personal Doctor". • The results for "Getting Needed Care" in Adult CAHPS report were also higher when compared to the prior year's results. • 2022 CAHPS results for CSHCS, and Healthy Michigan Plan were not available at the time of this response.
c. Identify any barriers to implementing initiatives: • Accuracy of member addresses and telephone numbers impact ability to successfully contact some members when implementing the various initiatives referenced above. • COVID-19 and the on-going public health emergency has continued to impact staffing at health care provider offices. • Some members have ongoing hesitancy to return to provider offices as they still feel unsafe or have concerns with following safety protocols in the office that were new to them.
HSAG Assessment: HSAG has determined that **Blue Cross Complete of Michigan** has addressed the prior year's recommendations. The SFY 2022 CAHPS activity confirmed that **Blue Cross Complete of Michigan**'s score for *Rating of Personal Doctor* for the adult Medicaid population was comparable to the national average. Also, **Blue Cross Complete of Michigan**'s score for *Rating of Health Plan* for the child Medicaid population was comparable to the 2021 NCQA child Medicaid national average.

HAP Empowered

Table 4-3—Prior Year Recommendations and Responses for HAP

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **HAP Empowered** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • HAP Empowered continued the prenatal care workgroup consisting of representatives from the Quality Management, Performance Improvement/HEDIS and Care Management departments. The workgroup meets monthly to discuss ongoing barriers, interventions, and strategies to improve prenatal care. To identify barriers associated with the pandemic, the workgroup created and continues to utilize a fishbone diagram as a QI tool. This helped to document barriers and initiate discussions for improvement. Furthermore, workplans are maintained to track progress. Sessions were also held to brainstorm and prioritize barriers into focus areas. • Interventions implemented during the baseline measurement period for the Timeliness of Prenatal Care measure include: o Prenatal Care Management Program (Internal) o Transitioned to a vendor for a maternity focused care management program powered by ProgenyHealth. o Progeny also outreaches to engage members and refer to Maternal Infant Health Program (MIHP) o Increased member incentive amount for prenatal care in 2021. Continued strategies to engage members and educate on incentive program.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HAP Empowered analyzes HEDIS results to measure the effectiveness of interventions and to identify additional opportunities for improvement. The overall MY2021 HEDIS prenatal care rate is 75.8%. HAP Empowered further compared the study indicator of the Black/African American rate to the overall rate. The Black/African American rate is 72.3% which is below the overall rate but does not indicate a statistically significant disparity. HAP Empowered continues to identify opportunities for improvement and collaborate on plan interventions. An additional improvement related to the interventions implemented is that 77.2% of members enrolled in the maternity case management program received timely prenatal care.
c. Identify any barriers to implementing initiatives: • A continued barrier is the ability to engage members in the programs available. Due to inaccurate contact information members are difficult to reach. Efforts continue to ensure contact information is updated and obtained when available.
HSAG Assessment: HSAG has determined that **HAP Empowered** addressed the prior year's recommendations. The MHP revisited its causal/barrier analysis to capture barriers associated with the PHE.

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

HSAG recommended the following:

- **HAP Empowered** should monitor performance improvement interventions currently in place and continue to expand upon or implement additional interventions, when necessary, to improve the performance related to the *Childhood Immunization Status* measure. The CDC recommends continued administration of routine immunization during the pandemic to prevent transmission of other preventable infectious diseases. According to the AAP, while telehealth visits are recommended, in-person visits, especially for vaccination, should not be discontinued unless community circumstances require the limitation of in-person visits, in which case curbside or drive-through vaccination can be implemented by clinics to limit patient-provider contact.
- **HAP Empowered** should conduct a root cause analysis or focused study to determine why some children did not receive lead blood tests by their second birthday. If it is determined that COVID-19 impacted performance for *Lead Screening in Children*, **HAP Empowered** should take a proactive approach in ensuring young children are receiving appropriate lead testing and care management. During the pandemic, the AAP recommended that well-child examinations occur in person whenever possible and within the child's medical home where continuity of care can be established. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Lead Screening in Children* measure.
- **HAP Empowered** should conduct a root cause analysis or focused study to determine why some adolescents were not always receiving one dose of meningococcal vaccine, one Tdap vaccine, and the complete HPV vaccine series by their 13th birthday. If it is determined that COVID-19 impacted performance for the *Immunizations for Adolescents* measure, **HAP Empowered** should take a proactive approach in ensuring adolescents receive their recommended vaccines. The easing of nationwide restrictions and opening of schools introduce a new risk for disease outbreaks among adolescents who may have missed routine immunizations due to the pandemic. Therefore, it is essential for pediatricians to ensure adolescents are up to date on their vaccines. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Immunizations for Adolescents* measure.
- **HAP Empowered** should conduct a root cause analysis or focused study to determine why members were not always receiving appropriate testing for pharyngitis to warrant antibiotic treatment. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Appropriate Testing for Pharyngitis* measure.
- **HAP Empowered** should conduct a root cause analysis or focused study to determine why some women did not receive prenatal and postpartum care. If it is determined that COVID-19 impacted performance for the *Prenatal and Postpartum Care* measure indicators, **HAP Empowered** should proactively alter its approach to prenatal and postpartum care through methods such as telemedicine, when possible, to improve upon performance related to the *Prenatal and Postpartum Care* measure. Additionally, if member mistrust in providers is identified as a root cause that impacted the rates for both *Prenatal and Postpartum Care* measure indicators, **HAP Empowered** should work toward strengthening patient-provider relationships in an effort to improve upon the rate for the *Prenatal and Postpartum Care* measure. The AMA has discussed ways to strengthen trusting patient-physician relationships and reduce health inequities: the medical profession should hear and amplify the voices of patients and families, partner with communities where disproportionate rates of maternal mortality exist, have greater collaboration with non-clinical community organizations with close ties to minoritized and marginalized groups to identify opportunities to best

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
support pregnant women and new families, and engage in the funding and development of outreach initiatives to promote comprehensive pre-pregnancy, prenatal, peripartum, and postpartum care. • Due to continued low performance for the *Asthma Medication Ratio* measure, **HAP Empowered** should monitor and target its efforts toward those with asthma medication ratios less than 50 percent to improve upon performance related to the *Asthma Medication Ratio* measure. Appropriate medication management for those with persistent asthma is especially important during the COVID-19 pandemic, as those with moderate-to-severe or uncontrolled asthma are more likely to be hospitalized from COVID-19.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Childhood Immunizations: HAP Empowered has been focused on improving its rates for childhood immunizations through the promotion of immunizations, immunization education to members, and improving access to childhood immunizations. Based on the performance of past and current initiatives, a number of initiatives have been continued, implemented and more are in development for 2023: • Monthly review of refreshed HEDIS data via a dashboard to monitor immunization rates • Collaborating across the organization to address key drivers of low immunization rates • Continued the member incentive for completing childhood immunizations in 2022 • December 2021 through February 2022, HAP Empowered conducted targeted telephonic outreach focused on children who needed at least one childhood immunization completed by August 2022 Through this outreach, the following items were provided: immunization education, assistance in addressing social determinants of health barriers, assistance in scheduling appointments and transportation to those appointments • Partnered with the Detroit Health Department and Detroit Public schools on providing children with their immunizations as well as other services (i.e., lead screening). Services were often provided at community events that took place at a number of locations (i.e., community centers) throughout the summer of 2022 • Retrained internal member-facing departments on the Customer Service Resource (CSR) tool which allows team members to see and remind members who call HAP Empowered what services and screenings they need to complete • Developing a comprehensive member outreach strategy for 2023 that includes telephonic outreach, member and provider letters, and texting messaging • Collaborating with Federally Qualified Health Centers (FQHCs) and Provider Groups in providing education on childhood immunizations, overcoming vaccine hesitancy, and providing immunizations. • Enhancing HEDIS reports for providers, so they are able to see their current immunization rates as well as the members need an immunization Lead Screening in Children: The root causes for the low lead screening rates include: • Continued low rate in Well-Child Visits within the First 15 Months of Life where lead testing is conducted in person • Limited access to lead screenings outside of a well-child visit (i.e. in home lead screenings, mobile units)

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

- Parents/Guardians do not fully understand the importance of the blood lead test and therefore do not consider it a priority (https://www.nbcnews.com/news/us-news/lead-poisoning-tests-children-pandemic-rcna28041).
- Provider capacity is still limited from the COVID-19 pandemic so appointment availability is limited.
- Parents/guardians do not have reliable transportation to get to/from the appointment.
- Parents/guardians are unable to get time off of work to take their child to their appointment.

Immunizations for Adolescents:
The root cause for low Immunizations for Adolescents Combo 2 include:

- Families are prioritizing the COVID-19 vaccinations series over the adolescent immunizations. Early in the distribution of the COVID-19 vaccine, it was recommended that people should not receive any other vaccines until a number of weeks after the last dose (not the booster) is received.
- HAP Empowered dedicated resources to COVID-19 (i.e., helping members through lock-down, educating members on importance of getting the COVID-19 vaccine and providing the COVID-19 vaccine). These resources were taken from the resources used to close gaps in care such as immunizations for adolescents.
- Parents/guardians need more education on the safety of the HPV vaccine.
- Parents/guardians do not think their child need the vaccine as their child is not "sexually active."
- Lack of education from the provider on the importance and benefits of the HPV vaccine.
- Provider capacity is still limited from the COVID-19 pandemic so appointment availability is limited. Therefore, immunizations are being completed late (after the child's 13th birthday).
- Parents/guardians do not have reliable transportation to get to/from the appointment.
- Parents/guardians are unable to get time off of work to take their child to their appointment(s).

Appropriate Testing for Pharyngitis
Barriers to obtaining appropriate testing for pharyngitis before prescribing of an antibiotic include:

- Lack of provider education around the need for appropriate testing prior to prescribing of an antibiotic.
- Lack of reporting out to provider groups on providers who are prescribing an antibiotic without conducting the appropriate test.
- Rise in telehealth appointments due to the pandemic increased the rate of the members being prescribed an antibiotic without appropriate testing.
- Members need education on when an antibiotic is necessary: (https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0366)
- Members want the antibiotic and failure to prescribe the member the antibiotic may negatively impact the provider's rating: (https://www.npr.org/sections/health-shots/2018/10/03/653446952/patients-give-doctors-high-marks-for-prescribing-antibiotics-for-common-sniffles)

Prenatal and Postpartum Care:
The following barriers to women receiving timely Prenatal and Postpartum Visits were identified:

- Members have disengaged from healthcare due to COVID-19 and are therefore not seeking maternity related care.
- Unable to reach the member when outreach is performed.
- Difficulty obtaining timely identification of pregnant members which would allow for timely intervention for the member's prenatal visit.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
• Lack of response/engagement from the member to participate in HAP Empowered's pregnancy programs such as the Member Incentive Program, Maternal Infant Home Program (MIHP) and Case Management programs. Some initiatives that HAP Empowered has implemented or revised due to these identified barriers include: • Increased the prenatal member reward from $50 to $75 in 2022. • Enhanced the Postpartum Hotlist to include more recent claims and therefore increased the frequency of the report. This allows for more real-time data and more intervention time for HAP Empowered. • Implemented Progeny Health as a Maternity Care Management Program. This program provides a high-touch approach to the maternity members, assists in obtaining prenatal and postpartum services, and connects the members with other resources that they may require. • Continued outreach to members to educate and refer to the Maternal Infant Health Program (MIHP). Asthma Medication Ratio: • HAP Empowered implemented a member-centric medication adherence program on November 1, 2021, in conjunction with the prescription benefit manager (PBM), with asthma included as a focus condition. The program uses pharmacy claims and predictive analysis to provide adherence support and address adherence barriers, including phone calls to members, letters, opportunities to speak with a pharmacist, and adherence aids/devices. • HAP Empowered continued the ongoing provider intervention program in conjunction with the PBM with quality and safety alerts to prescribers and pharmacies to support improvements in asthma care. • The allowed days supply per prescription fill was extended for additional medications in August 2021 to provide up to a 102-day supply, including asthma inhalers and other asthma maintenance medications. Allowing a three-month supply reduces barriers to adherence, including repeated trips to the pharmacy. • In early 2021, HAP Empowered expanded daily oversight of processed claims to include comprehensive review and reach-out for rejected claims for non-formulary drugs or drugs with utilization management. Asthma medications are a priority, with high-touch reach-out that includes interventions with the pharmacy, prescriber, and member as applicable to make sure members receive a medication.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HAP Empowered has seen an improvement in its Childhood Immunization Status rates in MY 2022. As of August 2022, HAP Empowered's Childhood Immunization Status rates for both Combos 3 and 10 and Lead Screening in Children have surpassed their Final MY 2021 rates. Additionally, Immunizations for Adolescents Combo 1 is also on track to surpass its MY 2021 rate. These improvements can be attributed too: • Targeted Telephonic Outreach: HAP Empowered conducted an outcomes analysis of the telephonic outreach that was conducted from August 2021 through February 2022. Some high-level outcomes include: o 27.95% of the members who were outreached to for childhood immunization closed their Childhood Immunization Status Combo 3 gap for MY 2022. o 18.64% of the members who were outreached to for lead screening closed their lead screening gap for MY 2022. o 45.56% of the members who were outreached to for adolescent immunizations closed their Immunization for Adolescents Combo 1 gap for MY 2022.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
○ 5.11% of the members who were outreached to for adolescent immunizations, closed their Immunization for Adolescents Combo 2 gap for MY 2022. • Due to this outcome, HAP Empowered is developing a more permanent member outreach strategy in 2023 for this population to help these members complete their immunizations within the recommended timeframe. • Detroit Health Department Partnership – Detroit Health Department/HAP Empowered has hosted eight immunization events throughout the summer of 2022. Members who did not attend the event did receive a reminder that they are due for some immunizations. HAP Empowered has also seen improvement in its Postpartum Care Visits since MY 2020. HAP Empowered had a rate of 52.68% in MY2020 and this improved to 64.57% in MY 2021. This can be attributed to: Postpartum Hotlist – the Postpartum Hotlist was implemented in late 2020. The Medicaid Case Management team conducts telephonic outreach to members who are on this list to remind the embers that they need a postpartum visit. • ProgenyHealth Maternity Management Program – the implementation of the ProgenyHealth Maternity Management program that includes a personalized care journey and resources for pregnant women, guidance and navigation through pregnancy and 8 months post-delivery, and technology enabled health services that include care plans and digital engagement tools. HAP Empowered has seen improvement in the Asthma Medication Ratio rate from year to year. ○ HAP Empowered had the following rates: ▪ MY 2020 = 46.27% ▪ MY 2021 = 48.30% ▪ MY 2022 (current) = 55.88% • HAP Empowered has seen an improvement in medication adherence for asthma, with an increase in trend of approximately 4% for proportion of days covered (PDC) from 7/1/21-6/30/22. • Results for the provider intervention program are produced annually after the end of the calendar year, so results are not yet available for 2022. • HAP Empowered has seen a significant increase in the number of prescriptions filled each month for asthma medications in extended days supplies. • HAP Empowered has performed reach-out on 100% of claims for asthma medications that were rejected for non-formulary or utilization management requirements, with subsequent follow-up to confirmed paid claims for the member.
c. Identify any barriers to implementing initiatives: • Texting Campaigns – HAP Empowered has not implemented a texting campaign for members who are under the age of 18. HAP Empowered has been in the process of mastering the data that connects the member to a parent/guardian. Additionally, the texting software that is used verifies that the person who receives the text message is a HAP member. This means that work arounds are needed for children who are HAP Empowered members, but their parent/guardian is not enrolled in any HAP plan. This has limited the amount of communication HAP Empowered has with members who are due for a childhood immunization, lead screening and/or immunization for adolescents. • Rewards Program – The Member Rewards Program was not implemented until May of 2022 due to the amount of work and time it took to build the claims logic. While the program did not go live until mid-year, all rewards earned since January 1, 2022, were honored. Additionally, while the number of members rewarded for completing childhood immunizations and lead screening has greatly increased in 2022, it is expected that this is solely due to going to a claims-based program. It is not clear on if the reward is motivating members to complete their immunization series and/or lead screening.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
• Customer Service Resource (CSR) Tool Updates – Certain immunizations needed for childhood immunizations were not included in the original design of the tool resulting in members not receiving the reminders for all of the immunizations that they were missing. The tool is currently being updated to include all immunization reminders. • Member-Centric Medication Adherence Program – It is often difficult to reach the member due to outdated or inaccurate contact information (mailing address and telephone number). There are ongoing efforts by HAP Empowered to ensure contact information is updated.
HSAG Assessment: HSAG has determined that **HAP Empowered** has partially addressed the prior year's recommendations. **HAP Empowered** has put forth effort to address HSAG's prior year recommendation for the *Childhood Immunization Status* measure indicators by providing education to members, continuously monitoring performance via a dashboard, providing member incentives for completion of immunizations, conducting member outreach, partnering with the Detroit Health Department and Detroit Public schools, collaborating with FQHCs and provider groups, and enhancing HEDIS reports for providers so they could see immunization rates and members that needed immunizations. Additionally, **HAP Empowered** demonstrated improved performance for the *Childhood Immunization Status* measure indicators. Although **HAP Empowered** demonstrated improved performance, significant barriers noted by **HAP Empowered** were member outreach and necessary updates for the CSR tool so that it included all required immunizations. As such, HSAG recommends that **HAP Empowered** continue its efforts on improving childhood immunizations, confirm that all required tool updates have been made, and monitor the impact of initiatives currently in place to ensure continuous improved performance. As it relates to the prior year's recommendation for the *Lead Screening in Children* measure, **HAP Empowered** has demonstrated efforts by conducting a root cause analysis and identifying factors that led to a decrease in performance. However, **HAP Empowered** continues to demonstrate low performance for the *Lead Screening in Children* measure. Significant barriers noted by **HAP Empowered** were lead test shortages due to the FDA recall on testing kits, parents not understanding the importance of blood lead testing, staffing shortages, transportation, and member outreach. HSAG recommends that **HAP Empowered** continue its efforts on improving lead screening for children. **HAP Empowered** is encouraged to attempt additional methods of member outreach, as well as educate providers and members on the use of other methods for lead testing and the importance of not delaying lead testing for children exposed to lead. Appropriate interventions should be implemented if other contributing factors are identified. As it relates to the prior year's recommendation for the *Immunizations for Adolescents* measure, **HAP Empowered** has demonstrated efforts by conducting a root cause analysis and identifying factors that led to a decrease in performance. However, **HAP Empowered** continues to demonstrate low performance for the *Immunizations for Adolescents* measure. Significant barriers noted by **HAP Empowered** were staffing shortages, prioritization of the COVID-19 vaccination series over the adolescent immunizations, lack of education on the safety of the HPV vaccine, transportation, and member outreach. HSAG recommends that **HAP Empowered** continue its efforts on improving immunizations for adolescents. **HAP Empowered** is encouraged to attempt additional methods of member outreach and provide member and provider education on the importance of immunizations for adolescents. Appropriate interventions should be implemented if other contributing factors are identified. As it relates to the prior year's recommendation for the *Appropriate Testing for Pharyngitis* measure, **HAP Empowered** has demonstrated efforts by conducting a root cause analysis and identifying factors that led to a

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
decrease in performance. However, **HAP Empowered** continues to demonstrate low performance for the *Appropriate Testing for Pharyngitis* measure. Significant barriers noted by **HAP Empowered** were staffing shortages, lack of provider and member education on need for appropriate testing, and member outreach. HSAG recommends that **HAP Empowered** continue its efforts on improving performance for the *Appropriate Testing for Pharyngitis* measure. **HAP Empowered** is encouraged to provide education to members and providers, as well as reinforce the importance of appropriate antibiotic prescribing habits. Appropriate interventions should be implemented if other contributing factors are identified. As it relates to the prior year's recommendation for the *Prenatal and Postpartum Care* measure indicators, **HAP Empowered** has demonstrated efforts by conducting a root cause analysis and identifying factors that led to a decrease in performance. Additionally, **HAP Empowered** demonstrated improved performance for the *Prenatal and Postpartum Care* measure indicators. Although **HAP Empowered** demonstrated improved performance, significant barriers noted by **HAP Empowered** were member outreach, timely identification of pregnant members, providers not allowing the mother to bring other children or family to appointments, and lack of engagement from members. As such, HSAG recommends that **HAP Empowered** continue its efforts on improving access to prenatal and postpartum care and monitor the impact of initiatives currently in place to ensure continuous improved performance. **HAP Empowered** could consider the use of telehealth services among providers and patients to help address some of the noted barriers. As it relates to the prior year's recommendation for the *Asthma Medication Ratio* measure, **HAP Empowered** has demonstrated efforts by implementing a member-centric medication adherence program, continuing with its provider intervention program to support improvement in asthma care, extending the allowed days' supply for prescription refills, and expanding upon its provider oversight. Additionally, **HAP Empowered** demonstrated improved performance for the *Asthma Medication Ratio* measure. Although **HAP Empowered** demonstrated improved performance, HSAG continues to recommend that **HAP Empowered** pursue further education and outreach to members with asthma, with a targeted focus on members with an asthma medication ratio less than 50 percent, to improve upon performance and asthma control for its members.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **HAP Empowered** previously submitted a CAP to address these findings [unable to send out member handbooks timely for three months and multiple appeals were not completed within the 30-day time frame with no extensions taken], which was accepted by MDHHS, or already identified and corrected this issue, **HAP Empowered** should ensure its CAP is fully implemented to mitigate the deficiencies. Additionally, **HAP Empowered** should implement a process to continuously monitor and track time frames in real time to ensure appeals are completed timely and develop a formal training and auditing process to address timeliness concerns and educate on appropriate uses of extensions with individual staff members. As MDHHS indicated that **HAP Empowered** already identified and corrected the issue related to the member handbook, HSAG has no additional recommendations. • As **HAP Empowered** previously submitted a CAP to address these findings [did not demonstrate compliance with the review criteria for submitting an annual quality program worksheet that included highlights, document names, and page numbers as required], which was accepted by MDHHS, **HAP Empowered** should ensure its CAP is fully implemented to mitigate the deficiencies.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • HAP Empowered has performed extensive training with all staff handling appeals and grievances in the second quarter of 2021 reinforcing all state/federal requirements specific to correct case identification, processing timeframes, payment and clinical decision-making requirements, proper use of extensions, notifications etc. • HAP Empowered developed enhanced inventory reporting which included a "7 – day case closure" report that identifies appeals and grievances nearing their due date. This report is reviewed daily and distributed to staff to assist in managing and preventing late cases. • HAP Empowered conducts weekly meetings with staff to review workload and any barriers to complete case handling under the regulatory requirements utilizing the enhanced inventory reporting. • HAP Empowered converted to a new Appeals and Grievance tracking and reporting system which increased/enhanced reporting capabilities. Due to the system conversion, all staff underwent case handling and system training from December 2021 through March 2022. • HAP Empowered implemented KPI's surrounding timeliness that is tracked by Compliance and provides internal corrective action, if applicable along with departmental case quality assurance program to ensure case documentation, timeliness and notifications are reviewed daily. • HAP Empowered has implemented a new assessment/survey that detailed structure data capturing all referrals, referral type, and key outcomes. The data is used to create a report that easily identifies users that are within the Community Health Worker (CHW) role and calculate all statistical elements needed for the quality program worksheet.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HAP Empowered has seen an improvement in timeliness of appeals. • HAP Empowered has successfully used the new report for the 2022 Compliance Review of the Quality Program Worksheet and received a score of "met".
c. Identify any barriers to implementing initiatives: • HAP Empowered reports no barriers to the appeal initiatives implemented, or tool created for the quality program workplan.
HSAG Assessment: HSAG has determined that **HAP Empowered** addressed the prior year's recommendations related to the member handbook, member appeals, and the annual quality program worksheet. The results of the SFY 2022 compliance review also confirmed that the MHP successfully remediated the deficiencies related to elements *3.2 Member Handbook* and *4.3 QIP Evaluation and Work Plan; UM Program Effectiveness Review*. However, HSAG was unable to confirm if **HAP Empowered** successfully remediated element *3.6 Written Member Appeal Decisions Rendered* (now referred to as *3.6-A Member Appeals* and *3.6-B Member Grievances*) as element 3.6 will be scored and included in the SFY 2023 compliance review. As such, HSAG recommends that **HAP Empowered** continue to monitor and implement actions to ensure member appeals are resolved timely. Of note, while the MHP's narrative did not specifically address element 3.2, MDHHS previously indicated that the MHP had already corrected the issue.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**HAP Empowered** should focus on improving parents/caretakers of child members' overall experiences with their child's health plan and identifying the root cause of the poorer experiences with the child's personal doctor. **HAP Empowered** should provide training and resources to providers to cultivate better relationships between providers and members, and to improve providers' communication skills. • CSHCS—**HAP Empowered** should monitor the measures to ensure significant decreases in scores over time do not occur. • Healthy Michigan—**HAP Empowered** should explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving members' overall experiences with their health plan and the provision of medical assistance with smoking and tobacco use cessation to members. **HAP Empowered** should provide training and resources to providers to promote smoking cessation with their members.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*: Adult and Child Medicaid: • HAP Empowered's HEDIS team coordinates meetings to collaborate on quality performance and best practices to ensure appropriate care and testing is done for all members by their PCP's. HAP Empowered has programs that does the following: o Assist HAP network PCP's in getting their patients into the office for a visit o Encouraging the member rewards program which incentivizes members to schedule an annual checkup with their PCP o Coordination between member and providers to help schedule office visits to reduce scheduling barriers o Advising providers of the rewards for meeting the 50th percentile for HEDIS measures CAHPS for CSHCS: • HAP Empowered has distributed overview of survey to network providers to help provide understanding of how both HAP and the provider are evaluated by HAP Empowered members. The overview provides best practice tips to assist providers in proving the member experience. • HAP Empowered reviews CAHPS results with its Member Connections Committee, a group comprised of cross-functional team members monthly to focus on customer experience. New Initiative for CAHPS for CSHCS: • HAP Empowered will provide more details to our departments during the Joint Operations Meetings (JOC) to promote a better understanding of member expectations and to help collaborate on how to increase member satisfaction. Increasing member satisfaction along with provider relationships will help HAP Empowered not only have more data to report, but an increase in scores. Tobacco Cessation: • In relation to the quality improvement initiatives for medical assistance with smoking and tobacco cessation, HAP Empowered is a Michigan tobacco quitline partner and offers the QuitLogix Program

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
through National Jewish Health. The program provides personalized, telephone-based coaching, customized support materials, an integrated online program, text messaging, email support, and free Nicotine Replacement Therapy (NRT) for all members. HAP Empowered continues to actively identify tobacco users via multiple sources and conducts outreach to enroll members in the tobacco cessation program. Sources include: o Self-Referral o Telephonic or online o Healthy Michigan Plan Health Risk Assessment o Care Management Assessments • In addition to the above, HAP Empowered developed an educational flyer that the Care Management team utilizes to educate and engage members in the program. There is a internal FAQ document available for CM and other departments to utilize when making referrals to the program. National Jewish Health has provided training to the Care Management department also. There are smoking cessation Quitline program resources available for providers in the Provider Manual. The Smoking Cessation formulary is available on the hap.org website.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Tobacco Cessation: o In 2021, 350 members have been enrolled or received tobacco cessation counseling through their PCP. There were 14 coaching calls and six Quitline services for members enrolled in the telephonic program.
c. Identify any barriers to implementing initiatives: • Adult and Child Medicaid & CAHPS for CSHCS: o There are no barriers in implementing initiatives. • Tobacco Cessation: o Member engagement/enrollment into the Tobacco Quitline program is a continued barrier. Ongoing outreach continues to eligible members.
HSAG Assessment: HSAG has determined that **HAP Empowered** has partially addressed the prior year's recommendations. The SFY 2022 CAHPS activity confirmed that **HAP Empowered**'s scores for *Rating of Health Plan* and *Rating of Personal Doctor* for the child Medicaid population were comparable to national averages; however, the scores for *Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Strategies* for the HMP population were statistically significantly lower than the 2021 NCQA adult Medicaid national averages. HSAG recommends that **HAP Empowered** continue to provide training and resources to providers to promote smoking cessation with their members.

McLaren Health Plan

Table 4-4—Prior Year Recommendations and Responses for MCL

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **McLaren Health Plan** should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For FY2022, MDHHS directed the MCOs [managed care organizations] that did not meet all required elements for the prior year's PIP to continue the project for Timeliness of Prenatal Care with a focus on racial disparities. McLaren implemented this project with the new racial disparity focus this year. Because of these changes, a new casual/barrier analysis was completed and all interventions for this project were either revised or new.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Because this project is in its baseline year, performance improvement is not yet measurable.
c. Identify any barriers to implementing initiatives: • No barriers to implementation have been identified.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** addressed the prior year's recommendations. The MHP revisited its causal/barrier analysis with the initiation of a revised PIP focused on a similar PIP topic.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **McLaren Health Plan** should conduct a root cause analysis or focused study to determine why some women did not receive prenatal and postpartum care. If it is determined that COVID-19 impacted performance for the *Prenatal and Postpartum Care* measure indicators, **McLaren Health Plan** should proactively alter its approach to prenatal and postpartum care through methods such as telemedicine, when possible, to improve upon performance related to the *Prenatal and Postpartum Care* measure. If a lack of optimal use of telehealth services for pregnant Medicaid members is identified as a root cause that impacted the rates for both *Prenatal and Postpartum Care* measure indicators, **McLaren Health Plan** could potentially discuss with MDHHS offering discounts on telecommunications and broadband service to its Medicaid members through State and federal programs, such as the Michigan Lifeline Program and the Federal Lifeline Program. • Due to continued low performance for the *Asthma Medication Ratio* measure, **McLaren Health Plan** should monitor and target its efforts toward those with asthma medication ratios less than 50 percent to improve upon performance related to the *Asthma Medication Ratio* measure. Appropriate medication management for those with persistent asthma is especially important during the COVID-19 pandemic, as those with moderate-to-severe or uncontrolled asthma are more likely to be hospitalized from COVID-19.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- McLaren Health Plan closely monitors prenatal and postpartum performance throughout the year. Providers are given monthly gaps in care reports that pinpoint which members have not received specific services. This allows them time to schedule the member for services or submit billing to close gaps if they have not done so. During 2020 COVID impacted all measures, McLaren saw a decline in performance metrics overall. Many members avoided care to limit exposure, especially pregnant moms, or recent delivered moms with newborns. Throughout 2021 this was still seen as performance still was below pre-covid rates. Providers and members were educated on the availability of telehealth services to obtain care throughout the pandemic. McLaren implemented a pilot program for mom's where they received a $50 box of diapers for completing a postpartum visit within 2021. The response was positive, so McLaren continued this effort in 2022. McLaren also conducts a quarterly drawing for moms who complete their postpartum visit for an iPad or Pack-n-play. Year to date (YTD) rates are higher than they were at the same time in 2021. A provider incentive is available to providers for completing both timely prenatal and postpartum care. Education on this incentive and appropriate reporting of care is distributed to providers regularly at rounding visits. McLaren also has a MOMs [McLaren Moms] mailing program which notifies members of the importance of prenatal care, dental care, postpartum care, newborn care, etc. throughout their entire pregnancy and postpartum. McLaren also utilizes a weekly delivery report to mail members the incentive flyer related to the diapers and drawing. In addition to the above, in 2021 McLaren collaborated with our Community Health Worker (CHW) organizations and determined an opportunity to conduct outreach to members. Our CHWs can assess for barriers that may be impacting their access to care and connect them with resources. These CHWs are now billing those SDoH diagnosis codes along with their services so McLaren can further analyze the data to determine additional barriers within the populations and look for interventions to address them. McLaren also implemented a new program, previously called Aunt Bertha but now Find Help, that members can utilize to find resources for a variety of needs from housing, clothes, food, financial assistance, etc. This program was implemented in 2021 and advertised to members and providers for use. CHWs and Nurse Case Managers can also use this program to connect members with local resources. Continual assessment of the prenatal and postpartum rates will occur to ensure additional interventions are implemented as needed and any barriers addressed.
- McLaren Health Plan closely monitors asthma medication ratio (AMR) performance throughout the year. In CY21 McLaren sent out postcards to members that educated them, in general, on the importance of taking their medication as prescribed and to communicate with the primary care regularly to ensure adequate medications. This postcard also included information on Pharmacy's refill notification programs that are automated and to contact their local pharmacy to enroll. The intention for this postcard was to bring additional awareness and hopefully assist these members in enrolling in a medication reminder program to ensure timely fills and medication adherence. McLaren sent this postcard out again in CY22. Providers are sent monthly gap in care reports that include members in this measure who are assigned to them who aren't appropriately managing their medications so outreach and education can occur. In MY21 we saw an increase in the denominator for the AMR measure of roughly 450 members from MY20 which is an 11% increase. The largest population in the measure were members ages 19-50. In various other measures this age group is found to have lower compliance

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
rates, often due to not accessing care or medications until an issue arises. McLaren has implemented a texting program to hopefully connect with this population specifically. With that increase McLaren was still able to see a slight increase in the rate. Education goes out to PCPs in quality quick tips to discuss the measure, the importance of regular visits with asthmatic patients, and medication adherence. Additionally, this measure is discussed in the bi-annual member and provider newsletter which provides education on asthma and the importance of management. The Pharmacy team at McLaren health plan is doing Retro Drug Utilization Review of asthma patients. Beneficiaries that received four or more prescriptions for an asthma medication over a 12-month period but did not receive a controller medication are included. McLaren is looking to identify candidates for evaluation of medication use and start treatment with a controller medication. Providers are informed of the members and shared information that will be useful to the prescriber when providing quality care. Medication use for asthmatic members is reviewed monthly for additional opportunities. Lastly, McLaren incorporates Asthma Admission in Young Adults as a measure within Alternative Payment Models to encourage these offices to monitor admissions, address those accessing the hospital for asthma related concerns, and managing their care more effectively.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • McLaren monitors their overall performance on a monthly basis. There is not a noted performance improvement for prenatal and postpartum care at this time, but continual efforts will occur, and new interventions will be implemented to drive performance in the upcoming measurement year. McLaren received positive feedback from both providers and members in relation to their incentives and will continue all of those in upcoming years. • McLaren monitors their overall performance on a monthly basis. McLaren saw a slight increase in MY21 from MY20 for AMR. McLaren will continue to monitor the rates for Asthma Medication Ratio and evaluate current interventions as well as the need for additional or modifications.
c. Identify any barriers to implementing initiatives: • Barriers that McLaren Health Plan has identified was continued hesitancy for in person office visits as COVID continued into CY21, especially moms with newborns. Additionally, offices found challenges with the great resignation and staffing shortages impacted the availability of appointments across all specialties. Also, McLaren continues to find challenges with member outreach and has started utilizing text messaging in order to have another avenue of outreach as phone calls and letters aren't as successful to educate members on their benefits or new incentive programs. • Barriers that McLaren Health Plan identify for the asthma medication ratio is the engagement from members in self-management. The population with the largest denominator for this measure is the 19–50-year-olds which historically have shown to have limited access to care until necessary. McLaren has utilized outreach calls and letters to educate members however with limited valid phone numbers or addresses this type of outreach has minimal success. McLaren's new text messaging program will hopefully allow us to reach a greater population and utilize this type of outreach to get them engaged with their healthcare.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** has partially addressed the prior year's recommendations. As it relates to the prior year's recommendation for the *Prenatal and Postpartum Care* measure indicators, **McLaren Health Plan** has demonstrated efforts by educating providers and members on the availability of telehealth services, implementing a pilot program for members where they received an incentive for completing postpartum visits, providing educational mailings to members, and collaborating with CHW organizations. However, **McLaren Health Plan** continues to demonstrate low performance for the *Prenatal and Postpartum Care* measure indicators. Significant barriers noted by **McLaren Health Plan** were

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
member hesitancy to attend in-person office visits, providers not allowing the mother to bring other children or family to appointments, staffing shortages, and member outreach. HSAG recommends that **McLaren Health Plan** continue its efforts on improving access to prenatal and postpartum care and monitor the impact of initiatives currently in place to ensure improved performance. **McLaren Health Plan** could consider continuing to further encourage telehealth services among providers and patients to help address some of the noted barriers. As it relates to the prior year's recommendation for the *Asthma Medication Ratio* measure, **McLaren Health Plan** has demonstrated efforts by providing education to members and providers, implementing a texting program for member outreach, conducting a drug utilization review of asthma patients, and incorporating the measure into its alternative payment model. Additionally, **McLaren Health Plan** demonstrated improved performance for the *Asthma Medication Ratio* measure. Although **McLaren Health Plan** demonstrated improved performance, significant barriers noted by **McLaren Health Plan** were member engagement in self-management and member outreach. As such, HSAG continues to recommend that **McLaren Health Plan** pursue continued further education and outreach to members with asthma, with a targeted focus on members with an asthma medication ratio less than 50 percent, to improve upon performance and asthma control for its members.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **McLaren Health Plan** was required to submit a CAP to remediate these findings [discrepancies in provider information were identified in the provider directory; **McLaren Health Plan** attested to nothing changing in policies and procedures in January 2020 and January 2021, which is not permitted for two consecutive years], **McLaren Health Plan** should ensure its processes are fully implemented and monitored to ensure no further deficiencies are identified. Additionally, **McLaren Health Plan** should conduct its own periodic secret shopper survey of a sample of its provider network and use the results of any future EQR-related network adequacy validation activity to further analyze the completeness and accuracy of its provider data.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • McLaren Health Plan ("MHP") has initiated several initiatives to improve provider directory accuracy. o Secret Shopper Calls to 10% of the PCP network in each county to validate they were accepting new patients. o Auditing of Network Adds, Changes and Terms to ensure high data quality. A sample of data entered by employee is audited monthly as well as the outcome in the directory to ensure the appropriate outcome as data flows through multiple systems. o MHP implemented activities to receive responses from providers attesting to the accuracy of the data in the provider directory. MHP built functionality into the provider portal for providers to complete an attestation to their directory information also allowing for changes to be submitted to the plan. MHP also mailed attestation forms to PCPs. MHP also provided education to providers on the attestation process during provider rounding. This is an ongoing process with the goal to validate provider data quarterly.

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): • Secret Shopper Calls: Calls were completed by an MHP employee presenting as a patient or patient representative. The MHP employee asked if the provider is accepting new McLaren Medicaid patients. They survey was completed with 666 PCP practices. Of the offices sampled, 12 with a closed status in the MHP directory indicating they were not accepting new MHP Medicaid patients reported they were accepting new patients. 60 practices that the directory showed as accepting new patients reported they were not accepting new patients. All other surveyed practices responses matched the current provider directory. Any discrepancies in the acceptance status were updated in the provider directory. • Auding of Network Adds, Changes and Terms: MHP implemented an audit process to ensure data received from providers matches the directory ensuring high data quality. This is essentially an audit of the data entry quality as there are many components of a provider's profile that can be modified and the data flows through multiple systems. Any discrepancies identified were updated in the provider directory. • Provider Attestations: MHP received approximately 8,500 provider attestations, some with changes, through all modes of communication (provider portal, mail response, and through the provider relations representative). All changes were updated in the provider directory.
c. Identify any barriers to implementing initiatives: • Discrepancies in provider attestation reporting at the PO/PHO [physician organization/physician-hospital organization] level compared to office level requiring follow up to validate accuracy.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** addressed the prior year's recommendations related to the provider directory and provider communication policies and procedures. The results of the SFY 2022 compliance review also confirmed that the MHP successfully remediated the deficiencies related to element *2.8 MHP Maintains Policies and/or Procedures that Establish a Regular Means of Communicating and Providing Information to Contracted and Non-Contracted Providers* (now referred to as *2.8 Communicate to All Providers*). However, while **McLaren Health Plan** implemented interventions to enhance the accuracy of its provider directory, the MHP received a *Not Met* score for element *2.21 Secret Shopper Calls* (previously referred to as *2.6 MHP Provider Directory*) during the SFY 2022 compliance review as discrepancies were identified in PCP locations and phone numbers, and with being listed as accepting new patients. However, **McLaren Health Plan** continues to work on strategies to resolve the deficiency through the SFY 2022 compliance review CAP which was approved by MDHHS. As such, HSAG has no additional recommendations at this time.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**McLaren Health Plan** should explore what may be driving lower experience scores with their child's health plan and develop initiatives designed to improve quality of care, timeliness of care, and access to care. • CSHCS—**McLaren Health Plan** should explore what may be driving this lower experience score with customer service and develop initiatives designed to improve quality of care. **McLaren Health Plan** should provide training and resources to their customer service support staff, as well as set customer service standards to hold staff accountable. In addition, **McLaren Health Plan** should consider obtaining direct patient feedback from members to drill down into areas that need improvement. • Healthy Michigan—**McLaren Health Plan** should monitor the measures to ensure significant decreases in scores over time do not occur.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- Adult & Child Medicaid/Healthy Michigan Plan: McLaren Health Plan continually works to improve our members' experiences and increase our CAHPS scores year over year. McLaren Health Plan continued to educate all staff on first call resolutions to ensure best customer service. Ongoing training with member facing staff on benefits, gaps in care (HEDIS), preventive care, appeals & grievances, and CAHPS to Customer Service which will aid in the first call resolution standard. McLaren implemented a training program on CAHPS to all departments within the health plan to ensure plan-wide understanding of what CAHPS is and how each department can impact the overall view of the health plan as well as look for feedback and ideas for various departments. Additionally, the health plan has increased their efforts to educate providers on CAHPS, share the health plans scores year over year, educate on their impact to scores, best practices, and ways improve coordination of care. Providers are educated through monthly Quality Quick Tips, Bi-annual provider newsletters, as well as ad hoc Provider Network Updates throughout the year. Provider relations also conducts provider visits with highly utilized specialty types. McLaren is exploring additional opportunities to continually monitor ratings of the health plan with targeted surveys such as post call satisfaction surveys, care management, provider surveys, etc. Provider Relations regularly monitors appointment standards are being met and investigates any complaints related to access to care with offices appropriately. Grievances are also monitored and evaluated for any trending in relation to offices or providers. In addition to developing internal work groups, McLaren will work with their CAHPS vendor to research best practices and further analysis of CAHPS results. Member satisfaction text messages is also a campaign McLaren is researching further for possible implementation in order to address those concerns directly which can be challenging when results from CAHPS exclude direct information.
- CSHCS: McLaren is continually looking to improve our CSHCS member experiences and improve our CAHPS scores each year. Designated representatives' complete outreach to all new CSHCS members each month to assist with transitions of care, authorizations, appointments, SDoH needs, transportation, etc. McLaren has found this outreach not as successful so is looking into other opportunities for outreach as well. Staff who work with CSHCS populations, including Customer Service, have annual trainings regarding benefits, additional services, and access. McLaren also has a designated CSHCS nurse and team to work closely with CSHCS members and families. In addition, Complex Case Managers are involved with high needs members to assist. McLaren has established relationships with the local health departments and family centers and provide information to families as events are held at these locations. Regular collaboration occurs when CSHCS members are onboarded and continually through their coverage. McLaren will continue to work closely with the CSHCS members and their families to establish areas that could use additional training or outreach. Investigation into post call satisfaction surveys, ad hoc member satisfaction surveys, and member advisories with CSHCS families present. Direct communication with these members and their families will continue to provide insight to McLaren on opportunities and barriers.
- Healthy Michigan Plan: McLaren will continue to monitor HMP rates year over year to ensure stable and improved performance. Similar to the Adult and Child McLaren will continue to utilize the feedback from CAHPS scores to evaluate internal opportunities for training, outreach, education to members and providers. Member satisfaction text messages is also a campaign McLaren is researching

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
further for possible implementation in order to address those concerns directly which can be challenging when results from CAHPS exclude direct information. McLaren is exploring additional opportunities to continually monitor ratings of the health plan with targeted surveys such as post call satisfaction surveys, care management, provider surveys, etc. McLaren implemented a training program on CAHPS to all departments within the health plan to ensure plan-wide understanding of what CAHPS is and how each department can impact the overall view of the health plan as well as look for feedback and ideas for various departments.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Medicaid Adult: Adult Medicaid results reflect improvement in How Well Doctors Communicate, Rating of Personal Doctor, and flu vaccinations. Opportunities for improvement on Getting Needed Care, Getting Care Quickly, Customer Service, and Rating of Health Care which all show a decline from 2021 rates. • Medicaid Child: McLaren saw improvements on Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Rating of Health care from 2021 to 2022. Opportunities in 2023 for Getting Needed Care, Rating of Personal Doctor, Specialist and Health Plan which show declines in rates from 2021 to 2022. • CSHCS: McLaren has not received 2022 results on the CSHCS CAHPS. McLaren saw improvements in Access to Specialized Services and Local Health Department Services from 2020 to 2021. However, all other measures reflected lower performance and fewer than 100 responses. • Healthy Michigan Plan: McLaren saw improvements in Getting Care Quickly, Rating of Personal Doctor, Rating of Specialist, and Rating of Health Plan in 2021 vs 2020 however 2022 results have not been received. Opportunities reflected in Getting Needed Care, How Well Doctors Communicate, and Rating of Health Care in 2021.
c. Identify any barriers to implementing initiatives: • CAHPS surveys are de-identified and absent of any specific information to be able to assist members facing challenges with their providers, their health care, or the health plan. Outreach efforts are provided to general populations based on results however, responses may be an individual experience or concerns that we are unable to directly impact. McLaren is hopeful that with the possible addition of member specific surveys completed at the time of interaction will help us drill down to specific areas or concerns that currently CAHPS doesn't allow. Trainings, education, outreach, and first call resolution goals and standards will be ongoing.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** has partially addressed the prior year's recommendations. The SFY 2022 CAHPS activity confirmed that **McLaren Health Plan**'s score for *Customer Service* for the CSHCS population was comparable to the national average; however, **McLaren Health Plan**'s score for *Rating of Health Plan* for the child Medicaid population was statistically significantly lower than the 2021 NCQA child Medicaid national average. **McLaren Health Plan** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends **McLaren Health Plan** continue to implement performance improvement interventions and evaluate their effectiveness.

Meridian Health Plan of Michigan

Table 4-5—Prior Year Recommendations and Responses for MER

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Meridian Health Plan of Michigan** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • In January 2022, Meridian obliged MDHHS's direction to terminate the previous 2019-2021 Prenatal Care Performance Improvement Project (PIP) and to identify a new study population to address racial health disparities in the Timeliness of Prenatal Care PIP. Meridian's new causal/barrier analysis captures current barriers including ongoing pandemic related barriers for the new 2021-2022 PIP population. Meridian has developed specific and targeted interventions to address the reexamined barriers. • Start Smart for Baby maternity case management program and Community Health Workers (CHW) teams identify and engage prenatal care PIP members to barriers and COVID-19 related hesitancy impeding timely prenatal care to ensure successful connections to care. Meridian implemented a new threshold bonus model in which providers will be increasingly incentivized for successfully reaching the 75th and 90th percentile for their assigned membership population's successful completion of timely prenatal care visits. Meridian publishes PPC HEDIS care gap reports and education to the providers for any members due for measure completion. Meridian promotes group prenatal care to the targeted PIP population, an evidenced-based, alternative model of care with proven results to enhance maternal and infant health outcomes. Meridian optimized existing relationships with a community health delegate for targeted outreach to prenatal members for care coordination to prenatal care and to address identified Social Determinants of Health needs (SDoH).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian successfully eliminated the disparity in the previous Prenatal Care PIP by the third remeasurement period and is working intensively to realize equity and improve the Timeliness in Prenatal Care in the new PIP.
c. Identify any barriers to implementing initiatives: • For the third consecutive measurement year, COVID-19 conditions remain a significant obstruction to successful efforts to achieve PIP objectives. Members remain hesitant to return to offices for routine prenatal care services. Providers' limited availability to accommodate timely prenatal care visits is often exacerbated by COVID-19. COVID-19 health and safety restrictions continue to inhibit Meridian's ability to fully resume and implement new interventions as well as its ability to provide certain resources to targeted populations. • As a part of the Centene Corporation acquisition, Meridian underwent a full system integration in 2021 and 2022, which resulted in a total transition of its systems, programs, trainings, and processes such as new provider portals and new HEDIS software engine. The technology transitions required Meridian to

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
build new processes, which impacted development and implementation of PIP interventions such as outreach, medical record request, data collection, abstraction processes, and reporting activities.
HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendations. The MHP revisited its causal/barrier analysis with the initiation of a revised PIP focused on a similar PIP topic.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Meridian Health Plan of Michigan** should conduct a root cause analysis or focused study to determine why some women did not receive prenatal and postpartum care. If it is determined that COVID-19 impacted performance for the *Prenatal and Postpartum Care* measure indicators, **Meridian Health Plan of Michigan** should proactively alter its approach to prenatal and postpartum care through methods such as telemedicine, when possible, to improve upon performance related to the *Prenatal and Postpartum Care* measure. If a lack of access to telehealth services for pregnant Medicaid members is identified as a root cause that impacted the rates for both *Prenatal and Postpartum Care* measure indicators, **Meridian Health Plan of Michigan** could continue to educate its members on the prenatal and postpartum benefits and services provided via telehealth. **Meridian Health Plan of Michigan** could also consider outreaching to patients with limited technology and connectivity and offer flexibility in platforms that can be used for video consultation, or non-video options, when possible. • **Meridian Health Plan of Michigan** should monitor performance improvement interventions currently in place and continue to expand upon or implement additional interventions, when necessary, to improve the performance related to the *Childhood Immunization Status* measure. The CDC recommended continued administration of routine immunization during the pandemic to prevent transmission of other preventable infectious diseases. According to the AAP, while telehealth visits are recommended, in-person visits, especially for vaccination, should not be discontinued unless community circumstances require the limitation of in-person visits, in which case curbside or drive-through vaccination can be implemented by clinics to limit patient-provider contact.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • A comprehensive analysis revealed the COVID-19 pandemic continues to be a significant barrier impacting HEDIS performance outcomes through measurement year 2021 and 2022. Health plan, provider, and member priorities were restructured due to the ongoing effects of COVID-19. Significant waves of virus activity in 2021 influenced enduring hesitancy amongst members to prioritize routine health care services. In response, Meridian executed multiple telehealth promotion awareness campaigns to members and providers with the goal of increasing telehealth utilization for eligible prenatal and postpartum care services. Meridian proactively altered its approach to prenatal and postpartum care interventions through the implementation of both, traditional and progressively-driven solutions. Meridian continued to execute conventional yet proven interventions such as telephonic outreach, member mailings, member incentives such as diaper raffles, and various provider educational outreach and other bonuses incentives. Additionally, Meridian implemented innovative, evidenced-based initiatives to appeal to its diverse member population by offering more community-based and

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
member-centric solutions, such as launching a pilot doula program which fully covers doula services for prenatal and postpartum members. Papa Inc. is a Meridian partner that dedicates time to actively listen and understand postpartum member needs. Papa provides respite care, in-home chore support, transportation assistance, address SDoH barriers, and companionship to influence healthy behaviors. Meridian partnered with multiple community-based organizations (CBO) with the shared vision of improving maternal outcomes. CBOs engage and connect with prenatal and postpartum members in their communities to specifically address barriers to care and provide support. Meridian employed digital communication platforms to efficiently convey prenatal and postpartum education & reminders to members. • Meridian remains committed to improving Childhood Immunization Status measure. For another consecutive year, Meridian has intensively devoted resources to consistently monitor performance and risks to ensure existing interventions remain effective and proactively exploit opportunities for intervention creation and expansion to realize performance objectives. Meridian arranged numerous initiatives to increase administration of immunizations associated with the Childhood Immunization Status (CIS) measure in 2021 and 2022. Meridian implemented member and provider educational flyer and reminder postcard mailing campaigns, launched year-round medical record review and abstraction activities to garner compliant data, as well as telephonic outreach campaigns such as monthly 1st Birthday Calls to members turning one year of age with appointment scheduling assistance. Meridian also launched digital text and email campaigns to provide education and reminders to members. Network Management department provided additional education and missed opportunity materials to high volume providers with CIS disparities. Provided additional education to parents of children due for measure. Community Health Workers educated members during home visits. Meridian supported IVaccinate efforts to promote vaccination series completion. In 2022, Meridian completed a formal Quality Improvement Activity (QIA) for the CIS measure with stated goals, methodology and strategies to improve year of over performance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Administratively, Meridian has realized a 0.30% increase in PPC Postpartum Care submeasure performance year to date comparing 2021 to 2022.
c. Identify any barriers to implementing initiatives: • For both, Childhood Immunization Status and Prenatal and Postpartum Care measures, COVID-19 conditions obstructed efforts to fully employ interventions and resources to enhance performance as desired. Members remain hesitant to return to offices for routine visits and preventive services. Furthermore, providers' have limited availability to accommodate routine services exacerbated by COVID-19. • Despite widespread efforts to educate families, there were significant reductions in administering immunizations due to parents' fears of contracting COVID-19 and uncertainty about whether children should continue to receive immunizations during the height of the pandemic and as the pandemic began to falter. Because immunizations must be administered in person, Childhood Immunization Status measure success is hampered by members' ongoing hesitancy to return in person, for non-emergent services. • High numbers of COVID-19 variant cases experienced across the State of Michigan in 2021 prevented Meridian from executing community events, such as immunization clinics and wellness fairs unlike in the pre-pandemic past. While Meridian was able to successfully host some community events in 2022, there were far fewer events held and participation rates were low. Due to fear of negative effects on the child's health, or for religious purposes, some parents do not want children to have any or all of the

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
recommended vaccinations completed. Members have expressed uncertainty about immunizations to Meridian outreach staff while performing HEDIS outreach. • The sunsetting of Meridian's proprietary system, Managed Care System (MCS), led to a significant loss in immunization data. Prior to the integration, members' MCIR identification numbers were entered into MCS, immunization event data flowed into the system to account for immunization compliance. Currently, Centene systems aren't yet equipped to capture this level of data which resulted in less immunization hits in 2021 and 2022 due to the systems change. • For both Childhood Immunization Status and Prenatal and Postpartum Care measures, Meridian experienced delays due to the yearlong integration to Centene systems such as the Quality Management Associates (QMAs) ability to enter pseudo claims in Quality Campaign Action Tool (QCAT) and HEDIS medical record review (HEDIS MRR) data until late 2021. Also, data streams and hybrid activities were impacted due to several electronic medical record system access and Electronic Data Interchange (EDI) barriers • For both Childhood Immunization Status and Prenatal and Postpartum Care measures, outreaching to members is often difficult due to the lack of success experienced with mailings and telephone calls. The effectiveness of member outreach is often hindered by members' failure to provide updated phone and address information to Meridian. Meridian identified that telephonic outreach to members were appearing as a spam risk for some mobile carriers.
HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** has partially addressed the prior year's recommendations. As it relates to the prior year's recommendation for the *Prenatal and Postpartum Care* measure indicators, **Meridian Health Plan of Michigan** has demonstrated efforts by executing telehealth promotion awareness campaigns to members and providers; altering the approach for prenatal and postpartum care interventions; partnering with CBOs; launching a pilot doula program; and continued member outreach, education, and incentives. While **Meridian Health Plan of Michigan** demonstrated improved performance for the *Postpartum Care* measure indicator, **Meridian Health Plan of Michigan** continues to demonstrate low performance for the *Timeliness of Prenatal Care* measure indicator. Significant barriers noted by **Meridian Health Plan of Michigan** were member hesitancy to attend in-person office visits, providers not allowing the mother to bring other children or family to appointments, staffing shortages, and member outreach. HSAG recommends that **Meridian Health Plan of Michigan** continue its efforts on improving access to prenatal and postpartum care and monitor the impact of initiatives currently in place to ensure continuous improved performance. **Meridian Health Plan of Michigan** could consider continuing to further encourage telehealth services among providers and patients to help address some of the noted barriers. **Meridian Health Plan of Michigan** has put forth effort to address HSAG's prior year recommendation for the *Childhood Immunization Status* measure indicators by providing education to members and providers, sending reminder postcards, and conducting member outreach. Additionally, **Meridian Health Plan of Michigan** demonstrated improved performance for the *Childhood Immunization Status—Combinations 3*, *7*, and *10* measure indicators. Although **Meridian Health Plan of Michigan** demonstrated improved performance, significant barriers noted by **Meridian Health Plan of Michigan** were member hesitancy to attend in-person office visits, member outreach, staffing shortages, and vaccine hesitant parents. As such, HSAG recommends that **Meridian Health Plan of Michigan** continue its efforts on improving childhood immunizations and monitor the impact of initiatives currently in place to ensure continuous improved performance. The CDC

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
offers provider resources related to vaccine conversations with parents that could potentially help address barriers related to vaccine hesitant parents and the delay of child vaccine schedules.[4-2]

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **Meridian Health Plan of Michigan** previously mitigated the issue or submitted a CAP to address the findings [third-party subrogation report reflected response times over 30 days; non-compliant National Council for Prescription Drug Programs (NCPDP) 70 rejections related to the pharmacy/managed care organization (MCO) common formulary], which was accepted by MDHHS, **Meridian Health Plan of Michigan** should ensure its CAP is fully implemented to mitigate the deficiencies and continue to monitor subrogation processes to ensure the deficiencies are fully mitigated. • As **Meridian Health Plan of Michigan** previously submitted a CAP to address these findings [Several deficiencies were identified throughout the year regarding the program integrity program, specifically the encounter adjustments validation report fell below the 85 percent benchmark set by MDHHS; MDHHS OIG contact information was missing from one of the policies, and outdated contact information was found in another policy; the policies did not appropriately address the policy and process in place to review system edits and gauge their effectiveness; the credentialing and screening policies did not address verification of Community Health Automated Medicaid Processing System (CHAMPS) enrollment; the policies did not appropriately address the policy of suspending payment to a provider upon notification by the U.S. Department of Health and Human Services (HHS) or MDHHS; inconsistencies were identified between the post-payment review report grid and the quarterly reports; the provider enrollment, screening and disclosure requirements forms were not complete; and **Meridian Health Plan of Michigan** did not perform data mining activities for six consecutive quarters], which was accepted by MDHHS, **Meridian Health Plan of Michigan** should ensure its CAP is fully implemented to mitigate the deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The deficiency in formulary compliance was the result of a misinterpretation of the state provided Masterfile and a timing issue with the application of the rebate eligibility file. With clarification from the state, the Masterfile was interpreted correctly to apply formulary coding. The timing issue was resolved with a change in process to implement changes to coding more frequently and implement daily monitoring of the national drug code (NDC) federal rebate status. (See Attachment 1 CAP Pharmacy/Managed Care Organizations (MCO) Common Formulary) • Compliance meets with the Special Investigation Unit (SIU) on a monthly basis to touch base on upcoming trainings, open Office of Inspector General (OIG) cases and any other applicable items. Compliance also hosts a quarterly meeting with all business owners responsible for submitting data for the quarterly Program Integrity report to review to guidance document, proposed changes, and upcoming due dates to ensure internal transparency and a timely submission.

[4-2] Centers for Disease Control and Prevention. Talking with Parents about Vaccines for Infants, updated April 11, 2018. Available at: https://www.cdc.gov/vaccines/hcp/conversations/talking-with-parents.html. Accessed on: Feb 1, 2023.

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): • To assure the coding is correct and timing for federal rebate status is applied correctly, Meridian implemented a process for self-audit on a monthly basis. The plan did undergo a change in Pharmacy Benefit Managers from Meridian Rx in 2021 to CVS Caremark in April of 2022. Post implementation, the plan began monthly formulary compliance audits for the plan pharmacy director to review. Any audits with more than 0.1% non-compliance are escalated for a root cause investigation and resolution as necessary. • Upon further investigation, Meridian has identified that the failure to meet the 85% validation threshold were as a result of internal reporting error. On June 26, 2021, Meridian received some responses from the state of Michigan in regard to questions pertaining to report expectations. Based on the feedback provided by MDHHS OIG following submission, Meridian has made the following changes to account for deficiencies. Meridian was supplying additional codes in the code adjusted field if there was not a procedure code present. To ensure Meridian reports all required information, but also includes the most accurate information, the OIG confirmed it would be best to leave the code adjusted field blank if all the plan has is revenue code and rely on the Transaction Control Numbers (TCNs), Member ID, Billing National Provider Identification (NPI), dates of service (DOS), and adjustment amount. This update was made on the September 6.8 Compliance Review submission. On this submission, Meridian was supplying header level adjusted TCN information. Per the guidance provided, the best method of creating/finding a match is reporting at the line level, the line TCN, not the header. This update was made on the September 6.8 Compliance Review submission. Lastly, Meridian was previously including rejected TCN information in the report. Meridian updated TCN logic per the guidance that the Original TCN pertains to the last accepted iteration of the claim prior to the correction (void or adjustment) due to an identified overpayment. New/Adjusted Line TCN is the new/adjusted line TCN assigned by MDHHS for the line/transaction; this could be avoided claim or a replacement claim, depending on the adjustment required. This update was made on the September 6.8. The SIU Team added the MDHHS OIG contact information to policies & procedures (P&P) 12.15: Fraud, Waste, and Abuse Policy. Compliance Team updated the MER Compliance & FWA Poster to include the correct Information. The Meridian Claims team updated P&P 9.29 to detail how and when reviews are performed, who performs the review (Meridian or their vendor), and how system edits are added, revised, or removed. Compliance was informed by corporate Credentialing leadership that the incorrect policies were submitted. Meridian Credentialing Policy 7.01 (Physician Credentialing) included CHAMPS verification process- this policy was retired in May 2021. Meridian has adopted Corporate Centene's Credentialing policy CC.CRED.01 which includes CHAMPS verification language. The Claims team updated Meridian policy MI 9.10 to include updated MDHHS OIG contact information as well as overview of payment suspension process to providers. Meridian's SIU and Healthcare Analytics team reviewed the annual and quarterly reports to determine why there were discrepancies in the overpayment amounts reported. After making the appropriate updates, Meridian scored as "Met" with a 95.57% match rate. Meridian misinterpreted the "check boxes" as bullet points that did not need to be completed in order to demonstrate that the health plan is meeting the criteria within the submission. Meridian Health Plan has checked the boxes to show that the criteria were met and is resubmitting the report. Going forward, Meridian will thoroughly review all requirements and criteria to ensure this is not overlooked in future reports. Meridian understands the importance of identifying and preventing fraud, waste and abuse and the activities that are necessary to safeguard Medicaid dollars. Meridian has been routinely conducting member data mining activities through the Benefit Monitoring Program (BMP). The purpose of the BMP is to closely monitor and identify Meridian enrollees who may be over utilizing and/or misusing their Medicaid services and benefits. The goal of

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
the BMP is to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to program enrollees. Meridian utilizes a variety of data reports and multiple sources to identify enrollees appropriate for BMP. Surveillance and benefits utilization are reviewed to ensure the appropriate amount, scope and duration of medically necessary services are being provided. Meridian was not aware that the BMP data could be represented on the data mining tab on the program integrity reports.
c. Identify any barriers to implementing initiatives: • The state Masterfile for the common formulary is not easily applied to formulary coding. The file requires manual manipulation and clinical review prior to coding. A standardized file indicating specific coverage coding by NDC would eliminate the need for extensive manual manipulation and clinical interpretation. • There are no barriers currently. The November 2021, February 2022, and August 2022 Program Integrity report submissions were in compliance with all reporting requirements, resulting in a "Met" score.
HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendations related to third-party subrogation requests, non-compliant pharmacy rejections, and the program integrity program. The results of the SFY 2022 compliance review also confirmed that the MHP successfully remediated the deficiencies related to elements *5.6 Pharmacy/MCO Common Formulary*, *5.8 Third Party Subrogation Requests*, *6.2 Quarterly Program Integrity Forms* (Data Mining), *6.9 OIG Program Integrity–Fraud Compliance Program*, *6.10 OIG Program Integrity* (Annual Program Integrity Report), and *6.12 OIG Program Integrity* (MHP and Provider Enrollment, Screening and Disclosure Requirements) (which is now scored as part of element 6.10). However, while **Meridian Health Plan of Michigan** implemented interventions to remediate the findings of element *6.8 Quarterly Program Integrity Forms* (Encounter Adjustments), the MHP received a *Not Met* score for this element during the SFY 2022 compliance review. However, **Meridian Health Plan of Michigan** continues to work on strategies to resolve the deficiency through the SFY 2022 compliance review CAP which was approved by MDHHS. As such, HSAG has no additional documentations at this time.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**Meridian Health Plan of Michigan** should monitor the measures to ensure significant decreases in scores over time do not occur. • CSHCS—**Meridian Health Plan of Michigan** should monitor the measures to ensure significant decreases in scores over time do not occur. • Healthy Michigan—**Meridian Health Plan of Michigan** should determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the plan that could be contributing to a lack of network adequacy and access issues.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Meridian has implemented interventions to increase CAHPS scores:

4. Prior Year Recommendation from the EQR Technical Report for CAHPS

- Access and Availability Audits: These audits are performed twice a year via our vendor (Faneuil) to ensure that our provider network is efficient enough to meet the needs of our members and that providers are following the guidelines set forth related to scheduling appointments
  - Meridian specialists met the geo-access and availability standards per the Network Adequacy and Accessibility audit
  - This is an ongoing initiative performed twice a year at mid-year and end of year
- CAHPS Champion Program: Identified staff members to service as "CAHPS Champions" for their teams to engage and provide education to their teammates about CAHPS and issues affecting member satisfaction
  - CAHPS Champions completed additional CAHPS training, attend Meridian's monthly Member Satisfaction Workgroup, and send out monthly CAHPS bulletins to their teams
  - This initiative began in March of 2022 and is ongoing
- Member Satisfaction Workgroup: Representatives from various departments (Quality, Customer Experience, Medical Management, Utilization Management, Vendor Management, Network Management, Pharmacy) participate in monthly workgroup facilitated by Quality aimed at providing education about CAHPS and discussion any member dissatisfaction issues and working together on solutions and interventions
  - This initiative is ongoing
- CAHPS Training: The Quality department facilitated live CAHPS training for all member and provider-facing staff
  - This initiative started in February of 2022 and will continue annually prior to the start of CAHPS season
- CAHPS Bulletin: Monthly newsletter sent to all member-facing staff providing education, reminders, updates, and tips surrounding CAHPS and member satisfaction
  - This initiative began in February 2022 and is ongoing
- Customer Service Reminders Checklist: Checklist developed by Quality based on the Customer Experience department's internal audit criteria and tied back to CAHPS to serve as a reminder for member-facing staff to provide excellent customer service to our members
  - This initiative began in February 2022 and will be updated on an annual basis
- Consumer Advisory Council (CAC) Meetings: Quarterly meetings held with various state and health plan representatives as well as members
  - Meetings utilized to gain feedback on member preferences and gain insight on how they feel about the plan itself and initiatives we are implementing
  - This initiative is ongoing
- CAHPS Best Practices: Connected with Quality Improvement staff from high-performing markets within Centene, Meridian's parent company, to learn about best practices they utilize to improve/maintain their CAHPS scores
  - This initiative began in May 2022 and is ongoing as needed
- Customer service training for member-facing vendor staff: Assigned customer service modules to Meridian's dental and transportation vendors' member-facing staff to ensure comparable training is being provided to all staff who speak with our members
  - This began in July 2022 and will be ongoing
- Patient Care Advocate Program: Frontline, member-focused team for member outreach working to encourage and increase rate of care gap closure
  - This is an ongoing initiative

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): • Medicaid CAHPS "Customer Service" measure saw a significant increase of 12.2 points from 2021 to 2022 (78.4 to 90.6) • Medicaid CAHPS "Getting Care Quickly" measure increased from 2021 to 2022 (78.4 to 78.8)
c. Identify any barriers to implementing initiatives: • Budget limitations have impacted the ability to implement planned initiatives. Meridian has also experienced decreasing CAHPS response rates, which may provide less insight into member satisfaction with their health care and Meridian.
HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** has addressed the prior year's recommendations. The SFY 2022 CAHPS activity confirmed that **Meridian Health Plan of Michigan**'s score for *Rating of Specialist* for the HMP population was comparable to the 2021 NCQA adult Medicaid national average.

Molina Healthcare of Michigan

Table 4-6—Prior Year Recommendations and Responses for MOL

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Molina Healthcare of Michigan** should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Molina Healthcare discontinued several interventions which were found to be ineffective in improving the overall Prenatal Care performance rate. However, Molina continues to educate members regarding returning to the provider for routine and prenatal care, encouraging pregnant women to discuss the safety of the COVID19 vaccine with their provider and increasing our efforts to educate women of childbearing age of the importance of receiving prenatal care as soon as they suspect they are pregnant. Women of childbearing age receive information regarding the resources and support that are available to them when they become pregnant.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Review to the RY 22 Prenatal Care data revealed that the performance in the rate for African American women increased to 66.20% which is a 1.64 percentage point increase from the RY 21 rate of 64.56%.
c. Identify any barriers to implementing initiatives: • The most significant barrier is the difficulty to establish early identification of pregnant women when they postpone seeking medical care to support their pregnancy.
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** addressed the prior year's recommendations. The MHP revisited its causal/barrier analysis process and continued or discontinued intervention efforts following an evaluation of each intervention.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Molina Healthcare of Michigan** should conduct a root cause analysis or focused study to determine why some women did not receive prenatal and postpartum care. If it is determined that COVID-19 impacted performance for the *Prenatal and Postpartum Care* measure indicators, **Molina Healthcare of Michigan** should proactively alter its approach to prenatal and postpartum care through methods such as telemedicine, when possible, to improve upon performance related to the *Prenatal and Postpartum Care* measure. • Due to continued low performance for the *Asthma Medication Ratio* measure, **Molina Healthcare of Michigan** should monitor and target its efforts toward those with asthma medication ratios less than 50 percent to improve upon performance related to the *Asthma Medication Ratio* measure. Appropriate medication management for those with persistent asthma is especially important during the COVID-19 pandemic, as those with moderate-to-severe or uncontrolled asthma are more likely to be hospitalized from COVID-19.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Prenatal and Postpartum Care • Based on the results of the root cause analysis Molina implemented a new telemedicine program. The program launched in May 2022 and at this time is primarily focused on providing this service for Postpartum Care visits. Asthma Medication Ratio • Members within the Asthma Medication Ratio measure are contacted by phone to identify barriers to getting medication. In addition, members are provided information regarding which medications are eligible for home delivery. Molina also uses pharmacy data to monitor the status of medication refills.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Prenatal and Postpartum Care • The initial results of the new initiatives reveal that the *Postpartum Care* rate reported in Aug 2022 improved by 2.89 percentage points compared to the Aug 2021 rate. Asthma Medication Ratio • The Aug 2022 *Asthma Medication Ratio* rate is 0.38 percentage point higher than the rate reported in Aug 2021.
c. Identify any barriers to implementing initiatives: Prenatal and Postpartum Care • Invalid member contact information and member's not answering the phone when called continues to be a barrier to providing information to members. Asthma Medication Ratio • Members relying on rescue medications instead of routinely taking their controller medications is a barrier to improving this measure.
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** has partially addressed the prior year's recommendations. As it relates to the prior year's recommendation for the *Prenatal and Postpartum Care* measure indicators, **Molina Healthcare of Michigan** has demonstrated efforts by implementing a new telemedicine program. However, **Molina Healthcare of Michigan** continues to demonstrate low performance for the *Prenatal and Postpartum Care* measure indicators. A significant barrier noted by **Molina Healthcare of Michigan** was member outreach. HSAG recommends that **Molina Healthcare of Michigan** continue its efforts on improving access to prenatal and postpartum care and monitor the impact of initiatives currently in place to ensure improved performance. **Molina Healthcare of Michigan** could consider continuing to further encourage telehealth services among providers and patients to help address the noted barrier. As it relates to the prior year's recommendation for the *Asthma Medication Ratio* measure, **Molina Healthcare of Michigan** has demonstrated efforts by conducting member outreach, providing education to members on medications available for home delivery, and using pharmacy data to monitor the status of medication refills.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
Additionally, **Molina Healthcare of Michigan** demonstrated improved performance for the *Asthma Medication Ratio* measure. Although **Molina Healthcare of Michigan** demonstrated improved performance, a significant barrier noted by **Molina Healthcare of Michigan** was members' reliance on rescue medications rather than routinely taking their controller medications. As such, HSAG continues to recommend that **Molina Healthcare of Michigan** pursue continued further education and outreach to members with asthma, with a targeted focus on members with an asthma medication ratio less than 50 percent, to improve upon performance and asthma control for its members.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **Molina Healthcare of Michigan** was required to develop a CAP to address these findings [discrepancies in provider contact information were identified in the provider directory and lack of dental providers noted for several counties], **Molina Healthcare of Michigan** should ensure its MDHHS-approved CAP is fully implemented to mitigate the deficiencies. Additionally, **Molina Healthcare of Michigan** should conduct its own periodic secret shopper survey of a sample of its provider network and use the results of any future EQR-related network adequacy validation activity to further analyze the completeness and accuracy of its provider data. • As **Molina Healthcare of Michigan** was required to submit a CAP [the third-party subrogation report reflected response times over 30 days], **Molina Healthcare of Michigan** continue to monitor this requirement to ensure its subrogation process is fully implemented to mitigate the identified deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Dental Network and Provider Directory Validation: • The Molina dental team routinely contacts every office on a bi-annual basis to assure accepting status, appointment availability and directory information is correct. The Molina team consistently contacts non-contracted dentists in all counties to add providers. • Molina reports deficiencies and asks for network exceptions as needed. While Molina does not meet ratios in Gladwin, Midland and Tuscola, all members have access within time and distance requirements. • Molina routinely conducts its own "secret shopper" type calls and documents/corrects directory information areas. • Dental providers are included in Molina's annual appointment availability survey, results of which are due in October 2022. Third-party subrogation response times over 30 days: • Molina partnered with its subrogation vendor, Optum, to revise their Standard Operation Procedure (SOP) to ensure compliance with the 30-day response requirements. • Created designated referral inbox and high priority queue for MI Medicaid cases • Dedicated staff allocated to Molina MI with backups available in case of personal time off (PTO) or health leave • Automated alerts and escalation

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
○ If the priority referral queue ages past 5 days, a Case Creation Manager is alerted. ○ Assess root cause of delay before it ages further (process gap, staffing capacity, etc.)
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Dental Network and Provider Directory Validation: • Molina has added 101 new dentists in 2022 thus far. Of particular note are the additions of dental providers added to Midland and Charlevoix counties, critical and hard to contract areas. • Molina outreached 90 Dental providers as part of Molina's monthly secret shopper program in 2022. Third-party Subrogation • The initiatives implemented have significantly reduced the average response time and resulted in all cases being responded to within 30 days through Q1 and Q2 of 2022. • Average response times: ○ Q2 2022: 6.8 days; no responses >30 days ○ Q1 2022: 11.5 days; no responses >30 days ○ Q4 2021: 10.8 days; one response >30days ○ Q3 2021: 9 days; no responses > 30days
c. Identify any barriers to implementing initiatives: Dental Network and Provider Directory Validation: • The primary barriers are the lack of available dentists in more rural areas, appointment availability at the FQHCs due to high demand, pay scale demands of hygienists and the overall low Medicaid fee schedule even though Molina contracts at percentage higher than the fee schedule. There is also a decrease in availability of dentists and hygienists overall. This is not unique to Michigan and may be a product of the COVID pandemic. Third-party Subrogation • No barriers identified or encountered during implementation.
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** addressed the prior year's recommendations related to the provider directory, dental network, and third-party subrogation requests. However, while **Molina Healthcare of Michigan** implemented interventions to enhance the accuracy of its provider directory, the MHP received a *Not Met* score for element *2.21 Secret Shopper Calls* (previously referred to as *2.6 MHP Provider Directory*) during the SFY 2022 compliance review as discrepancies were identified in PCP locations and phone numbers, and with being listed as accepting new patients. **Molina Healthcare of Michigan** continues to work on strategies to enhance the accuracy of its provider directory through the SFY 2022 compliance review CAP which was approved by MDHHS. As such, HSAG has no additional recommendations at this time. Additionally, while **Molina Healthcare of Michigan** implemented interventions to enhance compliance with the 30-day response time frame for third-party subrogation requests, the MHP received a *Not Met* score for element *5.8 Third Party Subrogation Requests* during the SFY 2022 compliance review. As **Molina Healthcare of Michigan** also continues to work on strategies to enhance timely response times through the SFY 2022 compliance review CAP which was approved by MDHHS, HSAG has no additional documentations at this time. Of note, while **Molina Healthcare of Michigan**'s narrative addressed its dental network, element *2.14 Dental Provider Directory* was not included in the SFY 2022 compliance review; therefore, HSAG was unable to verify successful remediation of this element.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**Molina Healthcare of Michigan** should monitor the measures to ensure significant decreases in scores over time do not occur. • CSHCS—**Molina Healthcare of Michigan** should explore what may be driving this lower experience score with customer service and develop initiatives designed to improve quality of care. **Molina Healthcare of Michigan** should provide training and resources to their customer service support staff, as well as set customer service standards to hold staff accountable. In addition, **Molina Healthcare of Michigan** should consider obtaining direct patient feedback from members to drill down into areas that need improvement. Lastly, **Molina Healthcare of Michigan** should continue to explore opportunities for improvement through its CAHPS Taskforce. • Healthy Michigan—**Molina Healthcare of Michigan** should monitor the measures to ensure significant decreases in scores over time do not occur.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Adult and Child Medicaid CAHPS and CSHCS CAHPS • Each final CAHPS report is reviewed by the CAHPS Taskforce to identify low performing measures, rate trends and to identify the questions that are the key drivers for impacting the rate. This information is used to develop initiatives to improve the rate of each key driver question. Healthy Michigan Program • In addition to the review of the quarterly Performance Monitoring Reports for the reported rate of each measure the health plan runs monthly internal reports which provide up-to-date monitoring of each measure. Each measure is assigned to the appropriate Molina department to develop initiatives to improve the rate and provide monthly updates to the workgroup which oversees the performance of the Health Michigan Program measures.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The 2022 Adult Medicaid CAHPS rates improved over the 2021 rates for the following measures: Rating of the Health Plan (57.7% to 62.0%), Getting Needed Care (83.6% to 87.0%), Getting Care Quickly (82.6% to 83.6%), Customer Service (87.2% to 94.9%), Advising Smokers and Tobacco Users to Quit (73.8% to 79.0%), Discussing Cessation Medications (58.4% to 61.8%) and Discussing Cessation Strategies (51.4% to 54.8%). • The 2022 Child Medicaid CAHPS rates improved over the 2021 rates for the following measures: How Well Doctors Communicate (91.5% to 94.6%), Customer Service (89.7% to 93.3%), and Transportation (58.3% to 73.1%) • Healthy Michigan Program: The July 2022 Quarterly Performance Monitoring Report has reported the following measures show improvement when compared to the previous quarter (April 2022): Diabetes-Diagnostic Dental (24.56% to 24.80%), Diabetes-Preventive Dental (11.56% to 11.96%), Pregnant Women Preventive Dental (11.05% to 12.06%), Pregnant Women Restorative Dental (6.01% to 6.10%), Outreach and Engagement to Facilitate Primary Care (56.34% to 56.45%), and chronic obstructive pulmonary disease (COPD) or Asthma in Older Adults Admission Rate* (60.79% to 59.92%).

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
• *This is a reverse rate. A lower rate indicates better performance.
c. Identify any barriers to implementing initiatives: • There are no significant barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** has addressed the prior year's recommendations. The SFY 2022 CAHPS activity confirmed that **Molina Healthcare of Michigan**'s score for *Customer Service* for the CSHCS population was comparable to the national average.

Priority Health Choice

Table 4-7—Prior Year Recommendations and Responses for PRI

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no substantial identified weaknesses, **Priority Health Choice** should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The MHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • In 2022, health plans began a new cycle for prenatal performance improvement projects. After the creation of the newest PIP, a new causal/barrier analysis was conducted using the most recent HEDIS data available. The Quality Improvement team has met with internal and external partners to discuss barriers to care and barriers to capturing prenatal data. Additionally, the integration of Total Health Care membership into Priority Health produced new barriers to care due to the location and makeup of the population. Thus far, the analysis has identified barriers such as transportation, lack on knowledge regarding the importance of prenatal care, and other SDoH to be contributing factors to the low prenatal rates amongst African Americans. An SDoH workstream has been created to help Priority Health identify and address SDoH concerns amongst membership. Additionally, the Plan has implemented the PriorityMOM program to address health literacy gaps associated with prenatal care. Finally, Priority is working with providers and community organizations to expand the availability centering pregnancy programs in high-need areas.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Priority Health is still working to implement many of the interventions listed above to address barriers to prenatal care. PriorityMOM is currently active, and members are engaging in the program, but more time must elapse in order to evaluate the program's impact.
c. Identify any barriers to implementing initiatives: • Identification of mothers early in the pregnancy is a barrier to success. Members that become pregnant while currently active with Priority Health are more difficult to identify and reach out to. The key to early intervention is early identification and outreach.
HSAG Assessment: HSAG has determined that **Priority Health Choice** addressed the prior year's recommendations. The MHP revisited its causal/barrier analysis with the initiation of a revised PIP focused on a similar PIP topic.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Priority Health Choice** should conduct a root cause analysis or focused study to determine why some women did not receive prenatal care. If it is determined that COVID-19 impacted performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator, **Priority Health Choice** should proactively alter its approach to prenatal care through methods such as telemedicine, when possible, to improve upon performance related to the *Prenatal and Postpartum Care* measure. • **Priority Health Choice** should conduct a root cause analysis or focused study to determine why members did not always have access to ambulatory or preventive care visits. If it is determined that COVID-19 impacted performance for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 45 to 64 Years*, and *Total* measure indicators, **Priority Health Choice** may consider telemedicine as an alternate approach to improving performance. Continued availability and promotion of telehealth services might play a prominent role in increasing access to services during the pandemic.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Prenatal Care: Priority Health completed a root cause analysis to identify causes for low prenatal care rates. In addition to the impacts seen at the height of the COVID-19 pandemic, the analysis identified transportation, lack of childcare, lack of understanding of the importance of early prenatal care, long wait times, economic challenges, and other SDoH as contributing factors. Identifying pregnant members early in their pregnancy journey is also a barrier for the health plan. Priority Health is currently investigating and seeking to implement the following interventions: o PriorityMOM – This is a program that went into effect in 2022 for all moms identified as pregnant. They receive an email inviting them to participate in the program. The program provides education to the member based on their stage in pregnancy. The program follows the member throughout the pregnancy providing education on things like prenatal visits, sleep safety, and nutrition along the way. o Centering Pregnancy - Working with partners in the community to expand availability of centering pregnancy programs in high-need areas. o Doula Programs – Doulas will be covered by Priority Health starting 10/1/2022. Priority is seeking community partners to create a referral process and increase the utilization of doulas in communities that may benefit from community-based prenatal care. • Adult Access to Care: Priority Health completed a root cause analysis to identify causes for low Adult Access to Care rates. The COVID-19 pandemic played a large role in reduced routine care visits in calendar year 2020. The impact of the pandemic is still seen in 2021 rates as well. To assist with re-engaging members back into primary care and routine visits, Priority Health is implementing a member education campaign via social media to promote the use of telemedicine and virtual care. The goal is to increase utilization of these options. Additionally, Priority Health is close to launching a text campaign to members reminding them of the importance of annual visits to a primary care provider. The texts will go out to members on September 23, 2022.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Priority Health is still working to implement many of the interventions listed above to address barriers to prenatal care and Adult Access to Care. PriorityMOM is currently active, and members are engaging in the program, but more time must elapse in order to evaluate the program's impact. Priority Health will be able to evaluate the success of the text campaigns and the evaluation will be used to determine if future text campaigns should be created for other measures.
c. Identify any barriers to implementing initiatives: • Prenatal Care: Identification of mothers early in the pregnancy is a barrier to success. Members that become pregnant while currently active with Priority Health are more difficult to identify and reach out to. The key to early intervention is early identification and outreach. • Adult Access to Care: No barriers to implement the intervention at this time.
HSAG Assessment: HSAG has determined that **Priority Health Choice** has partially addressed the prior year's recommendations. As it relates to the prior year's recommendation for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator, **Priority Health Choice** has demonstrated efforts by conducting a root cause analysis and identifying factors that led to a decrease in performance. However, **Priority Health Choice** continues to demonstrate low performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator. Significant barriers noted by **Priority Health Choice** were transportation, lack of childcare, lack of understanding of the importance of early prenatal care, long wait times, economic challenges, identification of pregnant members early in pregnancy, and providers not allowing the mother to bring other children or family to appointments. HSAG recommends that **Priority Health Choice** continue its efforts on improving access to prenatal care and monitor the impact of initiatives currently in place to ensure improved performance. **Priority Health Choice** could consider encouraging telehealth services among providers and patients to help address the noted barriers. Appropriate interventions should be implemented if other contributing factors are identified. As it relates to the prior year's recommendation for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 45 to 64 Years*, and *Total* measure indicators, **Priority Health Choice** has demonstrated efforts by conducting a root cause analysis and identifying factors that led to a decrease in performance. However, **Priority Health Choice** continues to demonstrate low performance for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 45 to 64 Years*, and *Total* measure indicators. As such, HSAG recommends that **Priority Health Choice** continue to outreach to schedule members for preventive or ambulatory health services to improve upon performance and access to preventive care for its members. Although the COVID-19 PHE was identified as a barrier, maintaining continuity of care to the extent possible can avoid additional negative consequences from delayed preventive, chronic, or routine care. Remote access to healthcare services may increase participation for those who are medically or socially vulnerable or who do not have ready access to providers. Remote access can also help preserve the patient-provider relationship at times when an in-person visit is not practical or feasible.[4-3] Appropriate interventions should be implemented if other contributing factors are identified.

[4-3] Centers for Disease Control and Prevention. Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic, Updated June 10, 2020. Available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html. Accessed on: Feb 1, 2023.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **Priority Health Choice** was required to submit a CAP to address these findings [discrepancies in provider contact information and whether the PCP was accepting new patients were identified in the provider directory], **Priority Health Choice** should ensure its MDHHS-approved CAP is fully implemented to mitigate the deficiencies. Additionally, **Priority Health Choice** should conduct its own periodic secret shopper survey of a sample of its provider network and use the results of any future EQR-related network adequacy validation activity to further analyze the completeness and accuracy of its provider data. • As **Priority Health Choice** submitted a CAP to MDHHS to remediate identified deficiencies [third-party subrogation report reflected response times over 30 days], **Priority Health Choice** should continue to monitor this requirement to ensure its subrogation process is fully implemented to mitigate the identified deficiencies. • As **Priority Health Choice** previously submitted a CAP to address these findings [several deficiencies identified throughout the year regarding the program integrity, including but not limited to, inconsistencies or discrepancies in various program integrity reports; the encounter adjustments validation report fell below the 85 percent benchmark set by MDHHS; and documents that included OIG contact information were inconsistent in the entity name and Web referral], which was accepted by MDHHS, **Priority Health Choice** should ensure its CAP is fully implemented to mitigate the deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Provider Contact Info: Priority Health continues to heavily reinforce provider expectations regarding notice of provider data changes. Priority Health strives to make all updates to the systems within 30 days of receipt of any new request to change information. Because we knew that we weren't always meeting that metric, we changed our expectation for providers to notify us. We now ask that they notify us 60 days in advance of the change instead of 30 days. This is clearly noted on priorityhealth.com in several areas of the Provider Manual. • In March of this year, we published an internal-only "To Do" for Priority Health employees and also a companion news article in the Provider Manual on priorityhealth.com reminding providers that they must re-attest their CAQH application every 120 days. We did this to remind providers of why keeping their CAQH attested is important to us. • Another improvement effort has been the remediation of our 4275 report. Data crosswalks between PH systems were updated, an internal audit dashboard was created to monitor any data gaps, and we utilized a program called Ultrix to better manage the data. • We also have a Team that reviews monthly reports from the CAQH product called "Direct Assure." These reports check for Retired and Deceased providers as well as note practitioners who have "opted out" of using Direct Assure. This monthly review of Direct Assure typically prompts additional research/review to validate the accuracy of the retired/deceased/opted out providers and then take steps to remove them from PH systems - OR – we clarify any change that the provider failed to notify Priority Health of.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
• Third Party Subrogation: Priority Health, in conjunction with its subrogation vendor: Optum; implemented a multifaceted compliance program that consists of weekly proactive reporting & monitoring, along with consistent education to ensure understanding of the MDHHS requirements. • Program Integrity: Root cause analysis identified 3 issues causing the low match rate: 1) all claim lines were being brought in, not just the lines with overpayment, 2) TCN's were being submitted when a claim had mixed line acceptance with RE and IO, 3) one of our vendor partners was not submitting all claims to the State Encounter Data System. Priority Health logic was updated to address errors one and two and our vendor partner updated their system to submit all claims. As part of our corrective action plan, we also submitted "test" encounters to the state to validate our programing changes were pulling correctly prior to finalizing updated logic. Testing with the State passed and updated logic was finalized to ensure accuracy of future submission. The implemented corrective action was successful.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Provider Contact Info: Priority Health is within Service Level expectations (30 days) as of August 2022. We believe this is, in part, due to the effective use of PRISM since its launch in October 2021. This process has taken Priority Health and the provider network time to get familiar with and is now showing the positive impact of the workflow. • We believe our provider education efforts regarding PRISM and CAQH re-attestations requirements have also had a positive impact on our provider data. • Priority Health is in the beginning stages of engaging with BetterDoctor, part of Quest Analytics Accuracy. This organization helps health plans improve the flow and quality of accurate provider data • Third Party Subrogation: As a result of these robust actions, Priority Health has been in compliance with the aforementioned MDHHS requirements for the past 7 calendar quarters (Q4 2020 to present). • Program Integrity: Subsequent quarterly submissions received passing score; most recent report for July 2022 demonstrated a 92.40% match.
c. Identify any barriers to implementing initiatives: • Provider Contact Info: We are finding that PRISM requests for demographic changes received from offices are still not always submitted timely (or thoroughly) causing discrepancies in our provider directory data. • We also find that the volume of changes submitted to Priority Health continues to impact timely updates and accuracy of provider data. • Third Party Subrogation: No barriers currently exist; Priority Health is meeting the MDHHS requirements. • Program Integrity: No barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that **Priority Health Choice** addressed the prior year's recommendations related to the provider directory, third-party subrogation requests, and program integrity. The results of the SFY 2022 compliance review also confirmed that the MHP successfully remediated the deficiencies related to elements *5.8 Third Party Subrogation Requests*, *6.1 Quarterly Program Integrity Forms* (Tips and Grievances), *6.8 Quarterly Program Integrity Forms* (Encounter Adjustments), *6.9 OIG Program Integrity–Fraud Compliance Program*, and *6.10 OIG Annual Program Integrity Report*. However, while **Priority Health Choice** implemented interventions to enhance the accuracy of its provider directory, the MHP received a *Not Met* score for element *2.21 Secret Shopper Calls* (previously referred to as *2.6 MHP Provider Directory*) during the SFY 2022 compliance review as discrepancies were identified in PCP locations and phone numbers, and with being listed as accepting new patients. **Priority Health Choice** continues to work on strategies to resolve the deficiency through the SFY 2022 compliance review CAP which was approved by

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MDHHS. As such, HSAG has no additional documentations at this time. Additionally, while **Priority Health Choice** implemented interventions to remediate the findings of element *6.2 Quarterly Program Integrity Forms* (Data Mining), the MHP received a *Not Met* score for this element during the SFY 2022 compliance review. As **Priority Health Choice** also continues to work on strategies to resolve the deficiency through the SFY 2022 compliance review CAP which was approved by MDHHS, HSAG has no additional documentations at this time.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**Priority Health Choice** should monitor the measures to ensure significant decreases in scores over time do not occur. • CSHCS—**Priority Health Choice** should monitor the measures to ensure significant decreases in scores over time do not occur. • Healthy Michigan—**Priority Health Choice** should monitor the measures to ensure significant decreases in scores over time do not occur.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Priority Health has implemented a CAHPS workgroup that includes team members from across the company. The workgroup meets monthly to discuss all CAHPS scores, review score trends, identify opportunities for improvement, and implement interventions. So far, from the workgroup, the following activities and interventions have been identified: o Conduct a telephonic outreach to original Total Health Care members that are active with Priority Health to complete a "1-Year Check-In". Priority Health wants to know how their first year with the plan has gone and offer any assistance to ensure they are enjoying their new plan. o Review and analyze Customer Service post-call surveys responses and follow up with any members listing their experience as poor. o Review drill down analysis into complaints and grievances to identity trends for dissatisfaction. o Have our CAHPS vendor complete a drill down analysis to stratify results based on geographic location to determine if one region is experiencing greater dissatisfaction compared to another.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • These activities and interventions are all currently in-flight. The one-year check-in with previous Total Health Care members will launch in November 2022. The rest of the activities are on the workplan to be completed by the end of calendar year 2022.
c. Identify any barriers to implementing initiatives: • No barriers to implementing initiatives at this time.
HSAG Assessment: HSAG has determined that **Priority Health Choice** has addressed the prior year's recommendations.

UnitedHealthcare Community Plan

Table 4-8—Prior Year Recommendations and Responses for UNI

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **UnitedHealthcare Community Plan** should revisit its causal/barrier analysis process to capture barriers associated with the pandemic and develop specific and targeted interventions to address those barriers.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • With the new 2022 Michigan Health Plan Performance Improvement Project UNI reviewed and updated the casual/barrier analysis including barriers related to the pandemic such as SDoH and provider office staff shortages.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • At the end of 2021, there was no longer a statistically significant difference in timeliness of prenatal care (TOPC) for Black and White birthing persons was 59.73% and 58.81% (x2 = .33, p = .5637).
c. Identify any barriers to implementing initiatives: • UNI continues to collaborate with provider offices still impacted by staffing shortages and help to remove administrative burdens.
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** addressed the prior year's recommendations. The MHP revisited its causal/barrier analysis with the initiation of a revised PIP focused on a similar PIP topic.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **UnitedHealthcare Community Plan** should monitor performance improvement interventions currently in place and continue to expand upon or implement additional interventions, when necessary, to improve the performance related to the *Childhood Immunization Status* measure. The CDC recommends continued administration of routine immunization during the pandemic to prevent transmission of other preventable infectious diseases. According to the AAP, while telehealth visits are recommended, in-person visits, especially for vaccination, should not be discontinued unless community circumstances require the limitation of in-person visits, in which case curbside or drive-through vaccination can be implemented by clinics to limit patient-provider contact. • **UnitedHealthcare Community Plan** should conduct a root cause analysis or focused study to determine why members were not always receiving appropriate testing for pharyngitis to warrant antibiotic treatment. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the *Appropriate Testing for Pharyngitis* measure.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • As UNI focuses on coronavirus disease 2019 (COVID-19) Re-engagement in preventive health care, we worked collaboratively with the Detroit Health Department and provider offices to sponsor health fairs throughout the Spring and Summer focused on immunizations. • The COVID-19 pandemic also impacted Appropriate Testing for Pharyngitis as some providers limited the oral testing required to warrant antibiotic treatment. In 2022, UNI increased focus on provider education regarding appropriate testing for pharyngitis to improve antibiotic stewardship.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • UNI notes an improvement in Childhood Immunization Status measure (Combo 10) of 6% since February 2022 and a 5% increase from the same time last year. • UNI noted a decline in Appropriate Testing for Pharyngitis from 2020 to 2021. However, UNI already notes a 3.61% increase in testing rates for 2022.
c. Identify any barriers to implementing initiatives: • Since the COVID-19 pandemic UNI is increasing efforts to address increased national and local vaccine hesitancy. • During the COVID-19, providers may have limited oral swabbing for pharyngitis to limit exposure and conserve personal protective equipment.
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** has partially addressed the prior year's recommendations. **UnitedHealthcare Community Plan** has put forth effort to address HSAG's prior year recommendation for the *Childhood Immunization Status* measure indicators by collaborating with the Detroit Health Department and provider offices on sponsoring health fairs focused on immunizations. However, **UnitedHealthcare Community Plan** continues to demonstrate low performance for the *Childhood Immunization Status* measure indicators. A significant barrier noted by **UnitedHealthcare Community Plan** was vaccine hesitancy. HSAG recommends that **UnitedHealthcare Community Plan** continue its efforts on improving childhood immunizations and monitor the impact of initiatives currently in place to ensure improved performance. The CDC offers provider resources related to vaccine conversations with parents that could potentially help address barriers related to vaccine hesitant parents and the delay of child vaccine schedules.[4-4] As it relates to the prior year's recommendation for the *Appropriate Testing for Pharyngitis* measure, **UnitedHealthcare Community Plan** has demonstrated efforts by providing education to providers on appropriate testing for pharyngitis. However, **UnitedHealthcare Community Plan** continues to demonstrate low performance for the *Appropriate Testing for Pharyngitis* measure. A significant barrier noted by **UnitedHealthcare Community Plan** was providers' limitation on oral swabbing for pharyngitis due to COVID-19. HSAG recommends that **UnitedHealthcare Community Plan** continue its efforts on improving performance for the *Appropriate Testing for Pharyngitis* measure and monitor the impact of initiatives

[4-4] Centers for Disease Control and Prevention. Talking with Parents about Vaccines for Infants, updated April 11, 2018. Available at: https://www.cdc.gov/vaccines/hcp/conversations/talking-with-parents.html. Accessed on: Feb 1, 2023.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
currently in place to ensure improved performance. **UnitedHealthcare Community Plan** is encouraged to continue with educating and outreaching to providers to reinforce the importance of appropriate antibiotic prescribing habits.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **UnitedHealthcare Community Plan** was required to submit a CAP to address these findings [discrepancies in provider contact information and whether the PCP was accepting new patients were identified in the provider directory], **UnitedHealthcare Community Plan** should ensure its MDHHS-approved CAP is fully implemented to mitigate the deficiencies. Additionally, **UnitedHealthcare Community Plan** should conduct its own periodic secret shopper survey of a sample of its provider network and use the results of any future EQR-related network adequacy validation activity to further analyze the completeness and accuracy of its provider data. • As **UnitedHealthcare Community Plan** submitted a CAP to MDHHS to remediate identified deficiencies [the third-party subrogation report reflected response times over 30 days and the MHP did not meet the 0.1 percent noncompliant claims threshold for products covered on the common formulary] or had an active mitigation plan, **UnitedHealthcare Community Plan** should continue to monitor these requirements to ensure its processes for pharmacy claims meet established thresholds.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UNI completed actions to successfully meet identified CAP deficiencies. In 2022, UNI continues to be compliant with provider director data conducting 250 secret shopper surveys per quarter. • UNI continues to monitor the process for third-party subrogation to ensure compliance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • UNI conducts quarterly reviews to ensure provider data accuracy. Additionally, UNI monitors field accuracy of provider data and maintains above 90%.
c. Identify any barriers to implementing initiatives: • Timely notification of changes by providers to UNI is a barrier.
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** addressed the prior year's recommendations related to the provider directory and third-party subrogation requests. However, while **UnitedHealthcare Community Plan** implemented interventions to enhance the accuracy of its provider directory, the MHP received a *Not Met* score for element *2.21 Secret Shopper Calls* (previously referred to as *2.6 MHP Provider Directory*) during the SFY 2022 compliance review as discrepancies were identified in PCP locations and phone numbers, and with being listed as accepting new patients. **UnitedHealthcare Community Plan** continues to work on strategies to resolve the deficiency through the SFY 2022 compliance review CAP which was approved by MDHHS. As such, HSAG has no additional documentations at this time. Additionally, while **UnitedHealthcare Community Plan** implemented interventions to enhance compliance with the 30-day response time frame for third-party subrogation requests, the MHP received a *Not Met* score for element *5.8 Third Party Subrogation Requests* during the SFY 2022 compliance review. As **UnitedHealthcare Community Plan** also continues to work on strategies to enhance timely response times through the SFY 2022

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
compliance review CAP which was approved by MDHHS, HSAG has no additional recommendations at this time. HSAG has determined that **UnitedHealthcare Community Plan** did not address the prior year's recommendation related to non-compliant pharmacy claims. **UnitedHealthcare Community Plan** did not address this recommendation in its narrative, and **UnitedHealthcare Community Plan** continued to receive a *Not Met* score for element *5.6 Pharmacy/MCO Common Formulary* during the SFY 2022 compliance review as the MHP was improperly using rejection codes and its claims logic preferred generic products when both the brand and generic are on the common formulary. As **UnitedHealthcare Community Plan** continues to work on strategies to resolve the deficiency through the SFY 2022 compliance review CAP which was approved by MDHHS, HSAG has no additional documentations at this time.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**UnitedHealthcare Community Plan** should focus on improving parents/caretakers of child members' overall experiences with their child's healthcare and identifying the root cause of the poorer experiences with the child's personal doctor. **UnitedHealthcare Community Plan** should provide training and resources to providers to cultivate better relationships between providers and members, and to improve providers' communication skills. • CSHCS—**UnitedHealthcare Community Plan** should monitor the measures to ensure significant decreases in scores over time do not occur. • Healthy Michigan—**UnitedHealthcare Community Plan** should monitor the measures to ensure significant decreases in scores over time do not occur.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UNI ensures inclusion of parents/caretakers in invites to the Member Advisory Group where we discuss results of our member experience survey and solicit identification of improvement opportunities. • UNI partnered with Press Ganey, an industry leader in patient experience, to offer 10 interactive patient experienced video-based trainings and downloadable guides to help providers and practice staff improve patient experiences. Education regarding improving patient experience included in UNI and provider joint operating committee meetings.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • From 2021 to 2022, UNI's child members experience with health care improved by 1.3% and experience with their personal doctor improved by 8.3%. UNI continues to monitor any significant changes in members experience.
c. Identify any barriers to implementing initiatives: • It is a challenge to monitor the impact of process improvement activities with annual survey data.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** has partially addressed the prior year's recommendations. The SFY 2022 CAHPS activity confirmed that **UnitedHealthcare Community Plan**'s score for *Rating of Personal Doctor* for the child Medicaid population was comparable to the national average; however, *Rating of All Health Care* for the child Medicaid population was statistically significantly lower than the 2021 child Medicaid national average. **UnitedHealthcare Community Plan** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends **UnitedHealthcare Community Plan** timely implement performance improvement interventions and evaluate their effectiveness.

Upper Peninsula Health Plan

Table 4-9—Prior Year Recommendations and Responses for UPP

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no substantial identified weaknesses, **Upper Peninsula Health Plan** should revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions. The MHP should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UPHP identified a new topic for the Performance Improvement Project in FY2022. Data analysis was performed to identify a statistically significant racial disparity, and a cause-and-effect analysis was performed to identify and prioritize barriers to completion of care for the target population. The final baseline report for this PIP was submitted on August 25th, 2022.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • UPHP has not experienced barriers to implementing interventions.
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** addressed the prior year's recommendations. The MHP revisited its causal/barrier analysis with the initiation of a revised PIP focused on a similar PIP topic.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • Due to continued low performance for the *Asthma Medication Ratio* measure, **Upper Peninsula Health Plan** should monitor and target its efforts toward those with asthma medication ratios less than 50 percent to improve upon performance related to the *Asthma Medication Ratio* measure. Appropriate medication management for those with persistent asthma is especially important during the COVID-19 pandemic, as those with moderate-to-severe or uncontrolled asthma are more likely to be hospitalized from COVID-19. • **Upper Peninsula Health Plan** should monitor performance improvement interventions currently in place and continue to expand upon or implement additional interventions, when necessary, to improve the performance related to the *Immunizations for Adolescents* measure. The easing of nationwide restrictions and opening of schools introduce a new risk for disease outbreaks among adolescents who may have missed routine immunizations due to the pandemic. Therefore, it is essential for pediatricians to ensure adolescents are up to date on their vaccines. • **Upper Peninsula Health Plan** should monitor performance improvement interventions currently in place and continue to expand upon or implement additional interventions, when necessary, to improve the performance related to the *Childhood Immunization Status* measure. The CDC recommends continued administration of routine immunization during the pandemic to prevent transmission of other preventable

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
infectious diseases. According to the AAP, while telehealth visits are recommended, in-person visits, especially for vaccination, should not be discontinued unless community circumstances require the limitation of in-person visits, in which case curbside or drive-through vaccination can be implemented by clinics to limit patient-provider contact.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

Asthma Medication Ratio (AMR)

- The UPHP quality department partnered with the UPHP pharmacy department to implement improvement initiatives to increase the rate of members with an AMR of greater than 0.5. UPHP performed a medical record review of seventy-one members with an AMR less than 0.5 identified during HEDIS Measurement Year (MY) 2021. Findings were shared broadly with clinical advisory committee and network quality staff.
- In CY 2021 UPHP initiated an Asthma and COPD Shared Savings which features AMR as a quality gate in. An updated shared savings program was launched in July 2022 and will be expanded to include a third clinic system.
- Arranged for in-person training dedicated to maximizing the use of the UPHP-supported Cotiviti Provider Intelligence Population Health Management Tool & Member Registry (Cotiviti PI) for clinical staff to monitor and intervene on attributed members with an identified AMR of less than 0.5.
- The Pharmacy Director recorded a radio spot that aired throughout Asthma Awareness Month (May 2022). Social media posts educated the community about asthma.

Immunizations for Adolescents (IMA)

- UPHP monitors measure performance monthly using proactive HEDIS data and internal dashboards. A Healthy Kids, Healthy Futures Vaccine Edition campaign was launched in response to performance in immunization measures.
- UPHP participated in several community events in SFY 2021-2022 which provided education about childhood immunizations including the Lake Superior Village Back-to-School Village Resource Fair and KI Sawyer Resource Fair. Other local / regional immunization events held by health departments and community partners were promoted directly to members through mail or telephone outreach.
- Other interventions included social media awareness campaign, targeted member phone outreach including offer of gift card incentives to complete care, network clinic quality staff meeting presentation, and member and provider newsletter articles.

Childhood Immunization Status (CIS)

- UPHP monitors measure performance monthly using proactive HEDIS data and internal dashboards. A Healthy Kids, Healthy Futures Vaccine Edition campaign was launched in response to performance in immunization measures.
- A text messaging / interactive voice recording (IVR) campaign was implemented for CIS in CY2021 and ran through January 2022.
- UPHP participated in several community events in SFY 2021-2022 which provided education about or administration of childhood immunizations including the Lake Superior Village Back-to-School Village Resource Fair and KI Sawyer Resource Fair. Other local / regional immunization events held

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
by health departments and community partners were promoted directly to members through mail or telephone outreach. • Other interventions included social media awareness campaign, targeted member phone outreach including offer of gift card incentives to complete care, network clinic quality staff meeting presentation, and member and provider newsletter articles.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Asthma Medication Ratio (AMR) • The HEDIS MY 2021 AMR rate was 57.59%. The HEDIS MY 2022 AMR measurement period is still open and will continue to update, but as of 09/01/2022 the current rate is 58.70%, an increase of just over one percentage point. A more comprehensive analysis of the effectiveness of our efforts will be completed when HEDIS MY 2022 results are finalized. • Both participants in our AMR Shared Savings program demonstrated a small improvement in their AMR rate of between one and four percentage points respectively, moving one clinic system from the 10th percentile HEDIS Medicaid HMO MY 2020 benchmark to the 25th percentile Immunizations for Adolescents (IMA) • Review of current IMA rates (August 2022) in comparison to August 2021 shows rate decrease of 4.31 percentage points (Combo 1), 5.82 (combo 2) = average 5.1%. Childhood Immunization Status (CIS) • The August 2022 HEDIS rate for CIS Combo 3 (61.20%) has surpassed the CY 2021 rate of 60.69%. Over 50% (7/12) of the PCP clinics that participated in the HKHF - Vaccine Edition campaign have shown an increase in Combo 3 completion rates, with an average rate increase of 16%. • Text messaging / IVR sample was too small to determine statistically significant improvement.
c. Identify any barriers to implementing initiatives: Asthma Medication Ratio (AMR) • Health systems have limited resources to dedicate to AMR improvement efforts, suffering from frequent staff turnover and/or inability to fill vacated positions. • Lack of significant member input or involvement in the design of improvement initiatives. Immunizations for Adolescents (IMA) • The UPHP IMA eligible population increased by 24.2% up to this point this year (856 in 2021; 1063 in 2022). This is a large increase of new members which may be auto assigned to a PCP; this coupled with staffing shortages and turnover in clinics makes engaging members challenging. • Other barriers noted include inaccurate PCP attribution for care gap lists, invalid phone numbers during outreach, parent refusal due to vaccine misinformation, immunizations completed but not during correct HEDIS timeframe (i.e., well-child visit is scheduled and will have done at the appointment, but date will not meet). Childhood Immunization Status (CIS) • Health systems have limited resources to dedicate to quality improvement efforts, suffering from frequent staff turnover and/or inability to fill vacated positions. • Other barriers noted include inaccurate PCP attribution for care gap lists; invalid phone numbers/addresses during outreach; parent refusals due to vaccine misinformation; immunizations completed but not during correct timeframe (i.e., well-child visit is scheduled and will have done at the appointment, but date will not meet).

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** has partially addressed the prior year's recommendations. As it relates to the prior year's recommendation for the *Asthma Medication Ratio* measure, **Upper Peninsula Health Plan** has demonstrated efforts by implementing improvement initiatives, initiating a shared saving program, providing in-person training to clinical staff members, and educating members. However, **Upper Peninsula Health Plan** continues to demonstrate low performance for the *Asthma Medication Ratio* measure. Significant barriers noted by **Upper Peninsula Health Plan** were staffing shortages, limited improvement effort resources, and member engagement in improvement initiatives. HSAG continues to recommend that **Upper Peninsula Health Plan** pursue further education and outreach to members with asthma, with a targeted focus on members with an asthma medication ratio less than 50 percent, to improve upon performance and asthma control for its members. As it relates to the prior year's recommendation for the *Immunizations for Adolescents* measure, **Upper Peninsula Health Plan** has demonstrated efforts by monitoring monthly performance via internal dashboards, participating in community events, educating members on childhood immunizations, providing member incentives, and conducting member outreach. However, **Upper Peninsula Health Plan** continues to demonstrate low performance for the *Immunizations for Adolescents* measure. Significant barriers noted by **Upper Peninsula Health Plan** were staffing shortages, vaccine hesitant parents, immunizations completed outside of the correct time frame, and member outreach. HSAG recommends that **Upper Peninsula Health Plan** continue its efforts on improving immunizations for adolescents. **Upper Peninsula Health Plan** is encouraged to attempt additional methods of member outreach and provide member and provider education on the importance of immunizations for adolescents. **Upper Peninsula Health Plan** has put forth effort to address HSAG's prior year recommendation for the *Childhood Immunization Status* measure indicators by participating in community events that provided education on childhood immunizations, conducting member outreach, educating providers and members, and providing member incentives. However, **Upper Peninsula Health Plan** continues to demonstrate low performance for the *Childhood Immunization Status* measure indicators. Significant barriers noted by **Upper Peninsula Health Plan** were staffing shortages, vaccine hesitant parents, immunizations completed outside of the correct time frame, and member outreach. HSAG recommends that **Upper Peninsula Health Plan** continue its efforts on improving childhood immunizations and monitor the impact of initiatives currently in place to ensure improved performance. The CDC offers provider resources related to vaccine conversations with parents that could potentially help address barriers related to vaccine hesitant parents and the delay of child vaccine schedules.[4-5]

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • As **Upper Peninsula Health Plan** was required to submit a CAP to address these findings [discrepancies in whether the PCP was accepting new patients and provider contact information were identified in the provider directory], **Upper Peninsula Health Plan** should ensure its MDHHS-approved CAP is fully implemented to mitigate the deficiencies. Additionally, **Upper Peninsula Health Plan** should conduct its own periodic secret shopper survey of a sample of its provider network and use the results of any future

[4-5] Centers for Disease Control and Prevention. Talking with Parents about Vaccines for Infants, updated April 11, 2018. Available at: https://www.cdc.gov/vaccines/hcp/conversations/talking-with-parents.html. Accessed on: Feb 1, 2023.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
EQR-related network adequacy validation activity to further analyze the completeness and accuracy of its provider data.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Upper Peninsula Health Plan's Provider Relations Department conducts quarterly audit reviews of the Provider Directory verifying provider information listed, and will update information as needed. Provider Relations Department will also be implementing their own PCP Secret Shopper Survey calls as well. Provider Relations Department also updated Quarterly Provider Verification Process of emailing provider offices provider information to review and update if needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The updated Quarterly Provider Practice Verification Process being emailed instead of faxed produced more responses and provider update requests.
c. Identify any barriers to implementing initiatives: • Staff turnover with provider offices can cause confusion of provider availability, but provider offices are now using the provider information through the Quarterly Provider Verification Process to keep staff notified on UPHP providers and their availability.
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** addressed the prior year's recommendation related to the provider directory. However, while **Upper Peninsula Health Plan** implemented interventions to enhance the accuracy of its provider directory, the MHP received a *Not Met* score for element *2.21 Secret Shopper Calls* (previously referred to as *2.6 MHP Provider Directory*) during the SFY 2022 compliance review as discrepancies were identified in PCPs being listed as accepting new patients. **Upper Peninsula Health Plan** continues to work on strategies to resolve the deficiency through the SFY 2022 compliance review CAP which was approved by MDHHS. As such, HSAG has no additional documentations at this time.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
HSAG recommended the following: • Adult and Child Medicaid—**Upper Peninsula Health Plan** should focus on identifying the root cause of the poorer experiences parents/caretakers are having with their child's personal doctor. **Upper Peninsula Health Plan** should provide training and resources to providers to cultivate better relationships between providers and members, and to improve providers' communication skills. • CSHCS—**Upper Peninsula Health Plan** should monitor the measures to ensure significant decreases in scores over time do not occur. • Healthy Michigan—**Upper Peninsula Health Plan** should explore what may be driving lower experience scores for *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* and develop initiatives designed to improve quality of care. **Upper Peninsula Health Plan** should provide training and resources to providers to promote smoking cessation with their members.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Adult and Child Medicaid • In 2021, UPHP implemented a CAHPS Taskforce. The CAHPS Taskforce is a subset of our Service Advisory Committee (SAC), tasked with analyzing CAHPS scores and identifying appropriate actions and initiatives to maintain or improve CAHPS scores. These initiatives are added to the QAI UM [Quality Assessment and Improvement and Utilization Management] Work Plan to track effectiveness. Current activities and planned interventions include educating network providers about CAHPS, CAHPS Scores, and best practices at the UPHP Annual Provider In-Service, scheduled October 12, 2022, and bimonthly newsletters. The Taskforce is working to implement a provider incentive tied to training specific to increasing patient satisfaction. The team is also using findings of an organization-wide communications audit to determine how we can communicate with our provider network most effectively. CSHCS • The CAHPS Taskforce, as described above, applies to all CAHPS results, including CSHCS. Current activities and planned interventions to maintain or improve our CSHCS CAHPS scores include ensuring Pediatric Specialists and Specialty Clinics are easily found in the CSHCS provider search, sharing the Specialty Clinic of UP Health System calendar with network and pediatric specialists, and rewriting the CSHCS welcome letter for clarity about how UPHP can help with Care Coordination. Healthy Michigan Plan • In November 2022, UPHP hosted a respiratory health awareness campaign and distributed materials to all network providers, corresponding with the Great American Smoke Out, to facilitate increased tobacco cessation counseling. Quit kits for providers/care managers to share with patients in a readiness to change state were assembled by UPHP staff and distributed to 18 patient centered medical homes (PCMH). Each quit kit included resources such as the Michigan Tobacco Quitline wallet card, helpful tobacco cessation tips from the CDC, smokefree.gov, and the Department of Health and Human Services, and novelty items. • Additional provider interventions included incentivizing eye care specialist providers and PCMH providers for providing and coding tobacco cessation counseling and educational provider newsletter articles.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Healthy Michigan Plan • UPHP CAHPS scores have increased by the following percentage points from CY 2018 to CY 2021: Discussing Strategies for Smoking Cessation increased by 7.2 percentage points (75th percentile rank). Discussing Medications for Smoking Cessation increased by 6.6 percentage points (90th percentile rank). Smokers Advised to Quit at an Office Visit increased by 2.3 percentage points (75th percentile rank). • CY 2022 CAHPS Rate for Smoking Cessation measures are not available currently for HMP to identify effectiveness of interventions. UPHP will monitor as data becomes available.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS
c. Identify any barriers to implementing initiatives: Healthy Michigan Plan • Attempts to assess the usefulness of provided materials and quit kits by way of surveys resulted in a poor response. Providers were emailed an invitation to complete a survey and quit kits included a QR code that brought recipients to an electronic survey. Although responses were favorable, only three providers and one quit kit recipient responded • CAHPS data relies upon member-reported outcomes and may not accurately reflect the provision of tobacco cessation counseling within the network. • Some individuals with tobacco claims express an inability or unwillingness to engage in smoking cessation conversations. • As offices adjust workflows to mitigate the backlog of overdue primary care services created by the COVID-19 pandemic, smoking cessation counseling may not be prioritized – especially for those members with long-term tobacco use who have previously not expressed an interest in quitting.
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** has addressed the prior year's recommendations. The SFY 2022 CAHPS activity confirmed that **Upper Peninsula Health Plan**'s score for *Rating of Personal Doctor* was comparable to the national average for the child Medicaid population. Also, the scores for *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the HMP population were comparable to national averages.

5. Medicaid Health Plan Comparative Information

In addition to performing a comprehensive assessment of each MHP's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each MHP to assess the CHCP. Specifically, HSAG identifies any patterns and commonalities that exist across the 10 MHPs and the CHCP, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which MDHHS could leverage or modify Michigan's CQS to promote improvement.

Medicaid Health Plan External Quality Review Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the MHPs.

Validation of Performance Improvement Projects

For the SFY 2022 validation, the MHPs submitted baseline data for the state-mandated PIP topic: *Addressing Disparities in Timeliness of Prenatal Care*. Table 5-1 provides a comparison of the validation scores, by MHP.

Table 5-1—Comparison of PIP Validation by MHP

Overall PIP Validation Status, by MHP		Design and Implementation Scores		
		Met	***Partially Met***	***Not Met***
AET	*Partially Met*	94%	6%	0%
BCC	*Met*	100%	0%	0%
HAP	*Met*	100%	0%	0%
MCL	*Met*	100%	0%	0%
MER	*Met*	100%	0%	0%
MOL	*Met*	100%	0%	0%
PRI	*Met*	100%	0%	0%
UNI	*Met*	100%	0%	0%
UPP	*Met*	100%	0%	0%

Performance Measure Validation

Table 5-2 displays the HEDIS MY 2021 performance levels. Table 5-3 displays the HEDIS MY 2020 and HEDIS MY 2021 Michigan Medicaid weighted averages, comparison of performance between 2020 and 2021, and the performance level for 2021. Statewide weighted averages were calculated and compared from HEDIS MY 2020 to HEDIS MY 2021, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 considered statistically significant due to large denominators. Of note, 2020 to 2021 comparison values are based on comparisons of the exact HEDIS MY 2020 and HEDIS MY 2021 statewide weighted averages rather than on rounded values.

For most measures in Table 5-3, the performance levels compare the HEDIS MY 2021 statewide weighted average to the NCQA Quality Compass national Medicaid HMO percentiles for HEDIS MY 2020 (referred to as "percentiles"), as displayed in Table 5-2.[5-1]

Table 5-2—HEDIS MY 2021 Performance Levels

Performance Levels	Percentile
★★★★★	90th percentile and above
★★★★	75th to 89th percentile
★★★	50th to 74th percentile
★★	25th to 49th percentile
★	Below 25th percentile

Table 5-3—Overall Statewide Averages for HEDIS MY 2020 and HEDIS MY 2021 Performance Measures

Measure	HEDIS MY 2020	HEDIS MY 2021	2020–2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.88%	58.84%	**-3.04⁺⁺**	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	67.71%	60.99%	**-6.72⁺⁺**	★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	50.92%	58.13%	**+7.21⁺**	★★★
Ages 12 to 17 Years	42.35%	49.93%	**+7.58⁺**	★★★
Ages 18 to 21 Years	27.36%	29.01%	**+1.65⁺**	★★★
Total	44.59%	50.49%	**+5.90⁺**	★★★

[5-1] MY 2021 performance levels were based on comparisons to national Medicaid HMO Quality Compass HEDIS MY 2020 benchmarks.

Measure	HEDIS MY 2020	HEDIS MY 2021	2020–2021 Comparison[1]	MY 2021 Performance Level[2]
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	57.30%	58.09%	+0.79	★★★
Ages 21 to 24 Years	63.68%	64.15%	+0.47	★★★
Total	60.20%	61.00%	**+0.80⁺**	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	60.53%	58.01%	**-2.52⁺⁺**	★★
Breast Cancer Screening				
Breast Cancer Screening	56.31%	52.30%	**-4.01⁺⁺**	★★
Living With Illness				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	83.13%	85.92%	**+2.79⁺**	★★★
*HbA1c Poor Control (>9.0%)**	43.03%	43.04%	+0.01	★★★
HbA1c Control (<8.0%)	47.46%	48.26%	**+0.80⁺**	★★★
Eye Exam (Retinal) Performed	53.65%	54.56%	**+0.91⁺**	★★★
Blood Pressure Control (<140/90 mm Hg)	58.38%	59.61%	**+1.23⁺**	★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	30.63%	30.62%	-0.01	★★★
Ages 65 to 74 Years	32.03%	29.92%	-2.11	★★
Ages 75 to 85 Years	29.97%	30.27%	+0.30	★★
Total	30.68%	30.57%	-0.11	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	54.48%	56.14%	**+1.66⁺**	★★★

[1] Weighted averages were calculated and compared from HEDIS MY 2020 to HEDIS MY 2021, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators. Rates shaded **green** with one cross (+) indicate statistically significant improvement from the previous year. Rates shaded **red** with two crosses (++) indicate a statistically significantly decline in performance from the previous year. Of note, 2020–2021 Comparison values are based on comparisons of the exact HEDIS MY 2020 and HEDIS MY 2021 statewide weighted averages, not rounded values.

[2] Performance Levels for MY 2021 were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks.

* For this indicator, a lower rate indicates better performance.

Performance Levels for MY 2021 represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 5-4 presents, by measure, the number of MHPs that performed at each performance level. The counts include only measures with a valid, reportable rate that could be compared to percentiles. Therefore, not all row totals will equal nine MHPs.

Table 5-4—Count of MHPs by Performance Level

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Child & Adolescent Care					
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	2	0	5	2	0
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	8	1	0	0	0
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	0	1	7	1	0
Ages 12 to 17 Years	1	2	6	0	0
Ages 18 to 21 Years	0	4	5	0	0
Total	1	1	7	0	0
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	1	0	4	4	0
Ages 21 to 24 Years	1	1	4	3	0
Total	1	0	4	4	0
Cervical Cancer Screening					
Cervical Cancer Screening	2	4	2	1	0
Breast Cancer Screening					
Breast Cancer Screening	1	5	2	1	0
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	0	1	3	3	2
*HbA1c Poor Control (>9.0%)**	2	1	2	2	2
HbA1c Control (<8.0%)	1	2	2	1	3
Eye Exam (Retinal) Performed	0	3	4	2	0
Blood Pressure Control (<140/90 mm Hg)	2	2	2	2	1
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	1	3	4	1	0
Ages 65 to 74 Years	2	2	4	1	0
Ages 75 to 85 Years	2	3	2	1	0
Total	1	4	3	1	0

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	2	0	4	2	1
Total	**31**	**40**	**76**	**32**	**9**

* For this indicator, a lower rate indicates better performance.

Performance Levels for MY 2021 represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 5-5 provides an MHP-to-MHP comparison with the statewide average in the four selected HEDIS measure domains. Green represents best MHP performance in comparison to the statewide average. Red represents worst MHP performance in comparison to the statewide average.

Table 5-5—MHP-to-MHP Comparison and Statewide Average

HEDIS Measure	Statewide Average	AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP
Child & Adolescent Care										
Well-Child Visits in the First 30 Months of Life										
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.84%	41.30%	61.80%	36.06%	58.66%	60.85%	55.95%	59.18%	57.52%	67.53%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.99%	41.89%	62.98%	46.05%	59.04%	61.93%	60.53%	65.58%	58.08%	67.43%
Child and Adolescent Well-Care Visits										
Ages 3 to 11 Years	58.13%	52.37%	59.20%	45.80%	54.63%	58.18%	59.60%	60.53%	57.53%	57.85%
Ages 12 to 17 Years	49.93%	44.76%	49.83%	34.35%	44.47%	49.86%	52.34%	51.89%	50.23%	51.87%
Ages 18 to 21 Years	29.01%	24.29%	31.08%	19.18%	23.41%	27.39%	31.90%	30.06%	32.09%	23.44%
Total	50.49%	44.00%	51.22%	36.69%	45.88%	50.75%	52.26%	52.67%	50.60%	49.99%
Women—Adult Care										
Chlamydia Screening in Women										
Ages 16 to 20 Years	58.09%	65.21%	58.41%	55.87%	53.84%	55.97%	62.05%	60.52%	60.01%	41.06%
Ages 21 to 24 Years	64.15%	65.67%	63.32%	60.48%	61.89%	64.36%	65.63%	66.59%	65.18%	51.13%
Total	61.00%	65.46%	61.08%	58.96%	57.84%	59.89%	63.67%	63.39%	62.36%	45.73%

HEDIS Measure	Statewide Average	AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP
Cervical Cancer Screening										
Cervical Cancer Screening	58.01%	46.47%	59.49%	43.80%	56.69%	56.83%	57.21%	63.99%	58.88%	61.31%
Breast Cancer Screening										
Breast Cancer Screening	52.30%	46.79%	52.25%	56.75%	53.67%	50.97%	51.37%	56.52%	51.15%	59.29%
Living With Illness										
Comprehensive Diabetes Care										
Hemoglobin A1c (HbA1c) Testing	85.92%	81.02%	85.40%	82.97%	86.13%	83.45%	87.10%	86.37%	89.78%	90.51%
*HbA1c Poor Control (>9.0%)**	43.04%	41.36%	37.96%	50.12%	54.74%	52.07%	39.90%	34.31%	33.09%	33.33%
HbA1c Control (<8.0%)	48.26%	50.12%	50.85%	44.28%	38.20%	40.63%	51.82%	55.72%	56.93%	55.47%
Eye Exam (Retinal) Performed	54.56%	51.58%	54.99%	49.88%	50.61%	51.34%	57.18%	61.31%	55.47%	59.61%
Blood Pressure Control (<140/90 mm Hg)	59.61%	51.34%	59.37%	53.28%	43.31%	55.72%	62.77%	69.59%	67.15%	82.48%
Kidney Health Evaluation for Patients With Diabetes										
Ages 18 to 64 Years	30.62%	20.01%	28.07%	31.20%	29.11%	30.15%	27.62%	34.91%	37.55%	34.50%
Ages 65 to 74 Years	29.92%	23.71%	29.59%	33.55%	42.42%	23.50%	30.61%	34.09%	43.35%	39.38%
Ages 75 to 85 Years	30.27%	23.35%	25.53%	32.35%	NA	23.60%	31.92%	29.77%	47.69%	35.06%
Total	30.57%	20.82%	28.08%	31.83%	29.22%	29.61%	27.91%	34.79%	37.87%	34.98%
Controlling High Blood Pressure										
Controlling High Blood Pressure	56.14%	60.10%	57.95%	57.32%	45.26%	48.91%	55.96%	66.42%	64.72%	79.08%

* For this indicator, a lower rate indicates better performance.

NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.

Compliance Review

MDHHS calculated the CHCP overall performance in each of the six performance areas. Table 5-6 compares the CHCP average compliance score in each of the six performance areas with the compliance score achieved by each MHP. The percentages of requirements met for each of the six standards reviewed during the SFY 2022 compliance review are provided.

Table 5-6—Compliance Monitoring Comparative Results

Standard		AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP	CHCP[1]
1	Administrative	100%	100%	100%	60%	100%	100%	100%	100%	100%	**95.6%**
2	Providers	95%	90%	86%	90%	90%	90%	90%	86%	81%	**88.9%**
3	Members	100%	100%	100%	100%	92%	100%	96%	100%	100%	**98.7%**
4	Quality	100%	100%	95%	100%	100%	100%	100%	95%	100%	**98.9%**
5	MIS/Financial	94%	100%	94%	97%	92%	94%	100%	92%	97%	**95.7%**
6	OIG/Program Integrity	100%	97%	94%	97%	97%	97%	97%	88%	100%	**96.3%**
Overall Score		**98%**	**98%**	**94%**	**96%**	**94%**	**96%**	**97%**	**92%**	**96%**	**95.9%**

Indicates the highest-performing MHP(s) in the standard.

Indicates the lowest-performing MHP(s) in the standard.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Network Adequacy Validation

During May and June 2022, HSAG completed an NVS among PCPs, pediatric providers, and OB/GYN providers contracted with one or more MHP to ensure members have appropriate access to provider information. The NVS included a PDV in which HSAG compared key indicators published in each online provider directory with the data in the MHPs' provider files. HSAG then validated the accuracy of the online provider directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories.

Table 5-7 summarizes findings by MHP regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers were able to locate in the MHPs' online directories.

Table 5-7—Summary of Sampled Providers Located in Online Directories

MHP	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory	
		Count	%	Count	%
AET	321	297	92.5%	24	7.5%
BCC	342	329	96.2%	13	3.8%
HAP	354	349	98.6%	5	1.4%
MCL	342	333	97.4%	9	2.6%
MER	363	331	91.2%	32	8.8%
MOL	324	312	96.3%	12	3.7%
PRI	324	306	94.4%	18	5.6%
UNI	333	322	96.7%	11	3.3%
UPP	103	97	94.2%	6	5.8%
MHP Total	**2,806**	**2,676**	**95.4%**	**130**	**4.6%**

Table 5-8 and Table 5-9 display, by MHP and study indicator, the percentage of sampled provider locations identified in the online directories with exact matches between the MHPs' provider data files and the online provider directory. Cases with unmatched results may include spelling discrepancies, incomplete information, or information not listed in the directory (e.g., the MHP's provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).[5-2]

Table 5-8—Study Indicator Matches

Indicator	AET		BCC		HAP		MCL		MER	
	Count	%	Count	%	Count	%	Count	%	Count	%
Provider's Name	297	100%	329	100%	347	99.4%	333	100%	329	99.4%
Provider Street Address	293	98.7%	288	87.5%	343	98.3%	328	98.5%	301	90.9%
Provider City	289	97.3%	292	88.8%	346	99.1%	317	95.2%	307	92.7%
Provider State	293	98.7%	299	90.9%	346	99.1%	329	98.8%	311	94.0%
Provider ZIP Code	292	98.3%	298	90.6%	346	99.1%	328	98.5%	309	93.4%
Provider Telephone Number	292	98.3%	283	86.0%	344	98.6%	326	97.9%	226	68.3%

[5-5] The denominator for each study indicator includes the number of cases in which the provider was found in the directory (i.e., as shown in Table 5-7).

Indicator	AET		BCC		HAP		MCL		MER	
	Count	%	Count	%	Count	%	Count	%	Count	%
Provider Type/Specialty	291	98.0%	298	90.6%	344	98.6%	329	98.8%	292	88.2%
Provider Gender	293	98.7%	298	90.6%	345	98.9%	328	98.5%	311	94.0%
Provider Accepting New Patients	283	95.3%	299	90.9%	346	99.1%	329	98.8%	311	94.0%
Non-English Language Speaking Provider (including American Sign Language)	265	89.2%	276	83.9%	260	74.5%	325	97.6%	250	75.5%
Provider Primary Language	293	98.7%	299	90.9%	86	24.6%	325	97.6%	49	14.8%

Table 5-9—Study Indicator Matches (continued)

Indicator	MOL		PRI		UNI		UPP		MHP Total	
	Count	%	Count	%	Count	%	Count	%	Count	%
Provider's Name	312	100%	304	99.3%	321	99.7%	96	99.0%	**2,668**	**99.7%**
Provider Street Address	304	97.4%	295	96.4%	303	94.1%	95	97.9%	**2,550**	**95.3%**
Provider City	304	97.4%	293	95.8%	313	97.2%	95	97.9%	**2,556**	**95.5%**
Provider State	305	97.8%	296	96.7%	315	97.8%	95	97.9%	**2,589**	**96.7%**
Provider ZIP Code	305	97.8%	296	96.7%	311	96.6%	95	97.9%	**2,580**	**96.4%**
Provider Telephone Number	299	95.8%	185	60.5%	301	93.5%	94	96.9%	**2,350**	**87.8%**
Provider Type/Specialty	301	96.5%	291	95.1%	315	97.8%	94	96.9%	**2,555**	**95.5%**
Provider Gender	257	82.4%	296	96.7%	306	95.0%	95	97.9%	**2,529**	**94.5%**
Provider Accepting New Patients	292	93.6%	296	96.7%	315	97.8%	92	94.8%	**2,563**	**95.8%**
Non-English Language Speaking Provider (including American Sign Language)	303	97.1%	290	94.8%	273	84.8%	85	87.6%	**2,327**	**87.0%**
Provider Primary Language	304	97.4%	295	96.4%	311	96.6%	95	97.9%	**2,057**	**76.9%**

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 2,278 sampled provider locations (i.e., "cases"), with an overall response rate of 67.2 percent (n=1,530). Table 5-10 summarizes the MHPs' secret shopper survey results.

Table 5-10—Summary of Secret Shopper Survey Results

MHP	Total Cases	Response Rate		Offering Specialty		Confirmed Provider		Accepting MHP		Accepting MI Medicaid	
		Cases Reached	Response Rate (%)	Offering Specialty	Rate (%)	Confirmed Provider	Rate (%)	Accepting MHP	Rate (%)	Accepting MI Medicaid	Rate (%)
AET	278	214	77.0%	165	77.1%	165	68.5%	113	91.2%	103	99.0%
BCC	269	174	64.7%	111	63.8%	111	68.5%	76	96.1%	73	98.6%
HAP	342	240	70.2%	188	78.3%	188	78.7%	148	83.8%	124	96.8%
MCL	314	223	71.0%	172	77.1%	172	73.8%	127	94.5%	120	93.3%
MER	220	166	75.5%	113	68.1%	113	85.8%	97	78.4%	76	98.7%
MOL	285	195	68.4%	100	51.3%	100	68.0%	68	82.4%	56	100%
PRI	182	96	52.7%	55	57.3%	55	67.3%	37	78.4%	29	72.4%
UNI	297	135	45.5%	62	45.9%	62	69.4%	43	83.7%	36	91.7%
UPP	91	87	95.6%	86	98.9%	86	94.2%	81	98.8%	80	97.5%
MHP Total	**2,278**	**1,530**	**67.2%**	**1,052**	**68.8%**	**1,052**	**75.1%**	**790**	**88.2%**	**697**	**96.0%**

Table 5-11 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 5-11—Appointment Availability Results

MHP	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)	Cases Offered an Appointment		Appointment Wait Time (Days)	
			Number	Rate (%)	Average	Median
AET	102	94.1%	96	90.6%	16	8
BCC	72	87.5%	63	81.0%	25	19
HAP	120	89.2%	107	79.4%	18	8
MCL	112	90.2%	101	83.2%	26	20

MHP	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)	Cases Offered an Appointment		Appointment Wait Time (Days)	
			Number	Rate (%)	Average	Median
MER	75	81.3%	61	70.5%	27	13
MOL	56	94.6%	53	71.7%	22	13
PRI	21	90.5%	19	78.9%	22	14
UNI	33	81.8%	27	66.7%	17	8
UPP	78	89.7%	70	74.3%	22	15
MHP Total	**669**	**89.2%**	**597**	**79.2%**	**21**	**12**

Consumer Assessment of Healthcare Providers and Systems Analysis

Comparative analyses identified whether one MHP performed statistically significantly higher or lower on each measure compared to the program average for a specific population, as well as the overall member experience ratings when scores were compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data.[5-3,5-4,5-5] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 5-12.

Table 5-12—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Table 5-13 through Table 5-17 provide a summary of the statistically significant findings (noted with arrows) from the MHP comparisons, as well as the overall member experience ratings (noted with stars) from the NCQA comparisons of the adult and child Medicaid populations.

5-3 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

5-4 The source for the national data contained in this publication is Quality Compass® 2021 and is used with the permission of NCQA. Quality Compass 2021 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

5-5 Since certain survey questions in the CAHPS 5.1 Child Medicaid Health Plan Survey were modified for inclusion in the CSHCS Survey, the results are not comparable to the NCQA benchmark data; therefore, NCQA comparison results were not presented in the 2021 and 2022 Michigan CSHCS CAHPS Reports. Only the scores and statistically significant results are presented in the Michigan CSHCS comparison tables.

Table 5-13—Statewide Comparisons: Adult Medicaid Global Ratings

Program/Plan Name	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*
Medicaid Managed Care Program	★★★ **63.7%**	★★ **56.2%**	★★ **66.5%**	★★ **66.5%**
AET	★★★ 65.3%	★ 51.6%	★★ 67.7%	★★ 66.3%+
BCC	★★★★ 69.1%	★★★ 59.2%	★★ 65.6%	★★★★ 74.1%
HAP	★★★ 64.2%	★★★ 59.3%	★★★ 72.7%	★★ 67.8%+
MCL	★★ 59.6%	★★ 58.1%	★★★ 69.5%	★ 62.2%+
MER	★★ 61.7%	★ 49.6%	★ 63.2%	★ 61.6%+
MOL	★★ 62.0%	★★ 55.7%	★ 64.7%	★★ 67.0%
PRI	★★★★ 66.7%	★★★ 61.8%	★★ 65.5%	★★★★★ 75.5%
UNI	★★★ 63.3%	★★★ 60.9%	★★★ 72.3%	★ 64.0%+
UPP	★★★★★ 71.1%	★★ 56.1%	★★★ 71.9%	★ 62.8%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
No arrows (↑ or ↓) indicate the scores were not statistically significantly higher or lower than the Medicaid managed care program average.

Table 5-14—Statewide Comparisons: Adult Medicaid Composite Measures

Program/Plan Name	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Medicaid Managed Care Program	★★ **82.8%**	★★ **82.0%**	★★ **91.4%**	★★★★ **91.5%**
AET	★★ 83.4%	★★★ 84.4%+	★★★ 92.7%	★★★ 89.9%+
BCC	★★ 83.5%	★★ 80.3%	★★ 92.1%	★★★★★ 92.7%+
HAP	★ 80.9%	★★★★ 85.2%+	★★★★★ 95.4%	★★★★ 91.6%
MCL	★★★ 85.3%	★★★★ 85.4%	★★★★ 94.1%	★ 87.1%+
MER	★ 79.2%+	★ 78.8%+	★ 89.0%	★★★ 90.6%+
MOL	★★★★ 87.0%	★★★ 83.8%	★ 88.6%	★★★★★ 94.9%+
PRI	★★★ 84.8%	★★★★ 85.8%	★★★ 92.9%	★★★ 90.4%+
UNI	★ 79.8%+	★★ 79.5%+	★★★ 93.1%	★★★★ 91.7%+
UPP	★★★ 84.4%	★★★★ 87.1%	★★★★★ 95.4%	★★★★★ 94.8%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
No arrows (↑ or ↓) indicate the scores were not statistically significantly higher or lower than the Medicaid managed care program average.

Table 5-15—Statewide Comparisons: Adult Medicaid Individual Item and Effectiveness of Care Measures

Program/Plan Name	*Coordination of Care*	*Advising Smokers and Tobacco Users to Quit*	*Discussing Cessation Medications*	*Discussing Cessation Strategies*
Medicaid Managed Care Program	★★ **83.5%**	★★★ **75.5%**	★★★ **54.8%**	★★ **47.3%**
AET	★ 79.7%+	★★ 72.4%	★★★★ 57.9%	★★★ 50.3%
BCC	★★★★↑ 90.8%+	★★ 74.5%	★★ 51.6%	★★ 44.0%
HAP	★★ 84.9%+	★ 70.7%	★★ 51.6%	★★ 44.4%
MCL	★★ 85.1%+	★ 70.7%	★★ 50.0%	★★ 43.9%
MER	★↓ 72.7%+	★★ 74.1%	★★★ 54.9%	★★ 46.0%
MOL	★★ 83.8%+	★★★ 79.0%	★★★★★ 61.8%	★★★★ 54.8%
PRI	★★★★★↑ 92.1%+	★★★ 76.9%	★★ 49.4%	★★ 44.7%
UNI	★★★ 88.1%+	★★★ 79.2%	★★★ 56.8%	★★★ 47.6%
UPP	★★ 83.7%+	★★★ 76.4%	★★★★ 58.9%	★★★★ 52.7%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ Indicates the score is statistically significantly higher than the Medicaid managed care program average.
↓ Indicates the score is statistically significantly lower than the Medicaid managed care program average.

Table 5-16—Statewide Comparisons: Child Medicaid Global Ratings

Program/Plan Name	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*
Medicaid Managed Care Program	★ **67.4%**	★ **68.8%**	★ **73.3%**	★ **68.4%**
AET	★ 64.8%	★ 63.4%+	★ 72.4%+	★★★★★ 80.0%+
BCC	★★ 71.0%	★★★ 74.8%	★ 72.9%	★ 70.8%+
HAP	★★ 71.3%	★ 64.2%+	★ 71.7%+	★★★★ 76.7%+
MCL	★ 62.7%	★ 70.7%	★ 71.7%	★ 62.5%+
MER	★★ 68.8%	★ 68.7%	★ 74.0%	★ 69.6%+
MOL	★ 63.3%	★ 65.9%	★ 68.5%	★ 57.4%+
PRI	★★ 70.7%	★★ 73.0%	★★ 78.0%	★★ 72.5%+
UNI	★ 68.3%	★ 63.9%	★★ 76.0%	★★★★ 76.6%+
UPP	★ 67.5%	★ 70.2%	★★ 76.7%	★★★ 75.0%+

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
No arrows (↑ or ↓) indicate the scores were not statistically significantly higher or lower than the Medicaid managed care program average.

Table 5-17—Statewide Comparisons: Child Medicaid Composite and Individual Item Measures[5-6]

Program/Plan Name	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*	*Coordination of Care*	*Transportation*
Medicaid Managed Care Program	★★ **84.3%**	★★ **87.5%**	★★★ **94.9%**	★★ **88.0%**	★★ **83.6%**	**49.0%**
AET	★★★ 88.3%+	★★★ 88.7%+	★ 91.8%+	★ 85.2%+	★★★ 88.5%+	62.5%
BCC	★★ 82.8%+	★★★ 88.3%+	★★★ 95.3%	★ 85.0%+	★ 75.5%+	NA
HAP	★★ 82.7%+	★★ 86.9%+	★★ 93.3%+	★★★★ 90.5%+	★★ 87.1%+	NA
MCL	★★★ 86.1%+	★★★★ 90.7%+	★★★ 95.0%	★★★★★ 94.3%+	★ 76.4%+	NA
MER	★★ 85.1%	★★★ 88.7%+	★★★ 95.4%	★ 86.5%+	★★ 85.9%+	NA
MOL	★★ 83.7%+	★★ 87.3%+	★★★ 94.6%	★★★★★ 93.3%+	★ 81.5%+	73.1%
PRI	★★★ 86.6%+	★★★ 89.6%+	★★★ 95.3%	★★ 86.8%+	★★ 87.8%+	NA
UNI	★ 80.9%+	★↓ 79.8%+	★★ 94.0%	★ 82.8%+	★★★★ 89.6%+	NA
UPP	★★★ 87.4%	★★★★★↑ 94.2%	★★★★ 97.1%	★★★★ 90.6%+	★★ 84.7%+	NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ Indicates the score is statistically significantly higher than the Medicaid managed care program average.
↓ Indicates the score is statistically significantly lower than the Medicaid managed care program average.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

[5-6] The *Transportation* composite measure survey questions are not included in the standard CAHPS 5.1H Child Medicaid Health Plan Survey. These questions are NCQA-approved supplemental items that were added to the survey. A 2021 NCQA benchmark is not available for this measure.

Table 5-18 through Table 5-20 provide a summary of the statistically significant findings (noted with arrows) of the CSHCS population analysis.

Table 5-18—Statewide Comparisons: CSHCS Global Ratings

Program/Plan Name	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Specialist Seen Most Often*	*Rating of CMDS Clinic*
CSHCS Managed Care Program	**67.3%**	**70.2%**	**73.5%**	**76.0%**
AET	58.3%+	69.2%+	NA	NA
BCC	69.4%	69.6%	73.7%	63.6%+
HAP	61.5%+	50.0%+	NA	NA
MCL	69.7%	73.5%	75.8%	63.2%+
MER	65.6%	71.7%	73.6%	77.8%+
MOL	64.2%	69.2%	68.8%	81.0%+
PRI	73.1%	72.2%	78.1%	88.0%+
UNI	65.1%	66.3%	70.5%	72.7%+
UPP	67.4%+	73.7%+	83.6%+	88.2%+

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
No arrows (↑ or ↓) indicate the scores were not statistically significantly higher or lower than the CSHCS Managed Care Program average.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

Table 5-19—Statewide Comparisons: CSHCS Composite Measures

Program/Plan Name	*Customer Service*	*How Well Doctors Communicate*	*Access to Specialized Services*	*Transportation*	*CSHCS Family Center*
CSHCS Managed Care Program	**86.7%**	**95.0%**	**70.9%**	**74.0%**	**82.8%+**
AET	NA	95.5%+	NA	NA	NA
BCC	82.1%+	94.3%	67.7%+	↓ 55.7%+	NA
HAP	NA	95.8%+	NA	NA	NA
MCL	87.9%+	95.5%	76.5%+	78.6%+	NA
MER	85.8%+	95.2%	70.5%+	74.3%+	NA
MOL	86.1%+	93.4%	73.4%+	82.4%+	NA
PRI	↑ 98.0%+	96.3%	70.2%+	87.1%+	NA
UNI	84.0%+	95.2%	70.0%+	61.1%+	NA
UPP	↑ 91.2%+	98.0%+	70.1%+	↑ 97.2%+	NA

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ Indicates the score is statistically significantly higher than the CSHCS Managed Care Program average.
↓ Indicates the score is statistically significantly lower than the CSHCS Managed Care Program average.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

Table 5-20—Statewide Comparisons: CSHCS Individual Item Measures

Program/Plan Name	*Access to Prescription Medicines*	*CMDS Clinic*	*Local Health Department Services*	*Not Felt Treated Unfairly: Race and Ethnicity*	*Not Felt Treated Unfairly: Health Insurance Type*
CSHCS Managed Care Program	**90.7%**	**84.4%**	**77.0%**	**96.6%**	**94.8%**
AET	NA	NA	NA	81.8%+	81.8%+
BCC	87.5%	76.5%+	76.2%+	95.3%	94.3%
HAP	90.9%+	NA	NA	↑ 100.0%+	100.0%+
MCL	94.0%	79.5%+	77.2%+	96.7%	92.4%
MER	88.7%	77.1%+	78.6%	↑ 99.2%	93.3%
MOL	92.0%	87.2%+	76.6%+	95.8%	95.8%
PRI	93.4%	96.0%+	78.8%+	97.2%	96.0%
UNI	90.2%	91.3%+	74.5%+	95.7%	96.7%
UPP	90.4%+	94.1%+	81.8%+	96.1%+	97.4%+

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ Indicates the score is statistically significantly higher than the CSHCS Managed Care Program average.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

Table 5-21 through Table 5-23 provide a summary of the statistically significant findings (noted with arrows) of the HMP population analysis, as well as the overall member experience ratings (noted with stars) from the NCQA comparisons.

Table 5-21—Statewide Comparisons: HMP Global Ratings

Program/Plan Name	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*
HMP Program	★★★ **62.6%**	★★ **56.4%**	★★ **68.7%**	★★ **65.6%**
AET	★ 56.4%	★ 50.9%+	★ 61.9%+	★ 59.0%+
BCC	★★ 61.6%	★★★ 58.5%	★★ 68.4%	★★ 67.6%+
HAP	★ 56.4%	★ 54.5%+	★★ 68.1%+	★ 63.0%+
MCL	★★ 62.0%	★ 50.0%	★ 63.6%	★ 58.0%+
MER	★★★ 64.4%	★ 53.4%	★★★ 70.4%	★ 58.5%+
MOL	★★★★ 67.0%	★★★ 58.3%	★★★ 71.2%	★★ 68.8%+
PRI	★★ 59.9%	★★ 57.1%	★★ 67.4%	★★★ 69.8%+
UNI	★★ 58.9%	★★★★ 65.5%	★★★ 71.3%	★★★★★ 76.9%+
UPP	★★★★ 67.2%	★ 51.6%	★★ 65.6%	★★★ 72.4%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
No arrows (↑ or ↓) indicate the scores were not statistically significantly higher or lower than the HMP Program average.

Table 5-22—Statewide Comparisons: HMP Composite Measures

Program/Plan Name	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
HMP Program	★★ **81.6%**	★★ **80.5%**	★★★ **92.6%**	★ **86.9%**
AET	★★ 83.1%+	★★★ 84.2%+	★★ 92.2%+	★ 80.6%+
BCC	★★ 83.6%+	★★ 82.2%+	★★★★★ 96.2%+	★ 86.3%+
HAP	★★ 82.8%+	★ 78.2%+	★★★★ 94.0%+	★ 85.5%+
MCL	★★★ 84.9%	★ 76.4%+	★★ 91.9%	★★★ 89.3%+
MER	★ 75.7%+	★ 79.0%+	★ 89.8%	★★★ 90.0%+
MOL	★ 76.9%+	★★ 80.5%+	★★ 91.2%	★ 81.7%+
PRI	★★ 83.7%	★★ 80.1%	★★ 91.6%	★ 83.8%+
UNI	★★★★★ 89.3%+	★★★ 84.0%+	★★★★★ 95.6%	★★★ 89.5%+
UPP	★★★ 84.9%	★★★★ 86.0%	★★★★★ 95.3%	★★★ 90.0%+

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
No arrows (↑ or ↓) indicate the scores were not statistically significantly higher or lower than the HMP Program average.

Table 5-23—Statewide Comparisons: HMP Individual Item and Effectiveness of Care Measures

Program/Plan Name	*Coordination of Care*	*Advising Smokers and Tobacco Users to Quit*	*Discussing Cessation Medications*	*Discussing Cessation Strategies*
HMP Program	★ **81.5%**	★★★ **77.3%**	★★★ **57.1%**	★★★ **47.4%**
AET	★ 79.2%+	★★★★ 81.5%+	★★★★ 58.0%+	★★ 43.8%+
BCC	★★★★ 88.9%+	★★★★↑ 82.1%	★★★★★ 63.4%	★★★★ 55.4%
HAP	★★★★ 90.5%+	★↓ 63.6%+	★ 45.5%+	★ 36.8%+
MCL	★ 76.9%+	★★ 73.0%	★★ 50.3%	★ 42.5%
MER	★ 75.0%+	★★★ 76.4%	★★★ 57.0%	★★ 45.9%
MOL	★ 82.8%+	★★★★↑ 82.1%	★★★★ 58.8%	★★★ 48.3%
PRI	★★★ 86.7%+	★★★ 75.7%	★★★ 56.8%	★★★ 47.9%
UNI	★ 80.4%+	★★ 74.2%	★★★ 56.0%	★★ 45.3%
UPP	★★★ 86.0%+	★ 69.7%	★★ 50.4%	★★ 45.0%

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ Indicates the score is statistically significantly higher than the HMP Program average.
↓ Indicates the score is statistically significantly lower than the HMP Program average.

Quality Rating

HSAG analyzed MY 2021 HEDIS results, including MY 2021 CAHPS data from the nine MHPs, for presentation in the 2022 Michigan Consumer Guide. The 2022 Michigan Consumer Guide analysis helps to support MDHHS' public reporting of health plan performance information. The 2022 Michigan Consumer Guide used a three-level rating scale to provide potential and enrolled Medicaid members with an easy-to-read "picture" of quality performance across MHPs and presented data in a manner that emphasizes meaningful differences between MHPs. The 2022 Michigan Consumer Guide used apples to display results for each MHP, which correlated to the performance ratings defined in Table 5-24. Table 5-25 shows the 2022 Michigan Consumer Guide, which demonstrates MHP comparative performance in MDHHS-established categories.

Table 5-24—Apple Ratings for the 2022 Michigan Consumer Guide

Rating	Plan Performance Compared to Statewide Average	
🍎🍎🍎🍎🍎	Above Average	The health plan's performance was above average compared to Michigan Medicaid health plans
🍎🍎🍎	Average	The health plan's performance was average compared to Michigan Medicaid health plans
🍎🍎	Below Average	The health plan's performance was below average compared to Michigan Medicaid health plans

Table 5-25—2022 Michigan Consumer Guide

Plan	Overall Rating*	Doctors' Communication and Service	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna Better Health of Michigan	🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎	🍎🍎	🍎🍎
Blue Cross Complete of Michigan**	🍎🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎	🍎🍎🍎🍎🍎
HAP Empowered	🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎	🍎🍎	🍎🍎
McLaren Health Plan**	🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎	🍎🍎	🍎🍎🍎
Meridian Health Plan of Michigan	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎	🍎🍎
Molina Healthcare of Michigan**	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎🍎	🍎🍎🍎
Priority Health Choice, Inc.	🍎🍎🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎🍎🍎🍎
UnitedHealthcare Community Plan**	🍎🍎🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎🍎
Upper Peninsula Health Plan	🍎🍎🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎🍎🍎🍎	🍎🍎🍎🍎🍎

**This rating includes all categories. This rating also includes how the member feels about their plan and the help the member receives from their plan.*
***Indicates the plan has a Multicultural Health Care distinction from the National Committee for Quality Assurance (NCQA) as of October 2022. Further details may be found on the NCQA website located here: https://reportcards.ncqa.org/methodology.*

6. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the MHPs 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 CHCP to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the 2020–2023 MDHHS CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members.

Table 6-1—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1—Ensure high quality and high levels of access to care	**Conclusions:** The results of the EQR activities demonstrated mixed performance related to high quality and high levels of access to care though the PMV activity. Within the Women—Adult Care domain, the total performance measure rate for *Chlamydia Screening in Women* ranked between the 50th and 74th Medicaid Quality Compass percentile and demonstrated a statistically significant improvement from the previous year, indicating more CHCP-enrolled women had at least one test for chlamydia. However, the *Cervical Cancer Screening* and *Breast Cancer Screening* performance measure rates ranked between the 25th and 49th Medicaid Quality Compass percentile and demonstrated a statistically significant decline from the prior year. Overall, the CHCP has substantial opportunities to increase the number of women who receive screening for cervical and breast cancer. Within the Living With Illness domain, all five rates under the *Comprehensive Diabetes Care* performance measure and the *Controlling High Blood Pressure* performance measure rate ranked between the 50th and 74th Medicaid Quality Compass percentile. The *Controlling High Blood Pressure* performance measure rate and four out of five rates for the *Comprehensive Diabetes Care* performance measure also demonstrated a significant improvement from the previous year, indicating more CHCP members had proper diabetes management and blood pressure control. Additionally, while the *Kidney Health Evaluation for Patients With Diabetes—Total* performance measure rate ranked between the 50th and 74th Medicaid Quality Compass percentile, its rate remained stable with no significant improvement or decline. The *Child and Adolescent Well-Care Visits—Total* performance measure rate also ranked between the 50th and 74th Medicaid Quality Compass percentile and demonstrated a significant improvement, while both indicator rates for the *Well-Child Visits in the First 30 Months of Life*	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	performance measure demonstrated a significant decline. While the CHCP increased the number of children and adolescent members 3 to 21 years of age receiving a well-care visit with a PCP or OB/GYN provider, enhanced focus is needed to improve the number of children 15 months or younger who receive all recommended well-child visits. The results of the NAV activity and compliance review activity suggest that the CHCP may be experiencing barriers to accessing care and services. Through the NAV activity, the secret shopper survey revealed a generally high percentage of providers who could not be reached (response rate of 67.2 percent) and a generally low percentage of providers who offered the requested specialty (68.8 percent) or offered the caller an appointment (79.2 percent). Additionally, through the PDV, the provider telephone number was only accurate 87.8 percent of the time. Further, all MHPs were placed on a compliance review CAP due to provider data discrepancies in the provider directories. These results suggest that barriers to care may include inaccurate information on provider networks, and challenges in reaching providers and scheduling timely appointments. Members may also have negative perceptions of the CHCP, due to programwide low ratings in several CAHPS measures for the adult and child Medicaid populations such as *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Coordination of Care*. Negative perceptions about the MHPs and their contracted providers may prevent members from accessing needed healthcare services. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress towards achieving Goal #1. These objectives should be specific, measurable, attainable, relevant, and time-bound and take into consideration the health status of all populations served by MDHHS' MHPs. Additionally, although MDHHS has mandated a PIP related to the timeliness of prenatal care, MDHHS could consider adding contract language requiring the MHPs to conduct a minimum number (e.g., two clinical and two non-clinical) of PIPs that align with specific areas of focus identified by MDHHS in support of Goal #1. For example, focus areas could include prevention and care of acute and chronic conditions, high-volume services, continuity and coordination of care, and SDOH, etc.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** Through the compliance review activity, MDHHS evaluates the MHPs' policies and procedures related to collaboration with LHDs to coordinate care for members who receive CSHCS. MHP care coordination plans must include how each MHP assesses the need for a care manager and develops a family-centered care plan in conjunction with a member's family and care team. CSHCS members are also assigned to CSHCS-attested PCP practices that provide family-centered care. MDHHS also evaluates the MHPs' CHW programs, which must include interventions delivered by CBOs and address SDOH, and promote health prevention and health education. CHWs must assist members in the community and navigate community resources, outreach, and culture responsiveness. All MHPs achieved full compliance for these requirements. However, through the CAHPS activity, parents/guardians of CSHCS members reported some negative experiences in several measures such as *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of CMDS Clinic*, *Access to Specialized Services*, *Transportation*, and *Local Health Department Services*. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #2. These objectives should be specific, measurable, attainable, relevant, and time-bound and take into consideration the health status of all populations served by MDHHS' MHPs. In addition to the CAHPS activity, HSAG recommends MDHHS consider adding contract language requiring the MHPs to conduct ongoing member experience surveys that target specific populations (e.g., CSHCS members) to obtain member-specific data to use to drive improvement in the care provided to these target populations, increase member satisfaction, and make progress toward achieving Goal #2.	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)	**Conclusions:** Many Medicaid members receiving services from MHPs are also enrolled in a PIHP for specialty behavioral health and substance use disorder services. Therefore, MDHHS requires the MHPs to collaborate with the PIHPs to improve integration of behavioral health and physical health services and to maintain coordinating agreements with all PIHPs in their service area for the purpose of referrals, care coordination, grievance and appeal resolution, and the overall continuity of care for members served by PIHPs. To incentivize collaboration and integration between the MHPs and PIHPs, MDHHS has developed a performance bonus program with shared metrics to measure the quality of care provided to members jointly served by the MHPs and PIHPs. Additionally, MDHHS monitors MHP care coordination processes through the compliance review activity, primarily through the Members standard. The CHCP received an overall compliance score of 98.7 percent, indicating the MHPs had the necessary processes in place to ensure members receive adequate care management and care coordination. Further, MDHHS, through its contract with the MHPs, requires the MHPs to support initiatives to increase the use of health information exchange and health information technology to improve care management and coordination, including the electronic exchange of member-level information. This includes maintaining an electronic data system that allows providers, LHDs, and CMDS clinics to exchange member-level information. However, many members reported that they did not feel their personal doctor seemed informed about the care they received from other doctors as demonstrated through *Poor* or *Fair* overall ratings for the *Coordination of Care* measure included as part of the CAHPS activity for the adult Medicaid, child Medicaid, and the HMP populations. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #3. These objectives should be specific, measurable, attainable, relevant, and time-bound and take into consideration the health status of all populations served by MDHHS' MHPs. Additionally, in support of Goal #3, MDHHS should continue its efforts to support integration of the Medicaid managed care programs (e.g., MHPs, PIHPs) and the services provided to promote communication and coordination of care and positively impact the health outcomes for all Medicaid populations.	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** For SFY 2022, MDHHS required the MHPs to initiate a new PIP topic that focused on disparities in the timeliness of prenatal care. As demonstrated through the PIP validation activity, eight of the nine MHPs received an overall validation status of *Met*, indicating that overall, the MHPs designed methodologically sound PIPs. The interventions implemented through the course of the PIP cycle are, or will be, aimed at eliminating the racial and ethnic disparity identified by each MHP, or improving timeliness of prenatal care for the lowest-performing population for those MHPs without an identified disparity. The interventions implemented by the MHPs should also have a positive effect on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* performance measure, as the rate for this performance measure ranked below the Medicaid 50th percentile and did not demonstrate an improvement from MY 2020 to MY 2021. These results demonstrate improvement is needed to ensure CHCP pregnant members are accessing a prenatal visit in the first trimester or within 42 days of enrollment with an MHP. Additionally, through the compliance review activity, MDHHS requires the MHPs to submit policies and procedures addressing health disparities through population health management. All MHPs received a score of *Met* for this requirement, demonstrating the CHCP had adequate processes for providing population health management services where telephonic and mail-based care management were not sufficient or appropriate, including services provided at adult and family shelters for members who are homeless, at a member's home, and/or at a member's place of employment or school. The CHCP's overall score for the Quality standard was 98.9 percent, indicating that all MHPs had sufficient QAPI programs in which various initiatives can be implemented and focused on eliminating healthcare disparities identified within the Medicaid population in Michigan. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #4. These objectives should be specific, measurable, attainable, relevant, and time-bound and take into consideration the health status of all populations served by MDHHS' MHPs. Additionally, MDHHS has required PIPs to support the reduction in disparities in the timeliness of prenatal care. As four MHPs have yet to implement interventions, MDHHS should consider reviewing planned interventions, when identified, to confirm that these interventions specifically target the disparate populations and have the likelihood of removing the barriers that prevent members' access to needed services. MDHHS	☒ Quality ☒ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	could also consider whether state-required interventions would be appropriate for the MHPs to implement for the PIPs mandated by MDHHS for SFY 2023. MDHHS could consult with HSAG through these processes.	
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** MDHHS has implemented several value-based initiatives, including the following: • Pay for Performance: HMP Cost-Sharing and Value-Based Services—Incentivizes MHPs to improve performance on HMP measures and key dental services metrics. • Performance Bonus: Integration of Behavioral Health and Physical Health Services—Incentivizes collaboration and integration between MHPs and PIHPs through joint care planning and reporting on select behavioral health performance measures. • Alternative Payment Model—Incentivizes MHPs to improve quality of care while better managing costs through reporting on select deliverables. However, the aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact these value-based initiatives and payment reforms had on improving quality outcomes. **Recommendations:** HSAG recommends that the CQS be revised to include the specific performance metrics (i.e., objectives) MDHHS will use to evaluate progress toward achieving Goal #5. These objectives should be specific, measurable, attainable, relevant, and time-bound and take into consideration the health status of all populations served by MDHHS' MHPs. While MDHHS stipulates its expectations related to value-based initiatives and payment reforms within its contract with the MHPs, HSAG did not evaluate the results of these activities as part of this EQR since they are not included as part of the annual EQR activities or tied to a performance measure that aligns to an objective under the CQS. Therefore, no additional recommendations can be provided in support of Goal #5.	☒ Quality ☐ Timeliness ☐ Access

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting External Quality Review Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCOs, PIHPs, PAHPs, and primary care case management (PCCM) entities are required to have a QAPI program, which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must involve:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve QI.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The EQR technical report must include information on the validation of PIPs required by the State and underway during the preceding 12 months.

The primary objective of PIP validation is to determine the MHP's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a MHP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the MHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the MHP during the PIP.

MDHHS requires that each MHP conduct one PIP subject to validation by HSAG. For this year's SFY 2022 validation, the MHPs submitted baseline data for the state-mandated PIP topic, *Addressing Disparities in Timeliness of Prenatal Care*. The selected PIP topic is based on the HEDIS *Prenatal and Postpartum Care* measure; however, each MHP was required to use historical data to identify racial/ethnic disparities within its population related to timeliness of prenatal care.

This topic has the potential to improve the health of pregnant members through increasing early initiation of prenatal care. Women who do not receive adequate or timely prenatal care are at an increased risk of complications and poor birth outcomes. The selected study topic addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

Technical Methods of Data Collection and Analysis

In its PIP evaluation and validation, HSAG used CMS EQR Protocol 1. Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Submission Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured all CMS EQR Protocol 1 requirements were addressed.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR Protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. The CMS EQR Protocols identify nine steps that should be validated for each PIP. For the SFY 2022 submissions, the MHPs reported baseline data and were validated for steps 1 through 8 in the PIP Validation Tool.

The nine steps included in the PIP Validation Tool are listed below:

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For

a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating of *Not Met* for the PIP. The MHP is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the PIP's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Partially Met*.
- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Not Met*.

The MHPs had an opportunity to resubmit a revised PIP Submission Form and provide additional information or documentation in response to HSAG's initial validation scores of *Partially Met* or *Not Met*, regardless of whether the evaluation element was critical or noncritical. HSAG offered technical assistance to any MHP that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

HSAG conducted a final validation for any resubmitted PIPs and documented the findings and recommendations for each PIP. Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MHP. These reports, which complied with 42 CFR §438.364, were provided to MDHHS which distributed them to the MHPs.

Description of Data Obtained and Related Time Period

For SFY 2022, the MHPs submitted baseline data. The type of data obtained from each MHP and the performance indicator measurement period dates are listed below.

Table A-1—Description of Data Obtained and Measurement Periods

MHP	Data Obtained	Measurement Period	Period to Which the Data Applied
AET	Administrative	Baseline	October 8, 2020–October 7, 2021
BCC	Administrative		
HAP	Hybrid		
MCL	Hybrid		
MER	Hybrid		
MOL	Administrative		
PRI	Hybrid		
UNI	Hybrid		
UPP	Administrative		

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG validated the PIPs to ensure it used a sound methodology in its design, implementation, analysis, and reporting of the project's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *Met*, *Partially Met*, and *Not Met*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline, prior remeasurement period results, and project 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 access to care and services furnished to the MHP's Medicaid members.

Performance Measure Validation

Activity Objectives

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of their QAPI programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(2). For the MCO, PIHP, PAHP, and PCCM entity, the EQR technical report must include information regarding the validation of performance measures (as required by the State) and/or performance measures calculated by the State during the preceding 12 months.

The primary objectives of the PMV process are to:

- Evaluate the accuracy of the performance measure data collected by the MHP.
- Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough IS evaluation, to assess each MHP's support system available to report accurate HEDIS measures.

Technical Methods of Data Collection and Analysis

MDHHS required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit conducted by an NCQA licensed organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's MY 2021 Volume 5, *HEDIS Compliance Audit: Standards, Policies and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the MHPs' processes consistent with the CMS EQR Protocols. To complete the validation of the performance measure process according to CMS EQR Protocol 2, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

Each NCQA HEDIS Compliance Audit was conducted by a certified HEDIS compliance auditor and included the following activities:

Pre-Review Activities: Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix V of the CMS EQR Protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. HSAG conducted a thorough review of the Roadmap and supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

On-Site Review Activities: The on-site reviews, which typically lasted one to two days, included:

- An evaluation of system compliance, focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.
- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with MHP staff members involved with any aspect of performance measure reporting.
- A closing conference at which the auditor summarized preliminary findings and recommendations.

Post-On-Site Review Activities: For each performance measure calculated and reported by the MHPs, the auditor aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The auditor assigned each measure one of seven audit findings: (1) *Reportable* (a reportable rate was submitted for the measure), (2) *Small Denominator* (the MHP followed the specifications, but the denominator was too small [e.g., <30] to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), (4) *Not Reportable* (the MHP chose not to report the measure), (5) *Not Required* (the MHP was not required to report the measure), (6) *Biased Rate* (the calculated rate was materially biased), or (7) *Un-Audited* (the MHP chose to report a measure that is not required to be audited).

HSAG performed a comprehensive review and analysis of the MHPs' Interactive Data Submission System (IDSS) results, data submission tools, and MHP-specific NCQA HEDIS Compliance Audit Reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- An NCQA-licensed organization completed the audit.
- An NCQA-certified HEDIS compliance auditor led the audit.
- The audit scope included all MDHHS-selected HEDIS measures.
- The audit scope focused on the Medicaid product line.
- Data were submitted via an auditor-locked NCQA IDSS.
- A final audit opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

Description of Data Obtained and Related Time Period

As identified in CMS EQR Protocol 2, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table A-2 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table A-2—Description of Data Sources

Data Obtained	Measurement Period
NCQA HEDIS Compliance Audit Reports were obtained for each MHP, which included a description of the audit process, the results of the IS findings, and the final audit designations for each performance measure.	Calendar Year (CY) 2021 (HEDIS MY 2021)
Performance measure reports, submitted by the MHPs using NCQA's IDSS, were analyzed and subsequently validated by HSAG.	CY 2021 (HEDIS MY 2021)
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2020 (HEDIS MY 2020)

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG evaluated the results for each performance measure assigned an audit finding of *Reportable*, *Small Denominator*, *No Benefit*, *Not Reportable*, *Not Required*, *Biased Rate*, or *Un-Audited*. HSAG further analyzed the results of the MHP's HEDIS MY 2021 performance measure rates and 2021 performance levels based on comparisons to national percentiles 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 MHP's Medicaid members.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the QAPI requirements described in 42 CFR §438.330. To meet this requirement, MDHHS performed annual compliance reviews of its contracted MHPs.

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 MHPs in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection and Analysis

MDHHS is responsible for conducting compliance activities that assess the MHPs' conformity with State requirements and federal Medicaid managed care regulations. To meet this requirement, MDHHS identifies the requirements necessary for review during the state fiscal year and divides the requirements into a 12-month compliance monitoring schedule. The MHPs were provided with a *FY2022 Compliance Review Packet* and *FY2022 MHP Compliance Review Timeline* that outlined the areas of focus for each month's review and the documents required to be submitted to MDHHS to demonstrate compliance.

This technical report presents the results of the compliance reviews performed during the SFY 2022 contract year. MDHHS conducted a compliance review of six standards listed in Table A-3. Table A-3 also crosswalks MDHHS' compliance review standards to the associated federal standards and citations.

Table A-3—Compliance Review Standards Crosswalk[1]

MDHHS Compliance Review Standard		Federal Standard and Citation
1	Administrative	§438.224 Confidentiality
2	Providers	§438.10 Information requirements §438.206 Availability of services §438.207 Assurances of adequate capacity and services §438.210 Coverage and authorization of services §438.214 Provider selection §438.230 Subcontractual relationships and delegation

MDHHS Compliance Review Standard		Federal Standard and Citation
3	Members	§438.10 Information requirements §438.100 Enrollee Rights §438.114 Emergency and poststabilization services §438.206 Availability of services §438.208 Coordination and continuity of care §438.210 Coverage and authorization of services §438.228 Grievance and appeal systems §438.230 Subcontractual relationships and delegation Subpart F Grievance and Appeal System
4	Quality	§438.208 Coordination and continuity of care §438.210 Coverage and authorization of services §438.236 Practice guidelines §438.330 Quality assessment and performance improvement program
5	MIS/Financial	§438.56 Disenrollment: Requirements and limitations §438.242 Health information systems
6	OIG/Program Integrity	§438.230 Subcontractual relationships and delegation Subpart H Additional Program Integrity Safeguards

[1] HSAG and MDHHS created a crosswalk to compare MDHHS compliance review standards to federal standards, but 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).

MDHHS reviewers used a compliance review tool for each MHP to document its findings and to identify, when applicable, specific action(s) required of the MHP to address any areas of noncompliance with contractual requirements.

Attestation—For certain elements, if an MHP met requirements in the last compliance review, the MHP was allowed to attest that the previously submitted documentation was still applicable and had not changed. These attestations are allowed every other year (e.g., if an MHP attested to an item in SFY 2021, it may not attest to the item again in SFY 2022).

Deeming—As all MHPs are NCQA-accredited, MDHHS considered certain elements deemable. In order for these elements to be deemable, the MHP must have had the NCQA Medicaid module completed. If the module was completed, the MHP was only required to share the results of that survey. If the MHP did not have the NCQA Medicaid module completed, the MHP would have been required to submit documentation for MDHHS' review. The elements that MDHHS considers NCQA deemable are outlined in the MDHHS CQS. If the MHP received a *Met* score for an item within the NCQA deemable portion of the compliance review during the SFY 2021 compliance review, and the documentation had not changed, an attestation that the documentation continues to include the required content was acceptable. If any item received a *Not Met* score in the SFY 2021 compliance review, documentation for that item must be submitted.

For each element reviewed, MDHHS assigned one of the following scores:

- *Met*—The MHP's submission met contract and compliance review requirements.
- *Not Met*—The MHP's submission did not meet contract or compliance review requirements.

For each MHP, MDHHS calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. MDHHS calculated the total score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard. MDHHS determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements). A summary of MHP-specific and program-wide results were provided to HSAG via the *All Plans FY2022 CR Results* report.

Upon receiving a *Not Met* finding, the MHPs were required to submit a CAP,[A-1] which was reviewed by MDHHS to determine acceptability. If an acceptable CAP was received by the due date, MDHHS provided documentation in the compliance review tools and the *Not Met* score remained. If a CAP was not received by the due date or if the CAP received by MDHHS did not meet requirements, the MHP was subject to financial penalties or paying liquidation damages outlined in the contact. MDHHS' CAP review process included the eight steps identified in Table A-4.

Table A-4—MDHHS CAP Review Process

Step	Entity Responsible for Completing Step	
	MDHHS	MHP
Step 1: Identify the Issue	✓	
Step 2: MHP Dispute of the CAP (optional)		✓
Step 3: MHP Corrective Action		✓
Step 4: Acceptance of Corrective Action	✓	
Step 5: MHP Revised Corrective Action (if needed)		✓
Step 6: Acceptance of Revised Corrective Action (if needed)	✓	
Step 7: Effectiveness of Corrective Action Plan		✓
Step 8: Closure	✓	

Focused Study—MDHHS also conducts an annual focused study with each MHP that consists of staff interviews and system demonstrations. Each year MDHHS determines the scope of the study based on

[A-1] Under limited circumstances, MDHHS did not require a CAP for a *Not Met* element. Reasons for not requiring a CAP included but were not limited to: when there is an existing CAP related to the findings; an MDHHS reviewer determined the findings were not egregious due to a lack of clarity of the state-specific requirement; submission was compliant but was not submitted timely.

current initiatives and improvement opportunities. The scope of the SFY 2022 virtual focused study included a review in three areas: CSHCS, Operations, and Quality. A case review specific to CSHCS and a live demonstration of the provider search function of the provider directory were also conducted.

Each MHP's focused study was scheduled over the course of two to three days between May and September 2022. The MHPs had pre-submission requirements for portions of the focused study in addition to the case review. MDHHS also requested that each MHP submit copies of slide desks and all presentation materials used during the study. MDHHS compiled these materials along with any follow-up documentation, attendance reports, and customized agendas. Specific MDHHS staff members were responsible for taking notes during each component of the review (i.e., CSHCS, Operations, and Quality) to document the findings of the focused study. The findings of the focused study were used to supplement the compliance review activity.

Description of Data Obtained and Related Time Period

To assess the MHPs' compliance with federal and State requirements, MDHHS obtained information from a wide range of materials produced by the MHPs throughout SFY 2022, including, but not limited to, the following:

- Policies and procedures
- Accreditation certificates or letters, organizational charts, governing board member appointment documentation, and board meeting minutes
- Operational plans, health plan profiles, administrative position descriptions, and management and financial reports
- Consolidated Annual Report, including financial information and member and provider incentives
- Provider contracts, network access plan, network access and provider availability documentation, and provider appeal logs
- Subcontract/delegation agreements and monitoring documentation
- CPGs and supporting documentation
- Member material timeliness documentation, including ID card mailings and new member packets
- Copies of member materials, including new member packets, member handbooks, member newsletters, member websites, and provider directories
- Maximum allowable cost (MAC) pricing reconsiderations process
- Grievance, appeal, and prior-authorization reports and notice templates
- QIPs and UM programs, QI workplans and worksheets, utilization reports, QI effectiveness reports, and committee meeting minutes
- Enrollment and disenrollment procedures
- PIPs
- Compliance plan and employee training documentation
- Program integrity forms and reports

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each MHP individually, HSAG used the quantitative results and percentage-of-compliance score calculated by MDHHS for each standard. HSAG determined each MHP's substantial strengths and weaknesses as follows:

- Strength—Any standard that achieved a 100 percent compliance score.
- Weakness—Any standard that scored 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 MHP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to each MHP's Medicaid members.

Network Adequacy Validation

Activity Objectives

The primary purpose of the SFY 2022 NVS was to assess the accuracy of the managed care network information supplied to Michigan Medicaid members using the MHPs' provider data files and online provider directories, and telephone survey calls to randomly sampled provider locations. As a secondary survey objective, HSAG collected appointment availability information for routine PCP, pediatric, and OB/GYN provider visits among new patients enrolled with an MHP under the MI Medicaid program. Specific survey objectives included the following:

- Determine whether service locations accept patients enrolled with the requested MHP for the MI Medicaid program and the degree to which MHP and MI Medicaid acceptance aligns with the MHP's provider data.
- Determine whether service locations accepting MI Medicaid for the requested MHP accept new patients and the degree to which new patient acceptance aligns with the MHP's provider data.
- Determine appointment availability with the sampled provider service locations for PCP, pediatric, or OB/GYN provider visits.

Technical Methods of Data Collection and Analysis

Each MHP submitted provider data to HSAG, reflecting PCPs, pediatric providers, and OB/GYN providers actively enrolled with one or more Michigan MHP that serve members in the MI Medicaid program as of February 15, 2022. Out-of-state providers located in Indiana, Ohio, or Wisconsin within a reasonable distance of the MHPs' applicable regions were included in the study. HSAG used these data to conduct the NVS.

The NVS included a PDV in which HSAG compared key indicators published in each online provider directory with the data in the MHP's provider file. HSAG then validated the accuracy of the online provider directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories. HSAG used an MDHHS-approved methodology and script to conduct the secret shopper telephone surveys. The secret shopper approach allows for objective data collection from healthcare providers without potential bias introduced by revealing the surveyors' identities. Using the provider data each MHP supplied to HSAG, secret shopper callers contacted sampled provider locations between May and June 2022 to inquire about appointment availability.

Several limitations and analytic considerations must be noted when reviewing NVS results:

- The provider data submitted by the MHPs in March 2022 may have changed and subsequently been updated in the MHPs' data systems and/or online provider directories prior to HSAG's PDV reviews and secret shopper survey calls in May and June 2022.
- Reviewers conducted the directory reviews using desktop computers with high-speed internet connections. Reviewers did not attempt to access or navigate the MHPs' online provider directories from mobile devices or using accessibility tools (e.g., software that reads the website content for users with limited eyesight). The current study cannot speak to whether the results are maintained across different types of devices that members may use to access provider directories.
- HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. PDV cases that did not match on these indicators were not included in the secret shopper survey. It is unknown if the telephone survey results would have been better, similar, or worse among the PDV cases that did not match on the eight key indicators described.
- To maintain the secret nature of the survey and to ensure consistent data collection across cases, callers used a standardized survey script and posed as members or parents/caretakers of members who were not existing patients at the sampled provider locations. As such, survey results may not represent appointment timeliness among MHPs' members who are existing patients or who may accept scenarios outside the survey script (e.g., leaving voicemails for an office, supplying personally identifying information, or obtaining an appointment through an Internet-based scheduling portal).
- HSAG based survey results for the time based on the first available appointment at the sampled location. As such, survey results may underrepresent timely appointments for situations in which members are willing to travel to an alternate location.
- Survey findings were compiled from self-reported responses supplied to callers by providers' office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication (e.g., MDHHS' encounter data files, online portals, speaking to a different representative at the provider's office).
  - The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).

  - Appointments may take longer to schedule during the COVID-19 PHE due to a variety of reasons, including staffing shortages, backlog of appointments, and enhanced cleaning procedures.
- MHPs are responsible for ensuring that MI Medicaid members have access to a provider location within MDHHS' contract standards, rather than requiring that each individual provider or location offer appointments within specified time frames. As such, extended appointment wait times from individual provider locations should be considered in the context of the MHP's processes for assisting MI Medicaid members who require timely appointments.

Description of Data Obtained and Related Time Period

HSAG completed PDV reviews and secret shopper calls during May and June 2022. Prior to analyzing the results, HSAG reviewed the responses to ensure complete and accurate data entry.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG analyzed the results of the activity to determine each MHP's substantial strengths and weaknesses by assessing (1) the degree to which the MHPs' online provider directory information is accurate, up-to-date, and easy to locate and navigate; (2) which service locations accepted patients enrolled with the requested MHP for the MI Medicaid program and the degree to which MHP and MI Medicaid acceptance aligned with the MHPs' provider data; (3) whether service locations accepting MI Medicaid for the requested MHP accepted new patients and the degree to which new patient acceptance aligned with the MHPs' provider data; and (4) appointment availability with the sampled service locations for routine PCP, pediatric, and OB/GYN visits.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

The CAHPS surveys ask adult members and parents/caretaker of child members to report on and evaluate their experiences with healthcare. The surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys are recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (without the CCC measurement set) to the child Medicaid population. Various methods of data collection were used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents), mixed-mode and Internet protocol methodology (i.e., mailed

surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents), or mail-only. For the adult and child Medicaid CAHPS surveys, based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2021; and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2021. For the CSHCS CAHPS survey, child members included as eligible for the survey were 17 years of age or younger as of February 28, 2022. For the HMP CAHPS survey, adult members included as eligible for the survey were 19 years or older as of February 28, 2022.

The survey questions were categorized into various measures of member experience. For the adult and child Medicaid and HMP CAHPS surveys, these measures included four global ratings, four composite measures, and three Effectiveness of Care measures.[A-2] The global ratings reflected respondents' overall experience with their/their child's personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation in the adult population.

For the CSHCS CAHPS survey, these measures included four global rating questions, five composite measures, and five individual item measures. The global ratings reflected respondents' overall experience with the health plan, healthcare, specialists, and CMDS clinics. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Customer Service* and *How Well Doctors Communicate*). The individual item measures were individual questions that looked at specific areas of care (e.g., *Access to Prescription Medicines*).

NCQA requires a minimum of 100 responses on each item to report the measure as a valid CAHPS survey result; however, for this report, if available, the MHPs' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Measure results that did not meet the minimum number of 100 responses are denoted in the tables with an asterisk (*). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

For each of the global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," or "Always." A positive or top-box response for the composites was defined as a response of "Always" or "Usually." The percentage of top-box responses is referred to as a top-box score for the composite measures. For the Effectiveness of Care measures, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results. Individual item measure question response choices were "Never," "Sometimes," "Usually," or "Always," and "Extremely Dissatisfied," "Somewhat Dissatisfied," "Neither Satisfied Nor Dissatisfied," "Somewhat Satisfied," or "Extremely Satisfied." A

[A-2] Effectiveness of Care measures related to smoking cessation were only included for the adult surveys.

positive or top-box response for the individual items was defined as a response of "Always" or "Usually" and "Somewhat Satisfied" or "Extremely Satisfied."

NCQA National Average Comparisons

Each MHP's 2022 adult and child CAHPS scores were compared to the 2021 NCQA adult and child Medicaid national averages, respectively.[A-3] A *t* test was performed to determine whether 2022 top-box scores were statistically significantly different from the 2021 NCQA adult and child Medicaid national averages. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than 0.05.

Colors and arrows are used to note statistically significant differences. An upward green (↑) arrow indicates a top-box score that was statistically significantly higher than the 2021 NCQA national average. A downward red (↓) arrow indicates a top-box score that was statistically significantly lower than the 2021 NCQA national average. Scores that were not statistically significantly higher or lower than the 2021 NCQA national averages are not denoted with arrows.

Plan Comparisons

The results of the MHPs were compared to the applicable program (i.e., Medicaid managed care program, CSHCS managed care program, and HMP program). Two types of hypothesis tests were applied to these results. First, a global *F* test was calculated, which determined whether the difference between the MHPs' scores was significant. If the *F* test demonstrated plan-level differences (i.e., *p* value < 0.05), then a *t* test was performed for each MHP. The *t* test determined whether each MHP's score was statistically significantly different from the applicable program.

Colors and arrows are used to note statistically significant differences. An upward green (↑) arrow indicates a top-box score that was statistically significantly higher than the applicable program. A downward red (↓) arrow indicates a top-box score that was statistically significantly lower than the applicable program. Scores that were not statistically significantly higher or lower than the applicable program are not denoted with arrows.

Description of Data Obtained and Related Time Period

HSAG administered the CAHPS surveys to the child Medicaid population for the MHPs, child members enrolled in CSHCS, and adult members enrolled in HMP. The MHPs provided HSAG with the adult Medicaid CAHPS survey data presented in this report. The MHPs reported that NCQA protocols were followed for administering the CAHPS surveys.

The CAHPS 5.1H Child Medicaid Health Plan Survey was administered to parents/caretakers of child members enrolled in the MHPs from February to May 2022. The CSHCS CAHPS survey was

[A-3] National Committee for Quality Assurance. *Quality Compass: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

administered to parents/caretakers of child members enrolled in the CSHCS Program from June to August 2022. The HMP CAHPS survey was administered to eligible adult members in the HMP from May to August 2022.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of services provided by the MHPs, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-5.

Table A-5—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Adult and Child Medicaid/HMP			
Global Ratings			
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Composite Measures			
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
*Transportation**	✓		✓
Individual Item Measure			
Coordination of Care	✓		
Effectiveness of Care Measures			
Advising Smokers and Tobacco Users to Quit	✓		
Discussing Cessation Medications	✓		
Discussing Cessation Strategies	✓		
CSHCS			
Global Ratings			
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Specialist Seen Most Often	✓		
Rating of CMDS Clinic	✓		

CAHPS Topic	Quality	Timeliness	Access
Composite Measures			
Customer Service	✓		
How Well Doctors Communicate	✓		
Access to Specialized Services	✓		✓
CSHCS Family Center	✓		
*Transportation**	✓		✓
Individual Item Measures			
Access to Prescription Medicines	✓		✓
CMDS Clinics	✓	✓	
Local Health Department Services	✓		
Not Felt Treated Unfairly: Race and Ethnicity	✓		
Not Felt Treated Unfairly: Health Insurance Type	✓		

*Transportation is a child composite measure presented in the 2022 Child Medicaid CAHPS Report and 2022 CHSCS CAHPS Report. Transportation results are not presented in Section 3 because the supplemental survey questions that make up the composite measure are not included in the standard CAHPS 5.1H Child Medicaid Health Plan Survey; therefore, a 2021 NCQA benchmark is not available for this measure.

Quality Rating

Activity Objectives

MDHHS contracted with HSAG to analyze MY 2021 HEDIS results, including MY 2021 CAHPS data from the nine MHPs for presentation in the 2022 Michigan Consumer Guide. The 2022 Michigan Consumer Guide analysis helps to support MDHHS' public reporting of health plan performance information.

Technical Methods of Data Collection and Analysis

MDHHS, in collaboration with HSAG, chose measures for the 2022 Michigan Consumer Guide based on a number of factors that were consistent with previous years. Per NCQA specifications, the CAHPS 5.1H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey instrument was used for the child population.

Table A-6 lists the 38 measures, 13 CAHPS and 25 HEDIS, and their associated weights.[A-4] The measures are organized by reporting category and subcategory.

Table A-6—Reporting Categories, Subcategories, Measures, and Weights

Measure	Measure Weight
Overall Rating[A-5]	
Adult Medicaid—*Rating of Health Plan* (CAHPS Global Rating)	1
Child Medicaid—*Rating of Health Plan* (CAHPS Global Rating)	1
Adult Medicaid—*Rating of All Health Care* (CAHPS Global Rating)	1
Child Medicaid—*Rating of All Health Care* (CAHPS Global Rating)	1
Doctors' Communication and Service	
Satisfaction With Providers	
Adult Medicaid—*How Well Doctors Communicate* (CAHPS Composite)	1
Child Medicaid—*How Well Doctors Communicate* (CAHPS Composite)	1
Adult Medicaid—*Rating of Personal Doctor* (CAHPS Global Rating)	1
Child Medicaid—*Rating of Personal Doctor* (CAHPS Global Rating)	1
Patient Engagement	
Medical Assistance With Smoking and Tobacco Use Cessation	
Advising Smokers and Tobacco Users to Quit	*1/3*
Discussing Cessation Medications	*1/3*
Discussing Cessation Strategies	*1/3*
Getting Care	
Access	
Adult Medicaid—*Getting Needed Care* (CAHPS Composite)	1
Adult Medicaid—*Getting Care Quickly* (CAHPS Composite)	1
Adults' Access to Preventive/Ambulatory Health Services	
Ages 20–44 Years	1/3
Ages 45–64 Years	1/3

[A-4] Six measures, *Adult Medicaid—Customer Service (CAHPS Composite)*, *Child Medicaid—Customer Service (CAHPS Composite)*, *Adult Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)*, *Child Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)*, *Child Medicaid—Getting Needed Care (CAHPS Composite)*, and *Child Medicaid—Getting Care Quickly (CAHPS Composite)*, were excluded from the 2022 Consumer Guide based on insufficient data reported by more than half of the MHPs. These measures will be reevaluated for inclusion in a future Consumer Guide. Additionally, the *Childhood Immunization Status—Combination 2* measure was removed as the measure was retired starting with MY 2021 HEDIS reporting.

[A-5] To calculate the Overall Rating category, all 38 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating reporting category are exclusive to the reporting category.

Measure	Measure Weight
Ages 65+ Years	1/3
Keeping Kids Healthy	
Immunizations and Screenings for Young Children	
Childhood Immunization Status—Combination 3	1
Lead Screening in Children	1
Immunizations for Adolescents	
Immunizations for Adolescents—Combination 2	1
Preventive Care	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
Body Mass Index (BMI) Percentile Documentation—Total	1/3
Counseling for Nutrition—Total	1/3
Counseling for Physical Activity—Total	1/3
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	1
Well-Child Visits for Ages 15 Months–30 Months—Two or More Well-Child Visits	1
Child and Adolescent Well-Care Visits	
Ages 3–11 Years	1
Ages 12–17 Years	1
Ages 18–21 Years	1
Living With Illness	
Diabetes	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	1/4
HbA1c Poor Control (>9.0 Percent)	1/4
HbA1c Control (<8.0 Percent)	1/4
Eye Exam (Retinal) Performed	1/4
Cardiovascular	
Controlling High Blood Pressure	1
Respiratory	
Asthma Medication Ratio—Total	1
Taking Care of Women	
Screenings for Women	
Breast Cancer Screening	1
Cervical Cancer Screening	1

Measure	Measure Weight
Chlamydia Screening in Women—Total	1
Maternal Health	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	1
Postpartum Care	1

HSAG computed six reporting category and 11 subcategory summary scores for each MHP, as well as the summary mean values for the MHPs as a group. Each score is a standardized score where higher values represent more favorable performance. Summary scores for the six reporting categories (Overall Rating, Doctors' Communication and Service, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women) and 11 subcategories (Satisfaction With Providers, Patient Engagement, Access, Immunizations and Screenings for Young Children, Immunizations for Adolescents, Preventive Care, Diabetes, Cardiovascular, Respiratory, Screenings for Women, and Maternal Health) were calculated from MHP scores on select HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets, and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG converted each individual question by assigning the top-box responses (i.e., "Usually/Always" and "9/10," where applicable) to a "1" for each individual question, as described in *HEDIS Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of "0." HSAG then calculated the percentage of respondents with a top-box response (i.e., a "1"). For composite measures, HSAG calculated the composite rate by taking the average percentage for each question within the composite.

2. For each HEDIS and CAHPS measure, HSAG calculated the measure variance. The measure variance for HEDIS measures was calculated as follows:

$$\frac{p_k(1-p_k)}{n_k-1}$$

where: p_k = MHP k score
n_k = number of members in the measure sample for MHP k

For CAHPS global rating measures, the variance will be calculated as follows:

$$\frac{1}{n}\frac{\sum_{i=1}^{n}(x_i-\bar{x})^2}{n-1}$$

where: x_i = response of member i
$\bar{x}$ = the mean score for MHP k
n = number of responses in MHP k

For CAHPS composite measures, the variance will be calculated as follows:

$$\frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\bar{x}_j)}{n_j}\right)^2$$

where: j = 1,…,m questions in the composite measure
i = 1….,n_j members responding to question j
x_{ij} = response of member i to question j (0 or 1)
$\bar{x}_j$ = MHP mean for question j
N = members responding to at least one question in the composite

3. For MHPs with *NR*, *BR*, and *NA* audit results, HSAG used the average variance of the non-missing rates across all MHPs. This ensured that all rates reflect some level of variability, rather than simply omitting the missing variances in subsequent calculations.

4. HSAG computed the MHP mean for each CAHPS and HEDIS measure.

5. Each MHP mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MHP means and dividing by the standard deviation of the MHP means to give each measure equal weight toward the category rating. If the measures are not standardized, a measure with higher variability would contribute disproportionately toward the category rating.

6. HSAG summed the standardized MHP means, weighted by the individual measure weights to derive the MHP category summary measure score.

7. For each MHP k, HSAG calculated the category variance, CV_k, as: $CV_k = \sum_{j=1}^{m}\frac{w_j}{c_j^2}V_j$

where: j = 1,…,m HEDIS or CAHPS measures in the summary
V_j = variance for measure j
c_j = group standard deviation for measure j
w_j = measure weight for measure j

8. The summary scores were used to compute the group mean and the difference scores. The group mean was the average of the MHP summary measure scores. The difference score, d_k, was calculated as d_k = MHP k score – group mean.

9. For each MHP k, HSAG calculated the variance of the difference scores, $Var(d_k)$, as:

$$Var(d_k) = \frac{P(P-2)}{P^2}CV_k + \frac{1}{P^2}\sum_{k=1}^{P}CV_k$$

where: P = total number of MHPs
CV_k = category variance for MHP k

10. The statistical significance of each difference was determined by computing a confidence interval (CI). A 95 percent CI was calculated around each difference score to identify MHPs that were significantly higher than or significantly lower than the mean. MHPs with differences significantly above or below zero at the 95 percent confidence level received the top (Above Average) and bottom (Below Average) designations, respectively. An MHP was significantly above zero if the lower limit of the CI was greater than zero and was significantly below zero if the upper limit of the CI was below zero. MHPs that did not fall either above or below zero at the 95 percent confidence level received the middle designation (Average). For a given measure, the formula for calculating the 95 percent CI was:

$$95\%\ \text{CI} = d_k \pm 1.96\sqrt{Var(d_k)}$$

A three-level rating scale provides consumers with an easy-to-read "picture" of quality performance across the MHPs and presents data in a manner that emphasizes meaningful differences between the MHPs. The 2022 Michigan Consumer Guide used apples to display results for each MHP.

Description of Data Obtained and Related Time Period

HEDIS MY 2021 rates were extracted from the auditor-locked IDSS data sets, and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files.

Appendix B. 2022 HEDIS Aggregate Report for Michigan Medicaid

Appendix B presents the final *2022 HEDIS Aggregate Report for Michigan Medicaid*.

Michigan Department of Health & Human Services

GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

2022 HEDIS Aggregate Report for Michigan Medicaid

October 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

During 2021, the Michigan Department of Health and Human Services (MDHHS) contracted with nine health plans to provide managed care services to Michigan Medicaid members. MDHHS expects its contracted Medicaid health plans (MHPs) to support claims systems, membership and provider files, as well as hardware/software management tools that facilitate valid reporting of the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] measures. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), to calculate statewide average rates based on the MHPs' rates and evaluate each MHP's current performance level, as well as the statewide performance, relative to national Medicaid percentiles.

MDHHS selected HEDIS measures to evaluate Michigan MHPs within the following eight measure domains:

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Obesity
- Pregnancy Care
- Living With Illness
- Health Plan Diversity
- Utilization

Of note, all measures in the Health Plan Diversity domain and some measures in the Utilization domain are provided within this report for information purposes only as they assess the health plans' use of services and/or describe health plan characteristics and are not related to performance. Therefore, most of these rates were not evaluated in comparison to national percentiles, and changes in these rates across years were not analyzed by HSAG for statistical significance.

The performance levels are based on national percentiles and were set at specific, attainable rates. MHPs that met the high performance level (HPL) exhibited rates that were among the 90th percentile in comparison the national average. The low performance level (LPL) was set to identify MHPs that were among the 25th percentile in comparison to the national average and have the greatest need for improvement. Details describing these performance levels are presented in Section 2, "How to Get the Most From This Report."

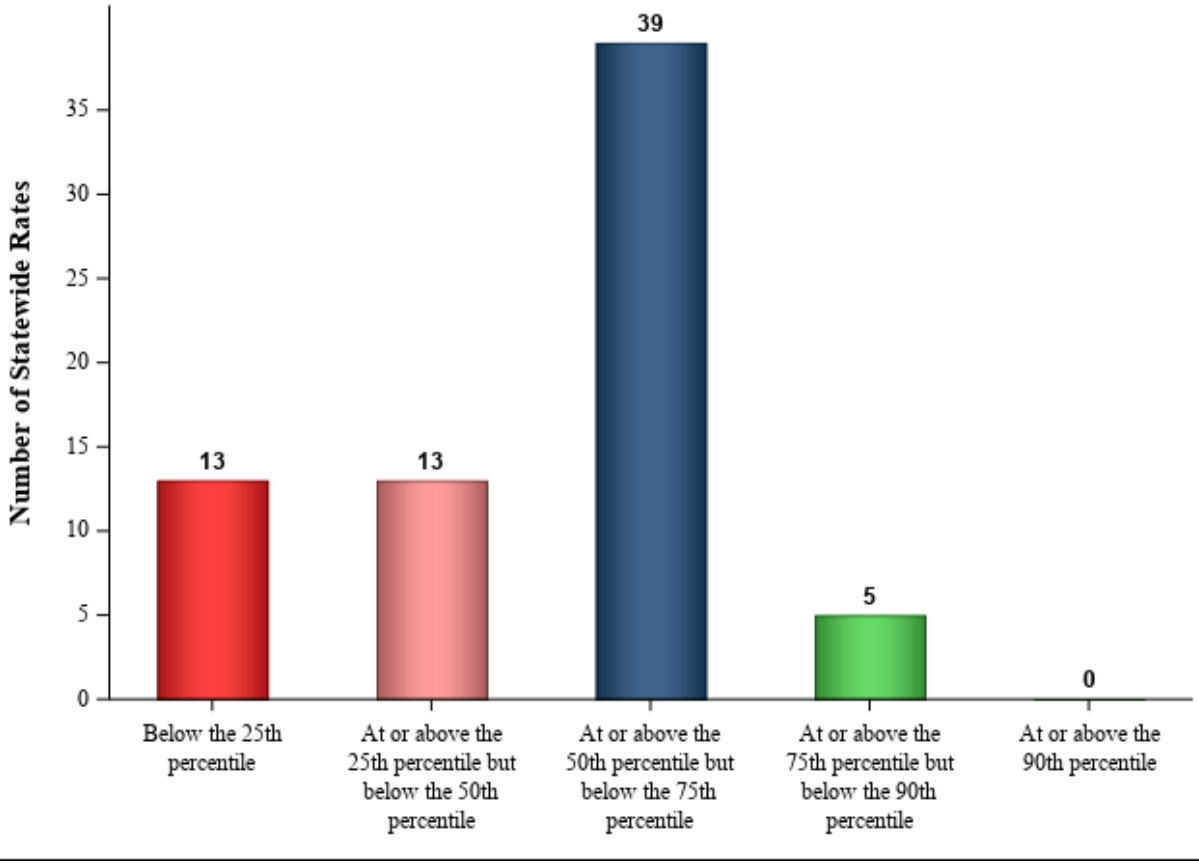
[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

In addition, Section 11 ("HEDIS Reporting Capabilities—Information Systems Findings") provides a summary of the HEDIS data collection processes used by the Michigan MHPs and the audit findings in relation to the National Committee for Quality Assurance's (NCQA's) information system (IS) standards.[1-2]

Summary of Performance

Figure 1-1 compares the Michigan Medicaid program's overall rates with NCQA's Quality Compass® national Medicaid HMO percentiles for HEDIS MY 2021, which are referred to as "percentiles" throughout this report.[1-3] For measures that were comparable to percentiles, the bars represent the number of Michigan Medicaid Weighted Average (MWA) measure indicator rates that fell into each percentile range.

Figure 1-1—Michigan Medicaid Statewide Averages Compared to National Medicaid Percentiles



[1-2] National Committee for Quality Assurance. *HEDIS® MY 2021, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C.

[1-3] Quality Compass® is a registered trademark for the National Committee for Quality Assurance (NCQA).

Of the 70 reported rates that were comparable to national Medicaid percentiles, 13 of the MWA rates fell below the 25th percentile and a total of 26 rates (about 37 percent) were below the 50th percentile. These results demonstrate a general statewide improvement in performance in comparison to the MY 2020 rates, which showed approximately 63 percent of the rates falling below the 50th percentile. A summary of MWA performance for each measure domain is presented on the following pages.

Child & Adolescent Care

For the Child & Adolescent Care domain, the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years*, *Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total* measure indicators were an area of strength. All measure indicators ranked above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2020 MWA. Priority Health Choice, Inc. and Molina Healthcare of Michigan ranked above the 50th percentile for the most measure indicators within the Child & Adolescent Care domain.

The MWA demonstrated a significant decline for the *Childhood Immunization Status—Combinations 3, 7, and 10; Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*; *Lead Screening in Children; Immunizations for Adolescents—Combination 1 and Combination 2*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* indicators. *Lead Screening in Children* had the highest number of MHPs that demonstrated a statistically significant decline in HEDIS MY 2021, as well as an MWA decrease of nearly 19 percentage points from HEDIS MY 2020. Additionally, the MWA ranked below the 25th percentile for all indicators for the *Childhood Immunization Status* measure, *Lead Screening in Children* measure, and the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

MDHHS should continue to monitor the MHPs' performance on the *Lead Screening in Children* measure to ensure that the MHPs' performance does not continue to decline and work toward possibly increasing the administration of lead blood tests for children 2 years of age. Exposure to lead can cause damage to the brain and other vital organs, as well as intellectual and behavioral deficits. Because children who are exposed to lead often have no obvious symptoms, lead poisoning often goes unrecognized.[1-4] MDHHS is encouraged to work with the MHPs, providers, and the Centers for Disease Control (CDC) to increase access to this important test. The CDC has developed the Childhood Lead Poisoning Prevention Program (CLPPP) to prevent childhood lead exposure before any harm occurs. Through CLPPP, the CDC supports state and local public health departments with funds for surveillance and prevention of lead exposure, including Michigan.[1-5]

[1-4] National Committee for Quality Assurance. Lead Screening in Children. Available at: https://www.ncqa.org/hedis/measures/lead-screening-in-children/. Accessed on: Sept 13, 2022.

[1-5] The Centers for Disease Control and Prevention. Overview of Childhood Lead Poisoning Prevention. Available at: https://www.cdc.gov/nceh/lead/overview.html. Accessed on: Sept 13, 2022.

MDHHS should continue to monitor the MHPs' performance on the *Childhood Immunization Status* and *Immunizations for Adolescents—Combination 1* and *Combination 2* measure indicators to ensure that the MHPs' performance does not continue to decline and work with the MHPs and providers to target improving child and adolescent vaccination rates. Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[1-6] The ongoing coronavirus disease 2019 (COVID-19) pandemic is a reminder of the importance of vaccination. The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face increased risks for outbreaks of vaccine-preventable diseases. Reminding parents of the vital need to protect their children against serious vaccine-preventable diseases, even as the COVID-19 pandemic continues, is critical. As social distancing requirements are relaxed, children who are not protected by vaccines will be more vulnerable to diseases such as measles. In response, continued coordinated efforts between health care providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[1-7]

Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators. Assessing physical, emotional, and social development is important at every stage of life, particularly with children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[1-8] If the decline in children accessing well-child visits with a primary care physician is linked to the COVID-19 public health emergency, MDHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for children to access these visits.

Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* measure indicators. ADHD is one of the most common mental disorders affecting children. When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness, and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.[1-9] If the decline in follow-up care for children prescribed ADHD

[1-6] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Sept 13, 2022.

[1-7] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Sept 14, 2022.

[1-8] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Sept 14, 2022.

[1-9] National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication. Available at: https://www.ncqa.org/hedis/measures/follow-up-care-for-children-prescribed-adhd-medication/. Accessed on: Sept 14, 2022.

medication is linked to the COVID-19 public health emergency, MDHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for children to access follow-up care.

Women—Adult Care

For the Women—Adult Care domain, the *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total* measure indicators were an area of strength. All measure indicators ranked above the 50th percentile with the *Chlamydia Screening in Women—Total* measure indicator demonstrating significant improvement from the HEDIS MY 2020 MWA. Priority Health Choice, Inc. and Blue Cross Complete of Michigan ranked above the 50th percentile for the most measure indicators within the Women—Adult Care domain.

The MWA demonstrated a significant decline for the *Cervical Cancer Screening* and *Breast Cancer Screening* measure indicators. No MHPs ranked above the HPL for any measure indicators. Additionally, Upper Peninsula Health Plan fell below the LPL for all *Chlamydia Screening for Women* measure indicators, HAP Empowered fell below the LPL for the *Cervical Cancer Screening* measure, and Aetna fell below the LPL for both the *Cervical Cancer Screening* and *Breast Cancer Screening* measures. The *Cervical Cancer Screening* and *Breast Cancer Screening* measures had the highest number of MHPs that demonstrated a statistically significant decline in HEDIS MY 2021, as well as an MWA decrease of over 2 percentage points from HEDIS MY 2020. Further, the *Breast Cancer Screening* measure had the most significant MWA decrease of over 4 percentage points from HEDIS MY 2020.

MDHHS should continue to monitor the MHPs' performance on the *Cervical Cancer Screening* and *Breast Cancer Screening* measure indicators to ensure that the MHPs' performance does not continue to decline and work with the MHPs toward establishing resources to increase access to routine cancer screenings. Screening can improve outcomes and early detection, reduce the risk of dying, and lead to a greater range of treatment options and lower health care costs.[1-10] Prolonged delays in screening related to the COVID-19 pandemic may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[1-11]

[1-10] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Sept 14, 2022.

[1-11] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Sept 14, 2022.

Access to Care

For the Access to Care domain, the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 65 Years and Older,* and *Total*; *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Ages 18 to 64 Years*; and *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years, Ages 18 to 64 Years,* and *Total* measure indicators were an area of strength. All measure indicators ranked above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2020 MWA. Upper Peninsula Health Plan and Meridian Health Plan of Michigan ranked above the 50th percentile for the most measure indicators within the Access to Care domain. Upper Peninsula Health Plan ranked above the HPL for *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older,* and Aetna Better Health of Michigan and Priority Health Choice, Inc. ranked above the HPL for *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years*.

The MWA demonstrated a significant decline for the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years,* and *Total* measure indicators. *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years,* and *Total* had the highest number of MHPs that demonstrated a statistically significant decline in HEDIS MY 2021 and MWA decrease from HEDIS MY 2020. Additionally, the MWA ranked below the 25th percentile for the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years,* and *Total* measure indicators.

MDHHS should continue to monitor the MHPs' performance for the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years,* and *Total* measure indicators to ensure that the MHPs' performance does not continue to decline. Proper testing and treatment of pharyngitis prevents the spread of sickness while reducing unnecessary use of antibiotics.[1-12]

Obesity

For the Obesity domain, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* were an area of strength. Both measure indicators ranked above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2020 MWA. Additionally, Upper Peninsula Health Plan, Blue Cross Complete of Michigan, Priority Health Choice, Inc., UnitedHealthcare Community Plan, Aetna Better Health of Michigan, and HAP Empowered ranked above the 50th percentile for the most measure indicators within the Obesity domain. Priority Health Choice, Inc. ranked above the HPL for all *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, and Upper Peninsula Health Plan ranked above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator.

[1-12] National Committee for Quality Assurance. Appropriate Testing for Children with Pharyngitis. Available at: https://www.ncqa.org/hedis/measures/appropriate-testing-for-children-with-pharyngitis/. Accessed on: Sept 14, 2022.

The MWA demonstrated a significant decline for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator. McLaren Health Plan ranked below the LPL for all three measure indicators.

MDHHS should continue to monitor the MHPs' performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator and work with the MHPs and providers to strategize the best way to utilize every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, MDHHS should continue to monitor McLaren Health Plan's performance for this measure to ensure the MHP's performance does not continue to decline and encourage higher performing MHPs to share and discuss best practices. Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases. Obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.[1-13]

Pregnancy Care

For the Pregnancy Care domain, *Prenatal and Postpartum Care—Postpartum Care* was an area of strength, as the measure indicator demonstrated significant improvement from the HEDIS MY 2020 MWA. Additionally, Upper Peninsula Health Plan and Blue Cross Complete of Michigan ranked above the 50th percentile for the most measure indicators within the Pregnancy Care domain. Upper Peninsula Health Plan ranked above the HPL for both *Prenatal and Postpartum Care* measure indicators.

Molina Healthcare of Michigan, Meridian Health Plan of Michigan, McLaren Health Plan, Aetna Better Health of Michigan, and HAP Empowered all fell below the LPL for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, and Molina Healthcare of Michigan, McLaren Health Plan, HAP Empowered, and Aetna Better Health of Michigan all fell below the LPL for *Prenatal and Postpartum Care—Postpartum Care*. MDHHS is encouraged to work with the higher performing MHPs to identify best practices for ensuring women's access to prenatal and postpartum care, which can then be shared with the lower performing MHPs to improve overall access.

Living With Illness

For the Living With Illness domain, *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*; *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*; and *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure indicators were an area of strength. All measure indicators ranked above the

[1-13] National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. Available at: https://www.ncqa.org/hedis/measures/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents/. Accessed on: Sept 14, 2022.

50th percentile and demonstrated significant improvement from the HEDIS MY 2020 MWA. Upper Peninsula Health Plan and UnitedHealthcare Community Plan ranked above the 50th percentile and the HPL for the most measure indicators within the Living With Illness domain.

The MWA demonstrated a significant decline for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessations Strategies*, and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure indicators. *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* had the highest number of MHPs that demonstrated a significantly significant decline in HEDIS MY 2021.

MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessations Strategies* measure indicators. Smoking and tobacco use are the largest causes of preventable disease and death in the United States. Comprehensive cessation interventions that motivate and help users to quit tobacco use can be very effective. Health care providers also play an important role in supporting tobacco users and their efforts to quit.[1-14] Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*. Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Medication non-adherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[1-15] If the decline in receipt of these services is determined to be related to the COVID-19 public health emergency, MDHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for adults to have access to these important services.

Health Plan Diversity

Although measures under this domain are not performance measures and are not compared to percentiles, changes observed in the results may provide insight into how select member characteristics affect the MHPs' provision of services and care.

[1-14] National Committee for Quality Assurance. Medical Assistance With Smoking and Tobacco Use Cessation. Available at: https://www.ncqa.org/hedis/measures/medical-assistance-with-smoking-and-tobacco-use-cessation/ Accessed on: Sept 15, 2022.

[1-15] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia. Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/ Accessed on: Sept 15, 2022.

Utilization

For the *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department (ED) Visits—Total* measure indicator, the MWA decreased by 15.11 visits per 1,000 member months from HEDIS MY 2019 to HEDIS MY 2021. The MWA for the *Outpatient Visits—Total* measure indicator decreased by 31.08 visits per 1,000 member months from HEDIS MY 2019 to HEDIS MY 2021.[1-16] Since the measure of outpatient visits is not linked to performance, the results for this measure are not comparable to percentiles. For the *Plan All-Cause Readmissions* measure, four MHPs had an observed-to-expected (O/E) ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on the patient mix. The remaining five MHPs' O/E ratio is more than 1.0, indicating that these MHPs had more readmissions.

Limitations and Considerations

Some behavioral health services are carved out and are not provided by the MHPs; therefore, exercise caution when interpreting rates for measures related to behavioral health.

[1-16] For the *ED Visits* indicator, awareness is advised when interpreting results for this indicator as a lower rate is a higher percentile.

2. How to Get the Most From This Report

Introduction

This reader's guide is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

Michigan Medicaid Health Plan Names

Table 2-1 presents a list of the Michigan MHPs discussed within this report and their corresponding abbreviations.

Table 2-1—2022 Michigan MHP Names and Abbreviations

MHP Name	Short Name	Abbreviation
Aetna Better Health of Michigan	Aetna	AET
Blue Cross Complete of Michigan	Blue Cross	BCC
McLaren Health Plan	McLaren	MCL
Meridian Health Plan of Michigan	Meridian	MER
HAP Empowered	HAP	HAP
Molina Healthcare of Michigan	Molina	MOL
Priority Health Choice, Inc.	Priority	PRI
UnitedHealthcare Community Plan	UnitedHealthcare	UNI
Upper Peninsula Health Plan	Upper Peninsula	UPP

Summary of Michigan Medicaid HEDIS MY 2021 Measures

Within this report, HSAG presents the Michigan MWA (i.e., statewide average rates) and MHP-specific performance on HEDIS measures selected by MDHHS for HEDIS MY 2021. These measures were grouped into the following eight domains of care: Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, Pregnancy Care, Living With Illness, Health Plan Diversity, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages MHPs and MDHHS to consider the measures as a whole rather than in isolation and to develop the strategic changes required to improve overall performance.

Table 2-2 shows the selected HEDIS MY 2021 measures and measure indicators as well as the corresponding domains of care and the reporting methodologies for each measure. The data collection or calculation method is specified by NCQA in the *HEDIS MY 2020 & MY 2021 and Volume 2 Technical Specifications*. Data collection methodologies are described in detail in the next section.

Table 2-2—Michigan Medicaid HEDIS MY 2021 Required Measures

Performance Measures	HEDIS Data Collection Methodology
Child & Adolescent Care	
Childhood Immunization Status—Combinations 3, 7, and 10	Hybrid
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits, and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*	Administrative
Lead Screening in Children	Administrative
Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, Ages 12 to 17 Years, Ages 18 to 21 Years, and *Total*	Administrative
Immunizations for Adolescents—Combinations 1 and *2*	Hybrid
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase and *Continuation and Maintenance Phase*	Administrative
Women—Adult Care	
Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*	Administrative
Cervical Cancer Screening	Hybrid
Breast Cancer Screening	Administrative
Access to Care	
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65 Years and Older, and *Total*	Administrative
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and *Total*	Administrative
Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and *Total*	Administrative
Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older, and *Total*	Administrative
Obesity	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	Hybrid

Performance Measures	HEDIS Data Collection Methodology
Pregnancy Care	
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	Hybrid
Living With Illness	
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	Hybrid
Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years, *Ages 65 to 74 Years*, *Ages 75 to 85 Years*, and *Total*	Administrative
Asthma Medication Ratio—Total	Administrative
Controlling High Blood Pressure	Hybrid
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	Administrative
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	Administrative
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative
Diabetes Monitoring for People With Diabetes and Schizophrenia	Administrative
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Administrative
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Administrative
Health Plan Diversity	
Race/Ethnicity Diversity of Membership	Administrative
Language Diversity of Membership—Spoken Language Preferred for Health Care, *Preferred Language for Written Materials*, and *Other Language Needs*	Administrative
Utilization	
Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total and *Outpatient Visits—Total*	Administrative
Inpatient Utilization—General Hospital/Acute Care—Total	Administrative
Use of Opioids From Multiple Providers—Multiple Prescribers, *Multiple Pharmacies*, and *Multiple Prescribers and Multiple Pharmacies*	Administrative
Use of Opioids at High Dosage	Administrative
Risk of Continued Opioid Use—At Least 15 Days Covered—Total and *At Least 31 Days Covered—Total*	Administrative
Plan All-Cause Readmissions—Index Total Stays	Administrative

Data Collection Methods

Administrative Method

The administrative method requires that MHPs identify the eligible population (i.e., the denominator) using administrative data, derived from claims and encounters. In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely using administrative data collected during the reporting year. Medical record review data from the prior year may be used as supplemental data. Medical records collected during the current year cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

Hybrid Method

The hybrid method requires that MHPs identify the eligible population using administrative data and then extract a systematic sample of members from the eligible population, which becomes the denominator. Administrative data are used to identify services provided to those members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher rates because the completeness of documentation in the medical record exceeds what is typically captured in administrative data; however, the medical record review component of the hybrid method is considered more labor intensive. For example, the MHP has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure and chooses to use the hybrid method. After randomly selecting 411 eligible members, the MHP finds that 161 members had evidence of a postpartum visit using administrative data. The MHP then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record review. Therefore, the final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52.3 percent, a 13.1 percentage point increase from the administrative only rate of 39.2 percent.

Understanding Sampling Error

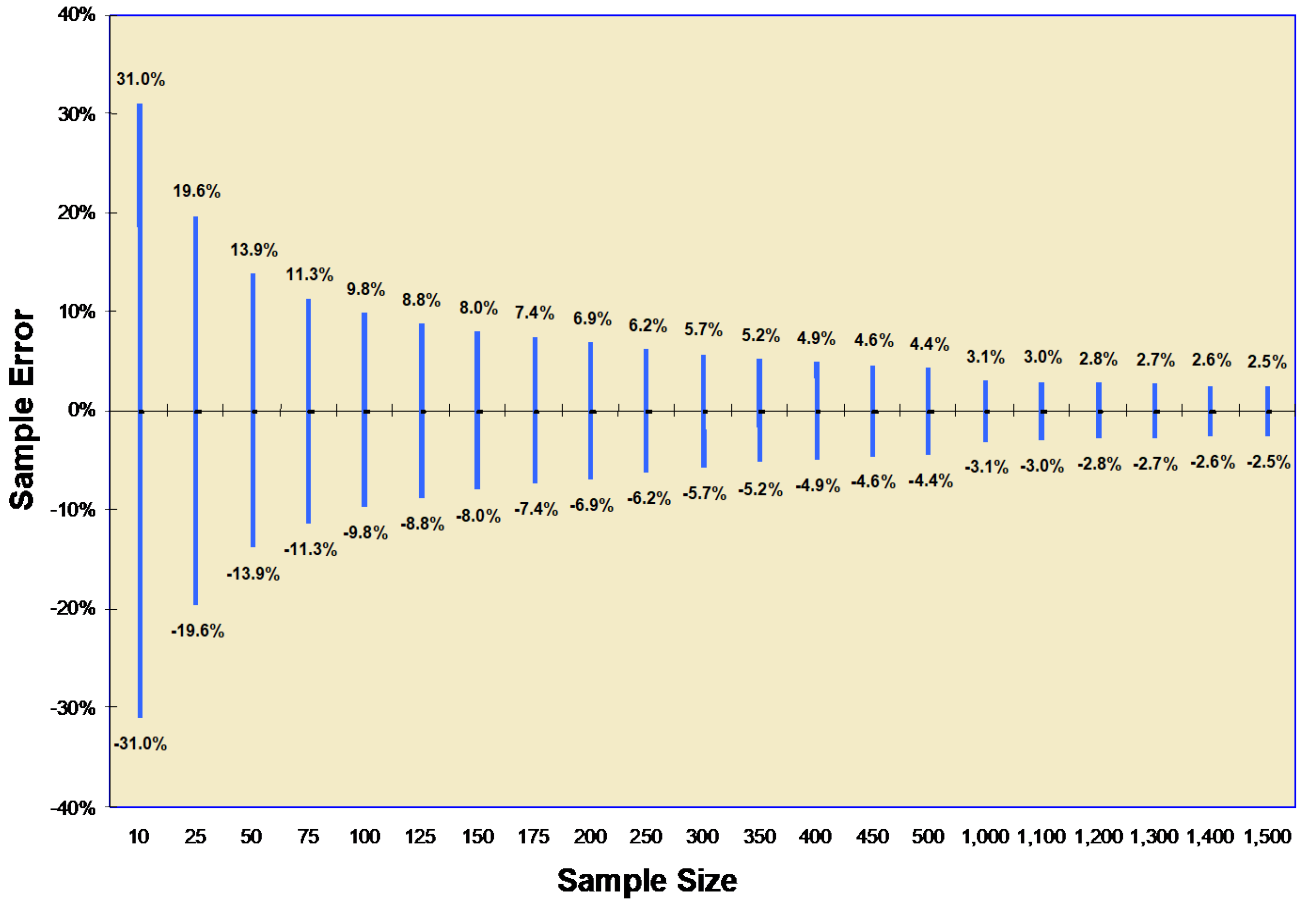
Correct interpretation of results for measures collected using HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to complete medical record review for the entire eligible population for a given measure. Measures collected using the HEDIS hybrid method include only a sample from the eligible population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire eligible population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process selecting at least 411 members of the eligible

population. MHP may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*).

Figure 2-1 shows that if 411 members are included in a measure, the margin of error is approximately ± 4.9 percentage points. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000. The smaller the sample included in the measure, the larger the sampling error.

Figure 2-1—Relationship of Sample Size to Sample Error



As Figure 2-1 shows, sample error decreases as the sample size gets larger. Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant. This does not mean that all such differences are important. On the other hand, the difference between two measured rates may not be statistically significant but may, nevertheless, be important. The judgment of the reviewer is always a requisite for meaningful data interpretation.

Data Sources and Measure Audit Results

MHP-specific performance displayed in this report was based on data elements obtained from the IDSS files supplied by the MHPs. Prior to HSAG's receipt of the MHPs' IDSS files, all the MHPs were required by MDHHS to have their HEDIS MY 2021 results examined and verified through an NCQA HEDIS Compliance Audit.

Through the audit process, each measure indicator rate reported by an MHP was assigned an NCQA-defined audit result. HEDIS MY 2021 measure indicator rates received one of seven predefined audit results: *Reportable (R), Small Denominator (NA), Biased Rate (BR), No Benefit (NB), Not Required (NQ), Un-Audited (UN),* and *Not Reported (NR).* The audit results are defined in Section 12.

Rates designated as *NA, BR, NB, NQ, UN,* or *NR* are not presented in this report. All measure indicator rates that are presented in this report have been verified as an unbiased estimate of the measure. Please see Section 11 for additional information on NCQA's Information System (IS) standards and the audit findings for the MHPs.

Calculation of Statewide Averages

For all measures, HSAG collected the audited results, numerator, denominator, rate, and eligible population elements reported in the files submitted by MHPs to calculate the MWA rate. Given that the MHPs varied in membership size, the MWA rate was calculated for most of the measures based on MHPs' eligible populations. Weighting the rates by the eligible population sizes ensured that a rate for an MHP with 125,000 members, for example, had a greater impact on the overall MWA rate than a rate for the MHP with only 10,000 members. For MHPs' rates reported as *NA*, the numerators, denominators, and eligible populations were included in the calculations of the MWA rate. MHP rates reported as *BR, NB, NQ, UN,* or *NR* were excluded from the MWA rate calculation. However, traditional unweighted statewide Medicaid average rates were calculated for some utilization-based measures to align with calculations from prior years' deliverables.

Evaluating Measure Results

National Benchmark Comparisons

Benchmark Data

HEDIS MY 2021 MHP and MWA rates were compared to the corresponding national HEDIS benchmarks, which are expressed in percentiles of national performance for different measures. For comparative purposes, HSAG used the most recent data available from NCQA at the time of the publication of this report to evaluate the HEDIS MY 2021 rates: NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2020 MWA, which are referred to as "percentiles" throughout this report.

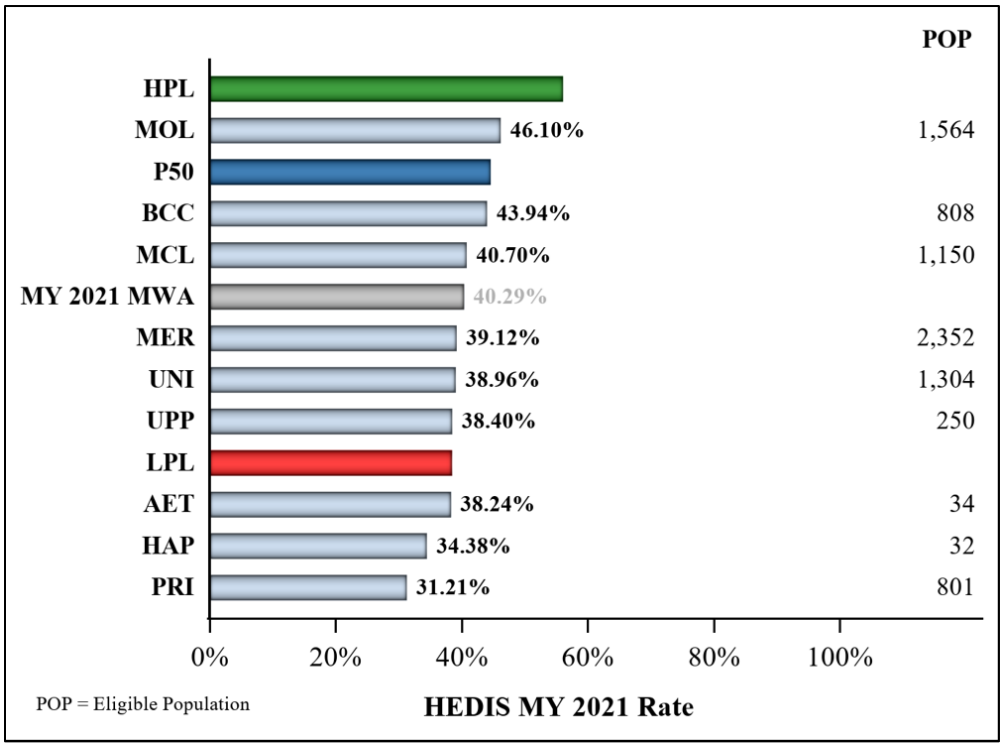
Additionally, benchmarking data (i.e., NCQA's Quality Compass and NCQA's Audit Means and Percentiles) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays.

Figure Interpretation

For each performance measure indicator presented in Sections 3 through 8 of this report, the horizontal bar graph figure positioned on the right side of the page presents each MHP's performance against the HEDIS MY 2021 MWA (i.e., the bar shaded gray); the HPL (i.e., the green shaded bar), representing the 90th percentile; the P50 bar (i.e., the blue shaded bar), representing the 50th percentile; and the LPL (i.e., the red shaded bar), representing the 25th percentile.

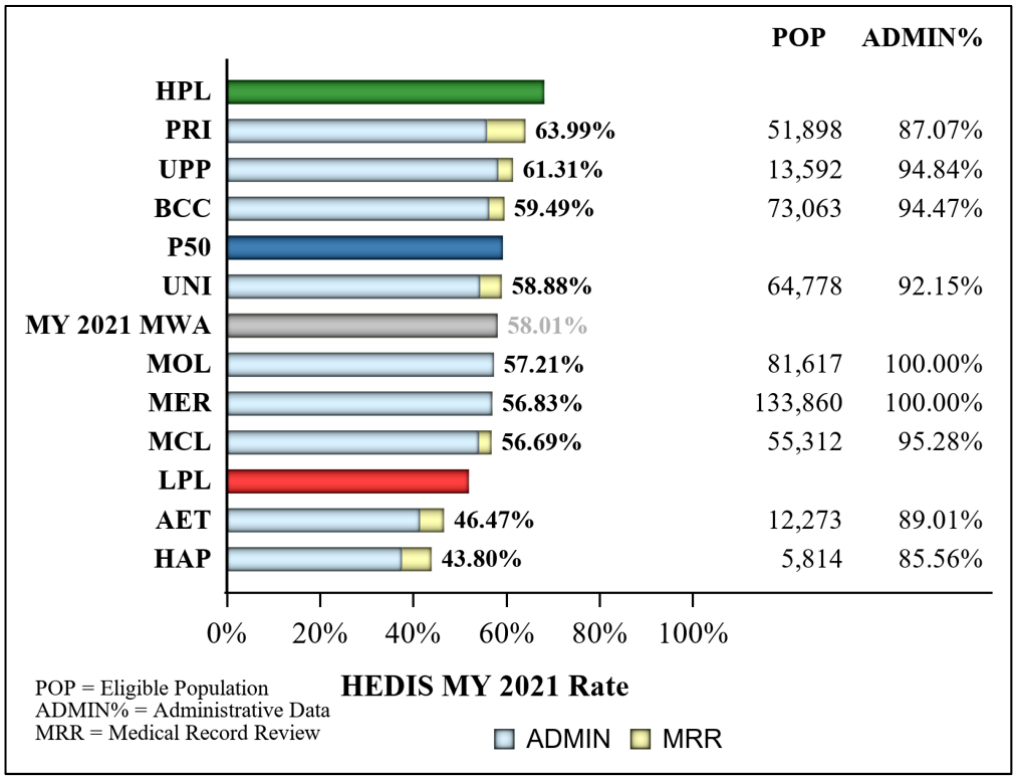
For measures for which lower rates indicate better performance, the 10th percentile (rather than the 90th percentile) and the 75th percentile (rather than the 25th percentile) are considered the HPL and LPL, respectively. An example of the horizontal bar graph figure for measure indicators reported administratively is shown below in Figure 2-2.

Figure 2-2—Sample Horizontal Bar Graph Figure for Administrative Measures



For performance measure rates that were reported using the hybrid method, the "ADMIN%" column presented with each horizontal bar graph figure displays the percentage of the rate derived from administrative data (e.g., claims data and supplemental data). The portion of the bar shaded yellow represents the proportion of the total measure rate attributed to medical record review, while the portion of the bar shaded light blue indicates the proportion of the measure rate that was derived using the administrative method. This percentage describes the level of claims/encounter data completeness of the MHP data for calculating a particular performance measure. A low administrative data percentage suggests that the MHP relied heavily on medical records to report the rate. Conversely, a high administrative data percentage indicates that the MHP's claims/encounter data were relatively complete for use in calculating the performance measure indicator rate. An administrative percentage of 100 percent indicates that the MHP did not report the measure indicator rate using the hybrid method. An example of the horizontal bar graph figure for measure indicators reported using the hybrid method is shown in Figure 2-3.

Figure 2-3—Sample Horizontal Bar Graph Figure for Hybrid Measures



Percentile Rankings and Star Ratings

In addition to illustrating MHP and statewide performance via side-by-side comparisons to national percentiles, benchmark comparisons are denoted within Appendix B of this report using the percentile ranking performance levels and star ratings defined below in Table 2-3.

Table 2-3—Percentile Ranking Performance Levels

Star Rating	Performance Level
★★★★★	At or above the 90th percentile
★★★★	At or above the 75th percentile but below the 90th percentile
★★★	At or above the 50th percentile but below the 75th percentile
★★	At or above the 25th percentile but below the 50th percentile
★	Below the 25th percentile
NA	NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB	NB indicates that the MHP did not offer the health benefit required by the measure.

Measures in the Health Plan Diversity and Utilization measure domains are designed to capture the frequency of services provided and characteristics of the populations served. With the exception of *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits*, *Use of Opioids From Multiple Providers*, *Use of Opioids at High Dosage*, *Risk of Continued Opioid Use*, and *Plan All-Cause Readmissions*, higher or lower rates in these domains do not necessarily indicate better or worse performance. A lower rate for *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits* may indicate a more favorable performance since lower rates of ED services may indicate better utilization of services. Further, measures under the Health Plan Diversity measure domain provide insight into how member race/ethnicity or language characteristics are compared to national distributions and are not suggestive of plan performance.

For the *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits* and *Plan All-Cause Readmissions* measure indicators, HSAG inverted the star ratings to be consistently applied to these measures as with the other HEDIS measures. For example, the 10th percentile (a lower rate) was inverted to become the 90th percentile, indicating better performance.

Of note, MHP and statewide average rates were rounded to the second decimal place before performance levels were determined. As HSAG assigned star ratings, an em dash (—) was presented to indicate that the measure indicator was not required and not presented in previous years' HEDIS

deliverables; or that a performance level was not presented in this report either because the measure did not have an applicable benchmark or a comparison to benchmarks was not appropriate.

Performance Trend Analysis

In addition to the star rating results, HSAG also compared HEDIS MY 2021 MWA and MHP rates to the corresponding HEDIS MY 2020 MWA rates. HSAG also evaluated the extent of changes observed in the rates between years. Year-over-year performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05 for MHP rate comparisons and a *p* value <0.01 for MWA rate comparisons. Note that statistical testing could not be performed on the utilization-based measures domain given that variances were not available in the IDSS files for HSAG to use for statistical testing. Further statistical testing was not performed on the health plan diversity measures because these measures are for information purposes only.

In general, results from statistical significance testing provide information on whether a change in the rate may suggest improvement or decline in performance. Throughout the report, references to "significant" changes in performance are noted; these instances refer to statistically significant differences between performance from HEDIS MY 2020 MWA to HEDIS MY 2021. At the statewide level, if the number of MHPs reporting *NR* or *BR* differs vastly from year to year, the statewide performance may not represent all of the contracted MHPs, and any changes observed across years may need to take this factor into consideration. Nonetheless, changes (regardless of whether they are significant) could be related to the following factors independent of any effective interventions designed to improve the quality of care:

- Substantial changes in measure specifications. The "Measure Changes Between HEDIS MY 2020 MWA and HEDIS MY 2021" section below lists measures with specification changes made by NCQA.
- Substantial changes in membership composition within the MHP.

Table and Figure Interpretation

Within Sections 3 through 8 and Appendix B of this report, performance measure indicator rates and results of significance testing between HEDIS MY 2020 MWA and HEDIS MY 2021 are presented in tabular format. HEDIS MY 2021 rates shaded green with one cross ($^{+}$) indicate a significant improvement in performance from the previous year. HEDIS MY 2021 rates shaded red with two crosses ($^{++}$) indicate a significant decline in performance from the previous year. The colors used are provided below for reference:

+ *Indicates that the HEDIS MY 2021 MWA demonstrated a significant improvement from the HEDIS MY 2020 MWA.*

++ *Indicates that the HEDIS MY 2021 MWA demonstrated a significant decline from the HEDIS MY 2020 MWA.*

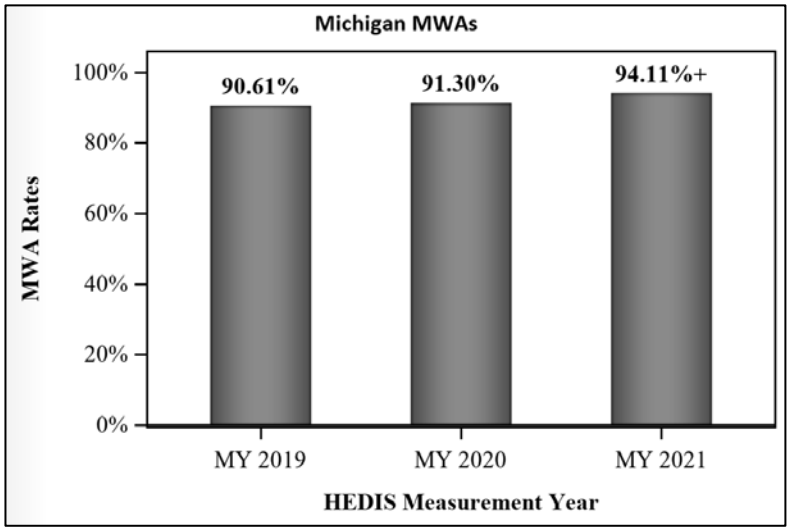
Additionally, benchmark comparisons are denoted within Sections 3 through 8. Performance levels are represented using the following percentile rankings:

Table 2-4—Percentile Ranking Performance Levels

Percentile Ranking and Shading	Performance Level
≥90th	At or above the 90th percentile
≥75th and ≤89th	At or above the 75th percentile but below the 90th percentile
≥50th and ≤74th	At or above the 50th percentile but below the 75th percentile
≥25th and ≤49th	At or above the 25th percentile but below the 50th percentile
≤25th	Below the 25th percentile

For each performance measure indicator presented in Sections 3 through 8 of this report, the vertical bar graph figure positioned on the left side of the page presents the HEDIS MY 2019, HEDIS MY 2020 MWA, and HEDIS MY 2021 MWAs with significance testing performed between the HEDIS MY 2020 MWA and HEDIS MY 2021 MWAs. Within these figures, HEDIS MY 2021 rates with one cross (+) indicate a significant improvement in performance from HEDIS MY 2020 MWA. HEDIS MY 2021 rates with two crosses (++) indicate a significant decline in performance from HEDIS MY 2020 MWA. An example of the vertical bar graph figure for measure indicators reported is included in Figure 2-4.

Figure 2-4—Sample Vertical Bar Graph Figure Showing Significant Improvement



Interpreting Results Presented in This Report

HEDIS results can differ among MHPs and even across measures for the same MHP.

The following questions should be asked when examining these data:

How accurate are the results?

All Michigan MHPs are required by MDHHS to have their HEDIS results confirmed through an NCQA HEDIS Compliance Audit. As a result, any rate included in this report has been verified as an unbiased estimate of the measure. NCQA's HEDIS protocol is designed so that the hybrid method produces results with a sampling error of ± 5 percent at a 95 percent confidence level.

To show how sampling error affects the accuracy of results, an example was provided in the "Data Collection Methods" section above. When an MHP uses the hybrid method to derive a *Postpartum Care* rate of 52 percent, the true rate is actually within ± 5 percentage points of this rate, due to sampling error. For a 95 percent confidence level, the rate would be between 47 percent and 57 percent. If the target is a rate of 55 percent, it cannot be said with certainty whether the true rate between 47 percent and 57 percent meets or does not meet the target level.

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. For internal purposes, MHPs should understand and consider the issue of sampling error when evaluating HEDIS results.

How do Michigan Medicaid rates compare to national percentiles?

For each measure, an MHP ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS MY 2020 MWA Medicaid 50th percentile. In addition, the HEDIS MY 2019, MY 2020, and MY 2021 MWA rates are presented for comparison purposes.

Michigan MHPs with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all MHPs nationally. Similarly, MHPs reporting rates below the 25th percentile (LPL) rank in the bottom 25 percent nationally for that measure.

How are Michigan MHPs performing overall?

For each domain of care, a performance profile analysis compares the MY 2021 MWA for each rate with the MY 2019 and MY 2020 MWA and the 50th percentile.

Measure Changes Between HEDIS MY 2020 and HEDIS MY 2021

The following is a list of measures with technical specification changes that NCQA announced for HEDIS MY 2021.[2-1] These changes may have an effect on the HEDIS MY 2021 rates that are presented in this report.

Plan All-Cause Readmissions (PCR)

- Clarified in the Plan Population definition that members must be 18 and older as of the earliest Index Discharge Date.
- Clarified in the *Reporting* sections for *Number of Members in Plan Population* and *Number of Outliers* that the member's age is determined as of the earliest Index Discharge Date.

Enrollment by Product Line (ENP)

- Removed reporting by gender, male and female. Only the total number of members is reported.

[2-1] National Committee for Quality Assurance. *HEDIS® MY 2020 & MY 2021, Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA Publication, 2016.

3. Child & Adolescent Care

Introduction

The Child & Adolescent Care domain encompasses the following HEDIS measures:

- *Childhood Immunization Status—Combinations 3, 7, and 10*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
- *Lead Screening in Children*
- *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, Ages 12 to 17 Years, Ages 18 to 21 Years,* and *Total*
- *Immunizations for Adolescents—Combinations 1 and 2*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 3-1 presents the Michigan MWA performance for the measure indicators under the Child & Adolescent Care domain. The table lists the HEDIS MY 2021 MWA rates and performance levels, a comparison of the HEDIS MY 2020 MWA to the HEDIS MY 2021 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2020 to HEDIS MY 2021.

Table 3-1—HEDIS MY 2021 MWA Performance Levels and Trend Results for Child & Adolescent Care

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Childhood Immunization Status				
Combination 3	55.46%	**-8.54**$^{++}$	0	5
Combination 7	46.83%	**-8.81**$^{++}$	0	4

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Combination 10	27.22%	**-6.00++**	0	4
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.84%	**-3.04++**	0	6
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.99%	**-6.72++**	0	8
Lead Screening in Children				
Lead Screening in Children	54.69%	**-18.75++**	0	9
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	58.13%	**+7.21+**	9	0
Ages 12 to 17 Years	49.93%	**+7.58+**	9	0
Ages 18 to 21 Years	29.01%	**+1.65+**	6	0
Total	50.49%	**+5.90+**	9	0
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	76.64%	**-6.04++**	0	5
Combination 2 (Meningococcal, Tdap, HPV)	32.85%	**-5.10++**	0	3
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	40.29%	**-5.74++**	0	5
Continuation and Maintenance Phase	51.24%	**-6.50++**	0	3

[1] HEDIS MY 2021 performance levels were based on comparisons of the HEDIS MY 2021 MWA rates to national Medicaid Quality Compass HEDIS MY 2020 MWA benchmarks. HEDIS MY 2021 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] HEDIS MY 2020 MWA to HEDIS MY 2021 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading+ *Indicates that the HEDIS MY 2021 MWA demonstrated a significant improvement from the HEDIS MY 2020 MWA.*

Red Shading++ *Indicates that the HEDIS MY 2021 MWA demonstrated a significant decline from the HEDIS MY 2020 MWA.*

Table 3-1 shows that for the Child & Adolescent Care domain, the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years*, *Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total* measure indicators were an area of strength. All measure indicators ranked above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2020 MWA. Priority and Molina ranked above the 50th percentile for the most measure indicators within the Child & Adolescent Care domain.

The MWA demonstrated a significant decline for the *Childhood Immunization Status—Combinations 3, 7, and 10; Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*; *Lead Screening in Children; Immunizations for Adolescents—Combination 1* and *Combination 2*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* indicators. *Lead Screening in Children* had the highest number of MHPs that demonstrated a statistically significant decline in HEDIS MY 2021, as well as an MWA decrease of nearly 19 percentage points from HEDIS MY 2020. Additionally, the MWA ranked below the 25th percentile for all indicators for the *Childhood Immunization Status* measure, *Lead Screening in Children* measure, and the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

MDHHS should continue to monitor the MHPs' performance on the *Lead Screening in Children* measure to ensure that the MHPs' performance does not continue to decline and work toward possibly increasing the administration of lead blood tests for children 2 years of age. Exposure to lead can cause damage to the brain and other vital organs, as well as intellectual and behavioral deficits. Because children who are exposed to lead often have no obvious symptoms, lead poisoning often goes unrecognized.[3-1] MDHHS is encouraged to work with the MHPs, providers, and the CDC to increase access to this important test. The CDC has developed the Childhood Lead Poisoning Prevention Program (CLPPP) to prevent childhood lead exposure before any harm occurs. Through CLPPP, the CDC supports state and local public health departments with funds for surveillance and prevention of lead exposure, including Michigan.[3-2]

MDHHS should continue to monitor the MHPs' performance on the *Childhood Immunization Status* and *Immunizations for Adolescents—Combination 1* and *Combination 2* measure indicators to ensure that the MHPs' performance does not continue to decline and work with the MHPs and providers to target improving child and adolescent vaccination rates. Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[3-3] The ongoing COVID-19 pandemic is a reminder of the importance of vaccination. The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face

[3-1] National Committee for Quality Assurance. Lead Screening in Children. Available at: https://www.ncqa.org/hedis/measures/lead-screening-in-children/. Accessed on: Sept 13, 2022.

[3-2] The Centers for Disease Control and Prevention. Overview of Childhood Lead Poisoning Prevention. Available at: https://www.cdc.gov/nceh/lead/overview.html. Accessed on: Sept 13, 2022.

[3-3] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Sept 13, 2022.

increased risks for outbreaks of vaccine-preventable diseases. Reminding parents of the vital need to protect their children against serious vaccine-preventable diseases, even as the COVID-19 pandemic continues, is critical. As social distancing requirements are relaxed, children who are not protected by vaccines will be more vulnerable to diseases such as measles. In response, continued coordinated efforts between health care providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[3-4]

Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicators. Assessing physical, emotional, and social development is important at every stage of life, particularly with children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-5] If the decline in children accessing well-child visits with a primary care physician is linked to the COVID-19 public health emergency, MDHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for children to access these visits.

Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* measure indicators. ADHD is one of the most common mental disorders affecting children. When managed appropriately, medication for ADHD can control symptoms of hyperactivity, impulsiveness, and inability to sustain concentration. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.[3-6] If the decline in follow-up care for children prescribed ADHD medication is linked to the COVID-19 public health emergency, MDHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for children to access follow-up care.

[3-4] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Sept 14, 2022.

[3-5] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Sept 14, 2022.

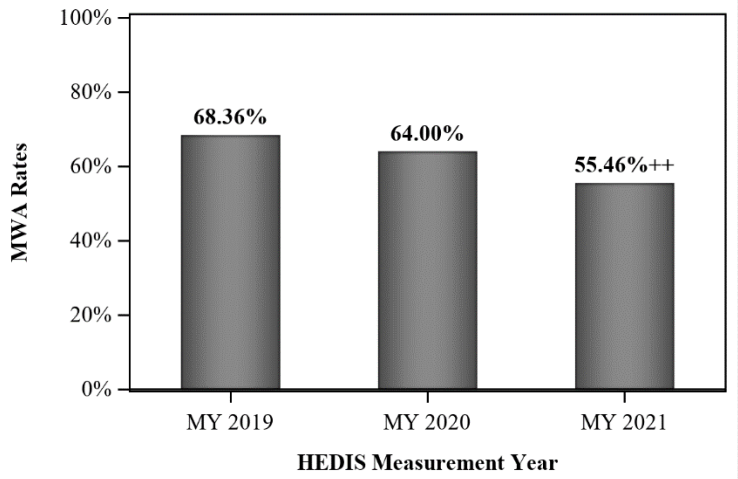
[3-6] National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication. Available at: https://www.ncqa.org/hedis/measures/follow-up-care-for-children-prescribed-adhd-medication/. Accessed on: Sept 14, 2022.

Measure-Specific Findings

Childhood Immunization Status—Combination 3

Childhood Immunization Status—Combination 3 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four diphtheria, tetanus, and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three haemophilus influenza type B (HiB), three hepatitis B (HepB), one chicken pox (VZV), and four pneumococcal conjugate (PCV).

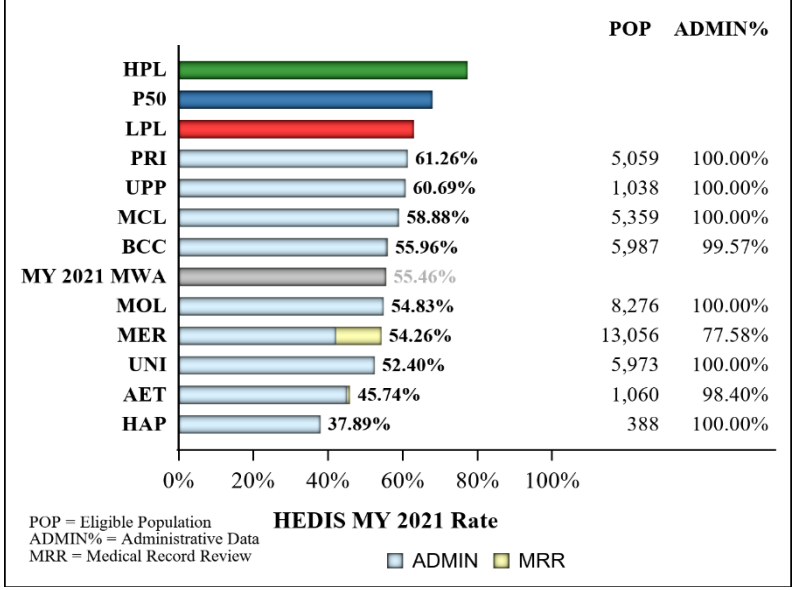
Figure 3–1—Childhood Immunization Status—Combination 3
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

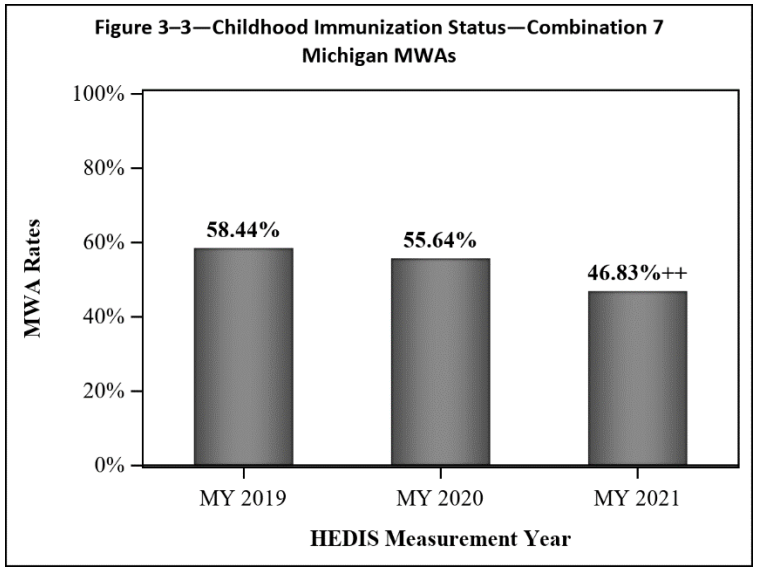
Figure 3–2—Childhood Immunization Status—Combination 3
Health Plan Ranking



All MHPs and the MWA fell below the 50th percentile, HPL, and the LPL. MHP performance varied by over 23 percentage points.

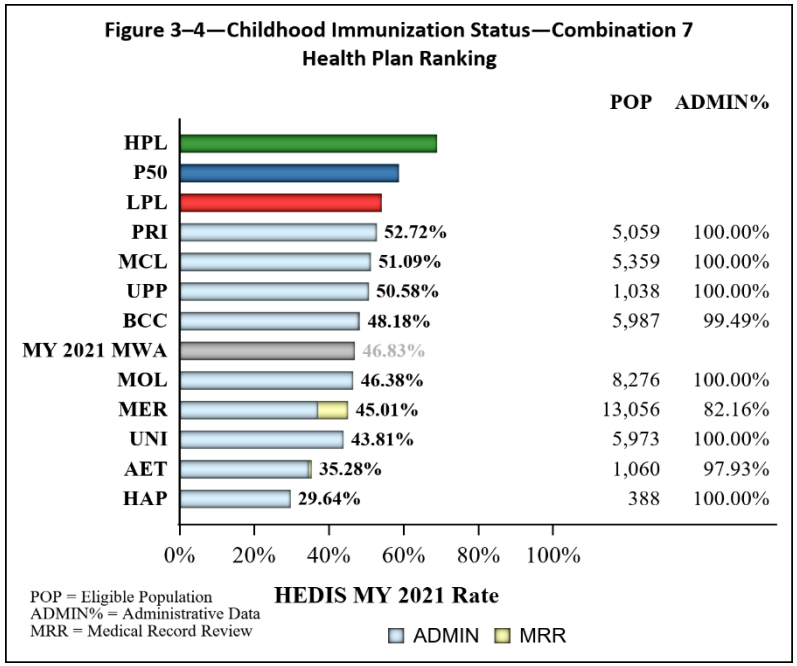
Childhood Immunization Status—Combination 7

Childhood Immunization Status—Combination 7 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, and two or three rotavirus (RV).



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

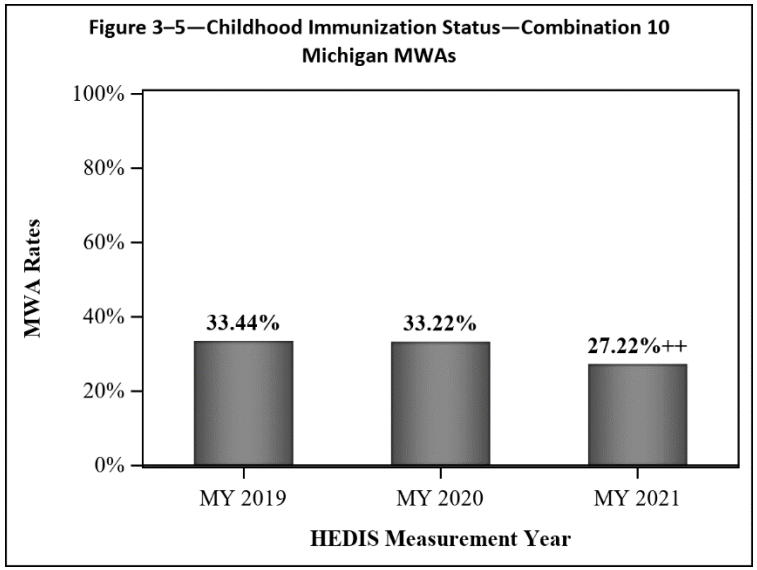
The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.



All MHPs and the MWA fell below the 50th percentile, HPL, and the LPL. MHP performance varied by over 23 percentage points.

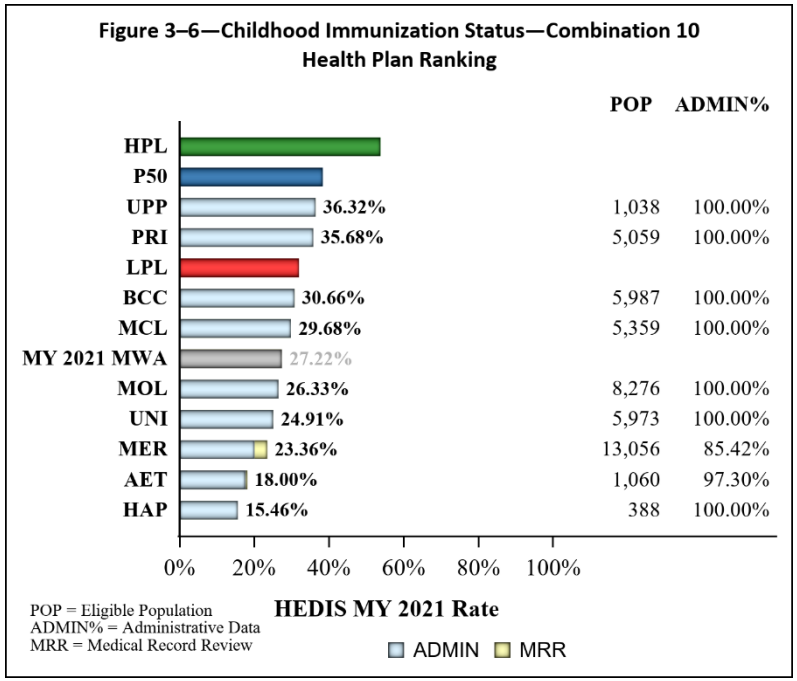
Childhood Immunization Status—Combination 10

Childhood Immunization Status—Combination 10 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two influenza.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

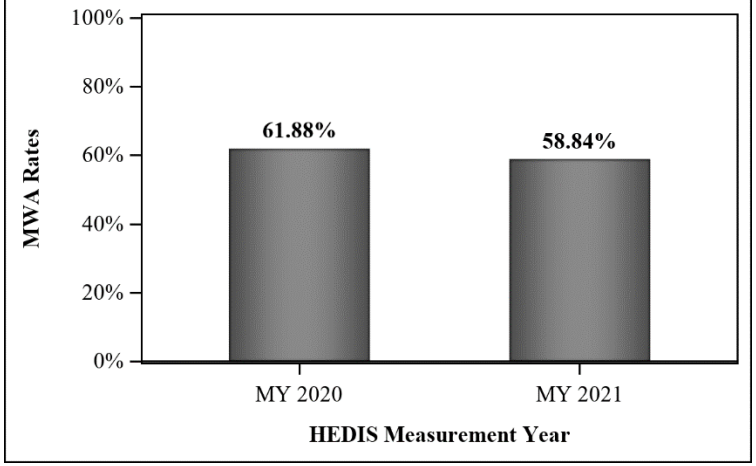


Two MHPs ranked above the LPL, but fell below the 50th percentile and HPL. Seven MHPs and the MWA fell below the LPL. MHP performance varied by over 20 percentage points.

Well-Child Visits in the First 15 Months—Six or More Well-Child Visits

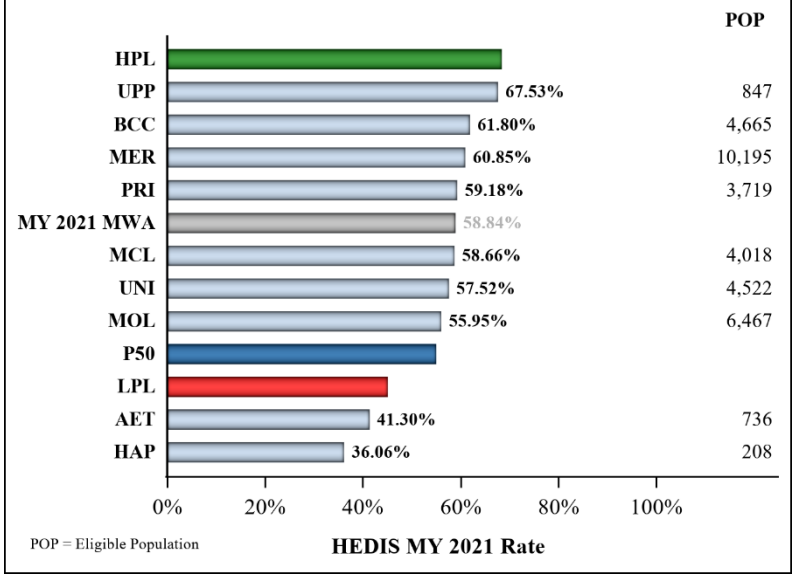
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits assesses the percentage of members who turned 15 months old during the MY who received six or more well-child visits with a PCP during their first 15 months of life.

Figure 3–7—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 3–8—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits
Health Plan Ranking

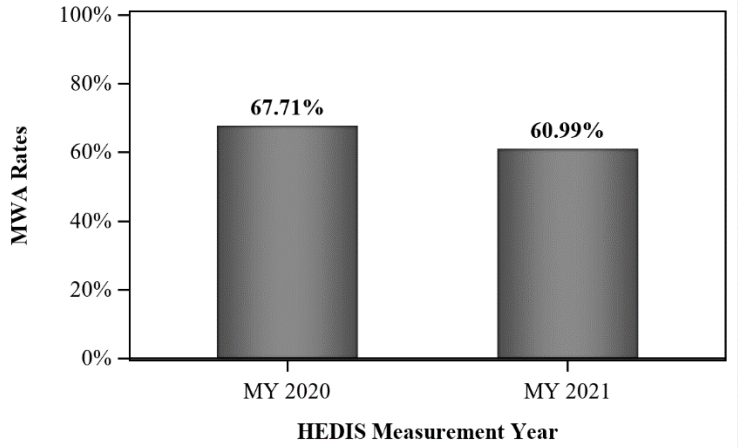


Seven MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs ranked below the LPL. MHP performance varied by over 31 percentage points.

Well-Child Visits in the First 15 Months to 30 Months—Two or More Well-Child Visits

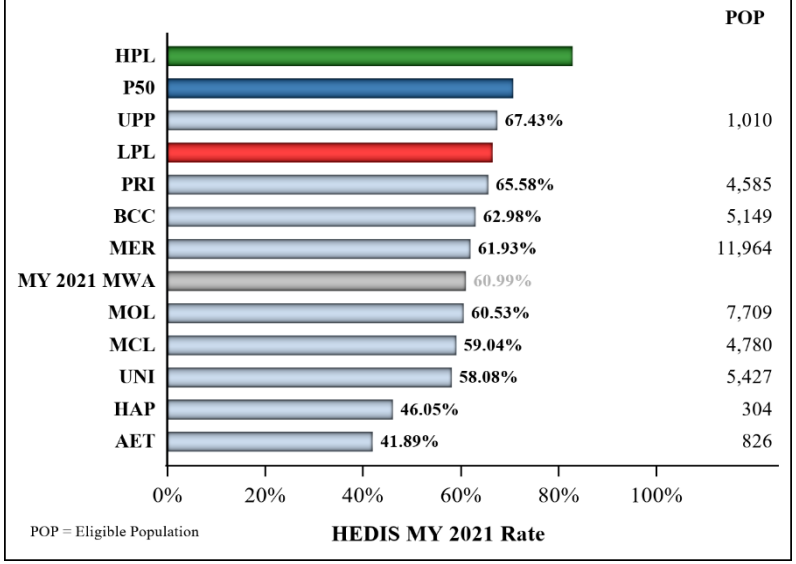
Well-Child Visits in the First 15 Months to 30 Months—Two or More Well-Child Visits assesses the percentage of members who turned 15 months old during the MY who received six or more well-child visits with a PCP during their first 15 months of life.

Figure 3–9—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

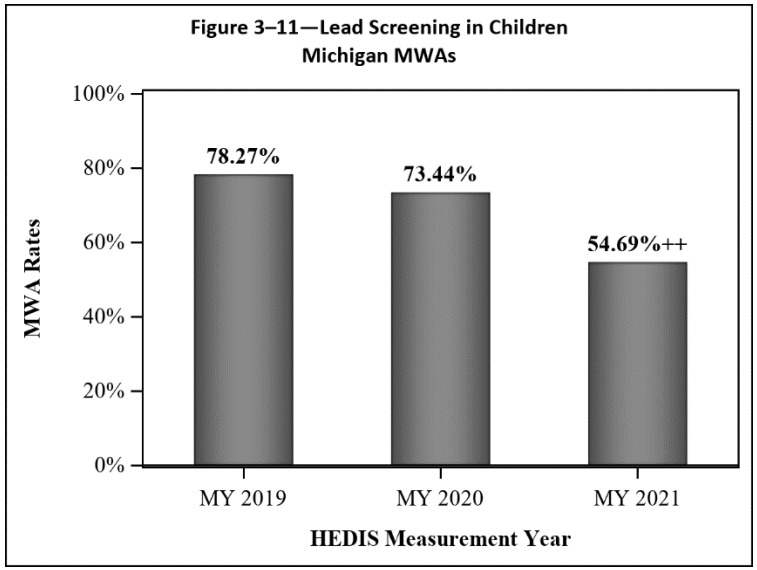
Figure 3–10—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits Health Plan Ranking



One MHP ranked above the LPL, but fell below the 50th percentile and HPL. Eight MHPs and the MWA fell below the LPL. MHP performance varied by over 25 percentage points.

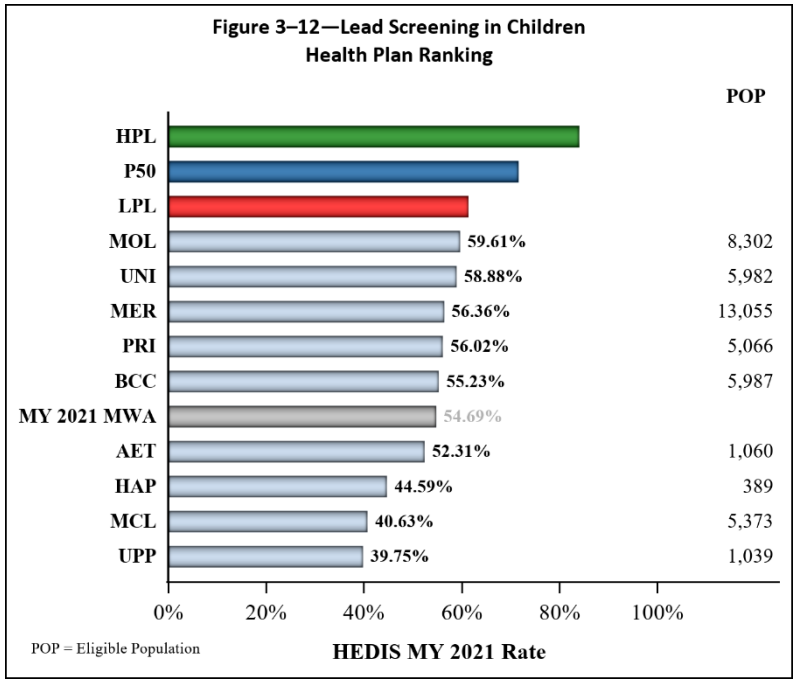
Lead Screening in Children

Lead Screening in Children assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

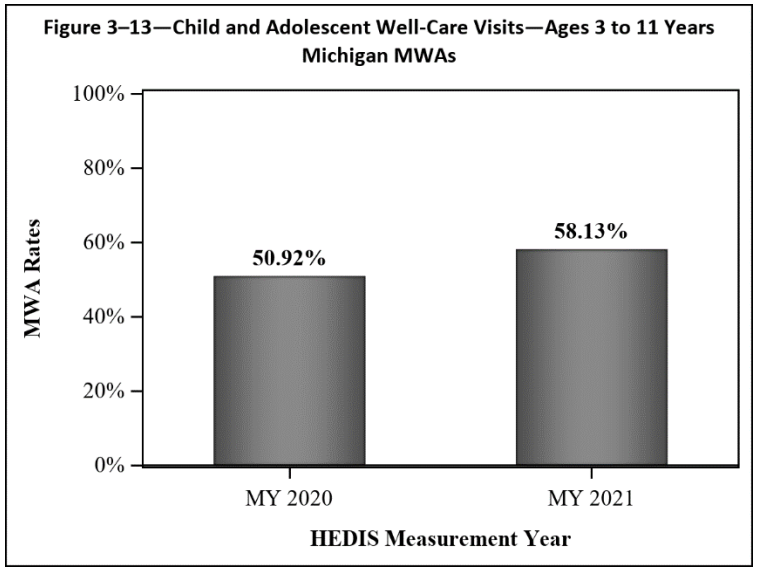
The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.



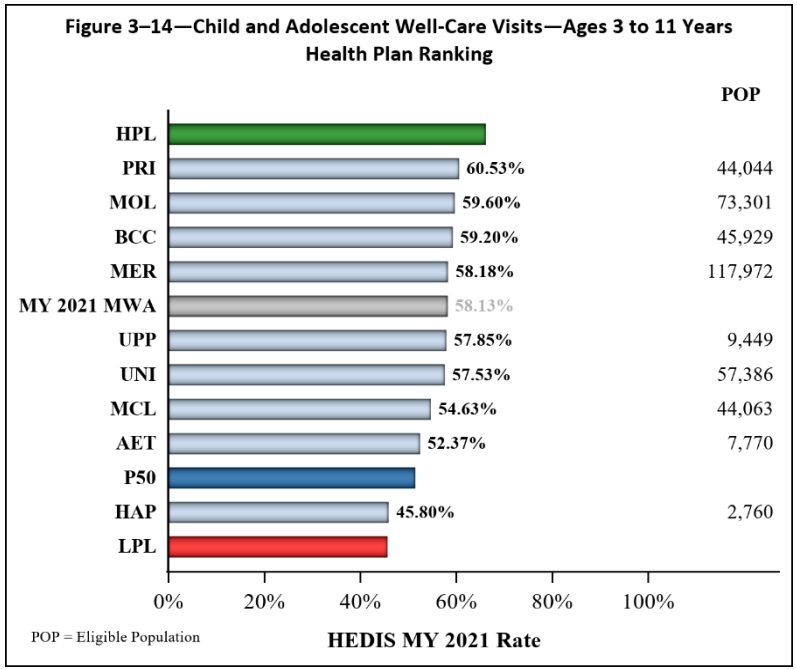
All MHPs and the MWA fell below the 50th percentile, HPL, and the LPL. MHP performance varied by over 19 percentage points.

Child and Adolescent Well-Care Visits—Ages 3 to 11 Years

Child and Adolescent Well-Care Visits assesses the percentage of members who were 3 to 11 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

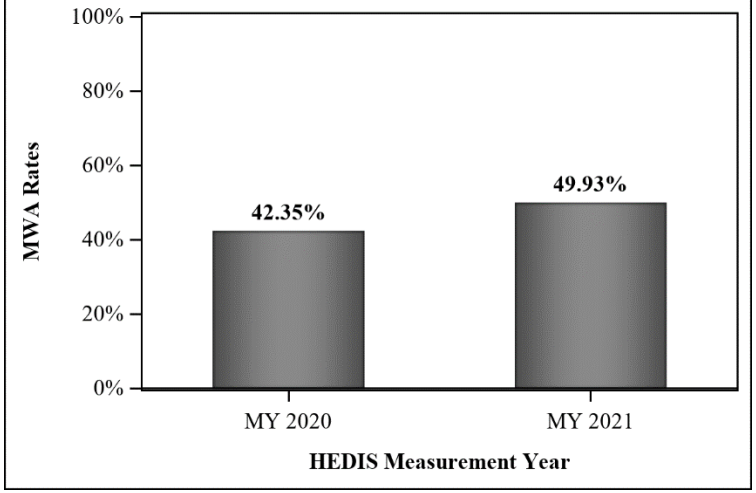


Eight MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. All MHPs ranked above the LPL. MHP performance varied by over 14 percentage points.

Child and Adolescent Well-Care Visits—Ages 12 to 17 Years

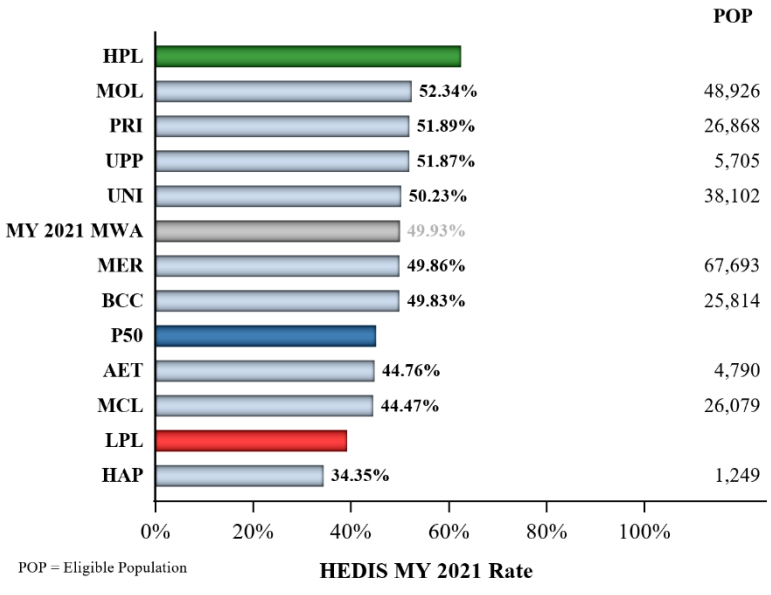
Child and Adolescent Well-Care Visits assesses the percentage of members who were 12 to 17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.

Figure 3–15—Child and Adolescent Well-Care Visits—Ages 12 to 17 Years
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 3–16—Child and Adolescent Well-Care Visits—Ages 12 to 17 Years
Health Plan Ranking

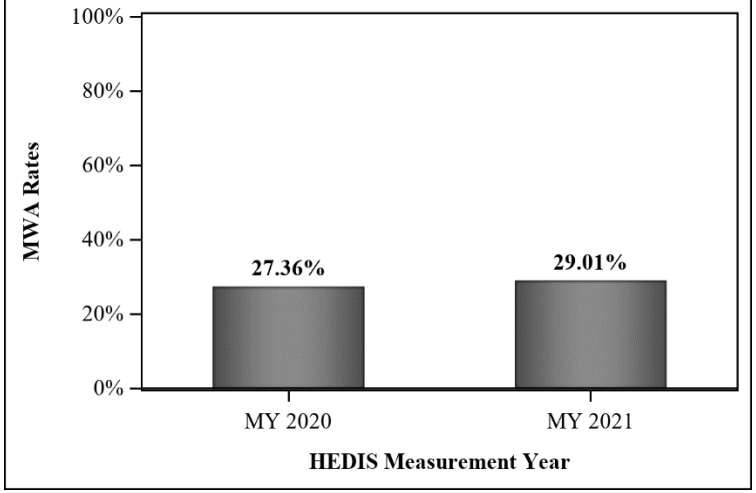


Six MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 17 percentage points.

Child and Adolescent Well-Care Visits—Ages 18 to 21 Years

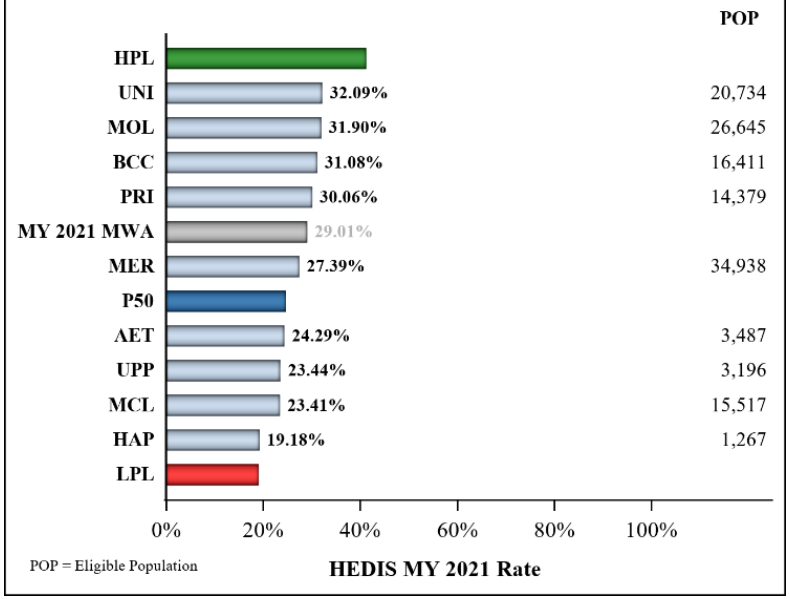
Child and Adolescent Well-Care Visits assesses the percentage of members who were 18 to 21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.

Figure 3–17—Child and Adolescent Well-Care Visits—Ages 18 to 21 Years
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

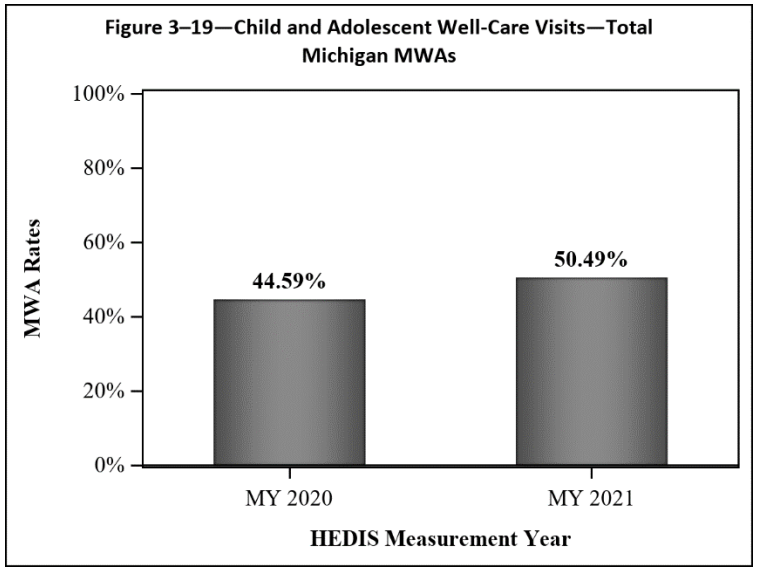
Figure 3–18—Child and Adolescent Well-Care Visits—Ages 18 to 21 Years
Health Plan Ranking



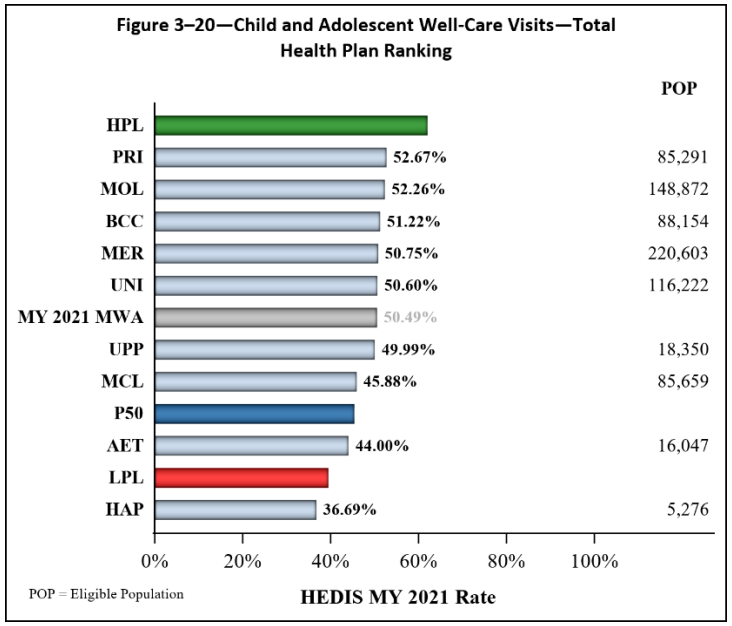
Five MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. All MHPs ranked above the LPL. MHP performance varied by over 12 percentage points.

Child and Adolescent Well-Care Visits—Total

Child and Adolescent Well-Care Visits—Total assesses the percentage of members who were 3 to 21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



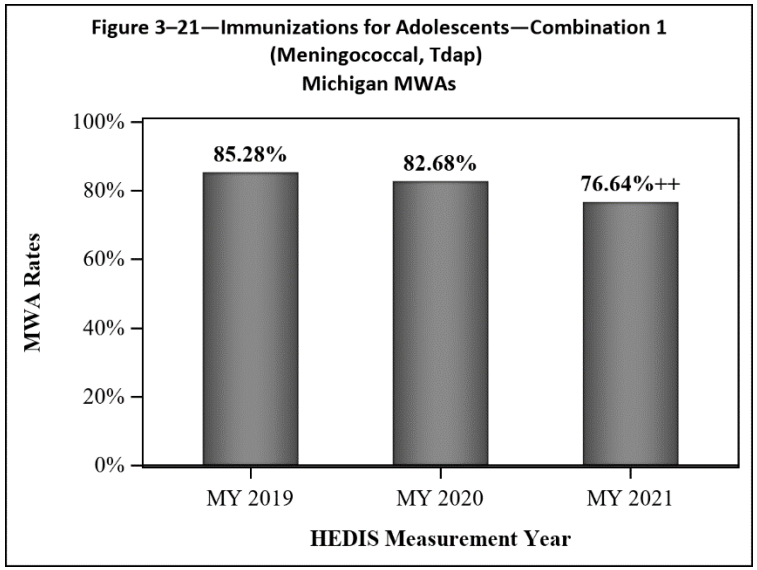
The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.



Seven MHPs ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 15 percentage points.

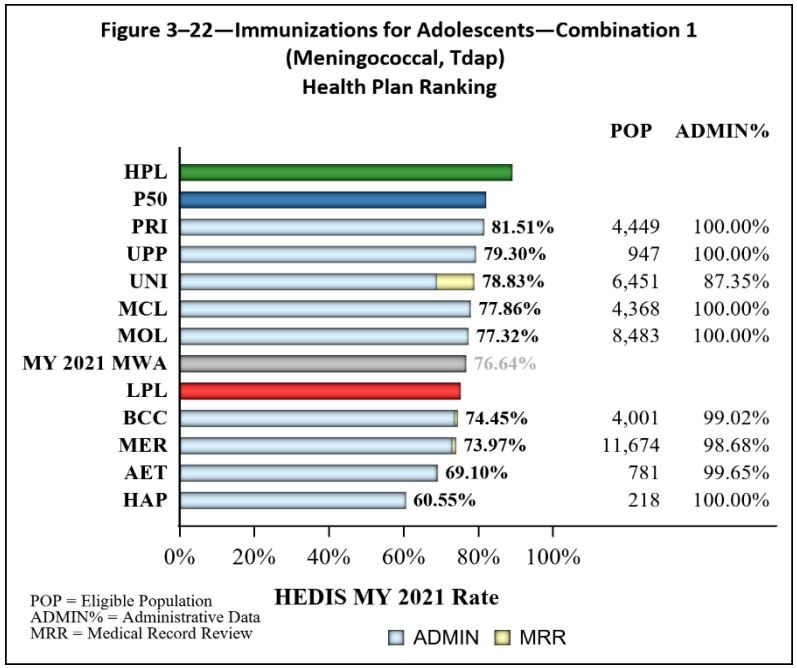
Immunizations for Adolescents—Combination 1

Immunizations for Adolescents—Combination 1 assesses the percentage of adolescents 13 years of age who had the following by their thirteenth birthday: one dose of meningococcal vaccine and one Tdap vaccine.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

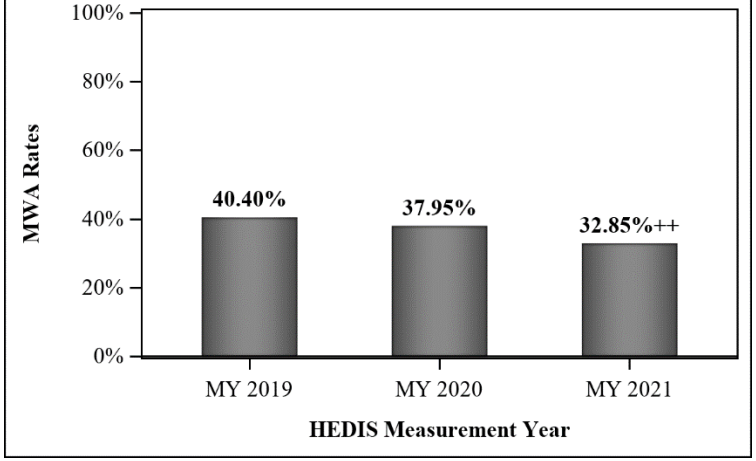


Five MHPs and the MWA ranked above LPL, but fell below the 50th percentile and the HPL. Four MHPs fell below the LPL. MHP performance varied by over 20 percentage points.

Immunizations for Adolescents—Combination 2

Immunizations for Adolescents—Combination 2 assesses the percentage of adolescents 13 years of age who had the following by their thirteenth birthday: one dose of meningococcal vaccine, one Tdap vaccine, and two HPV.

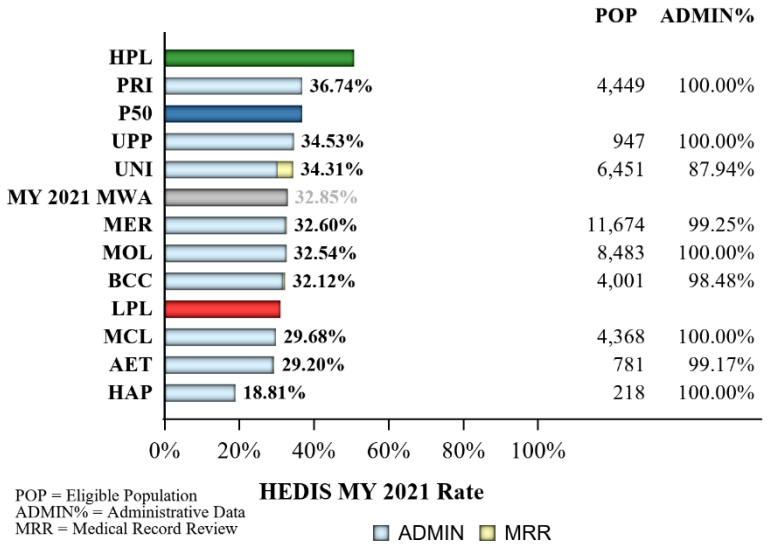
Figure 3–23—Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV) Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

Figure 3–24—Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV) Health Plan Ranking

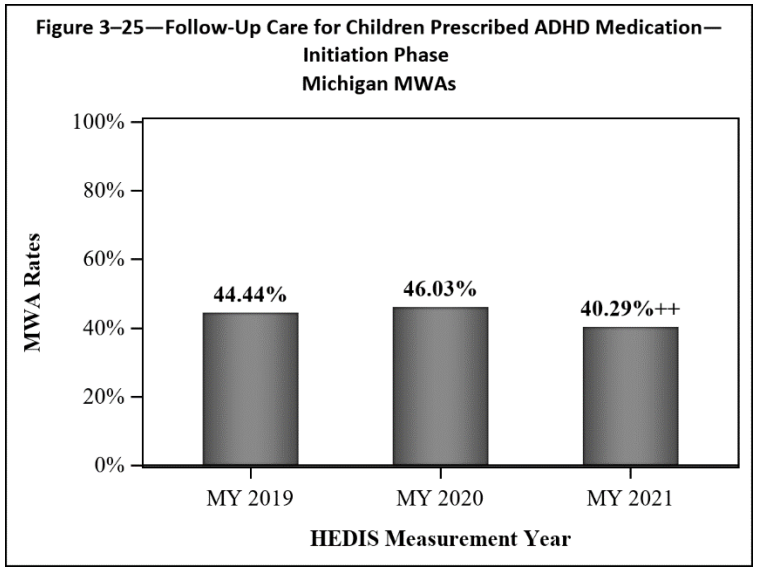


One MHP ranked above the 50th percentile, but fell below the HPL. Five MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. Three MHPs fell below the LPL. MHP performance varied by over 17 percentage points.

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase assesses the percentage of children 6 to 12 years of age who were newly prescribed ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.

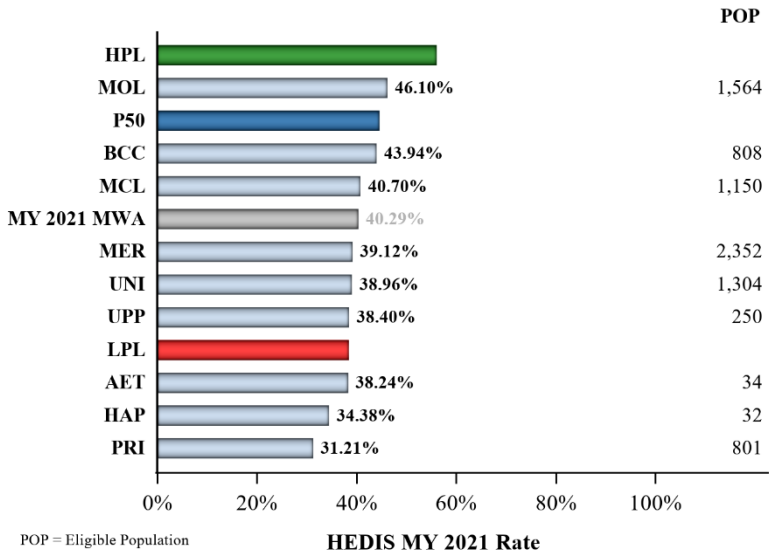
Figure 3–25—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

Figure 3–26—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase
Health Plan Ranking

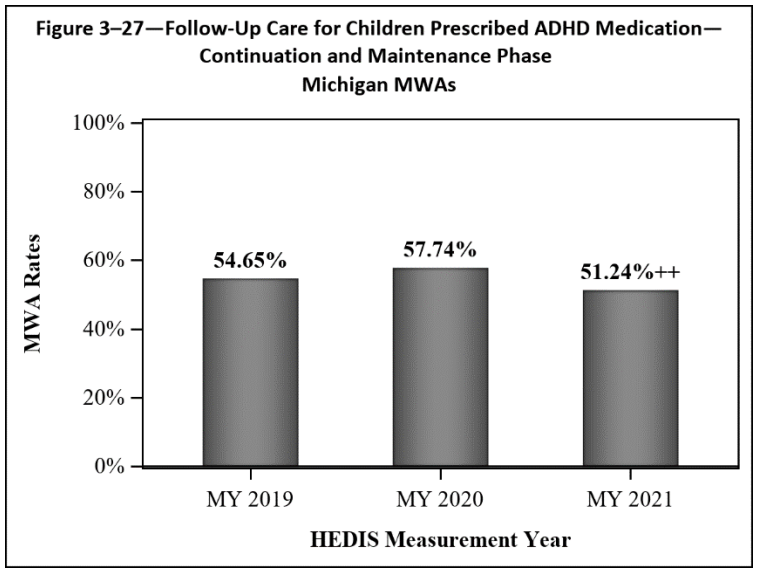


One MHP ranked above the 50th percentile, but fell below the HPL. Five MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. Three MHPs fell below the LPL. MHP performance varied by over 14 percentage points.

Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase

Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase assesses the percentage of children 6 to 12 years of age newly prescribed ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the initiation phase ended.

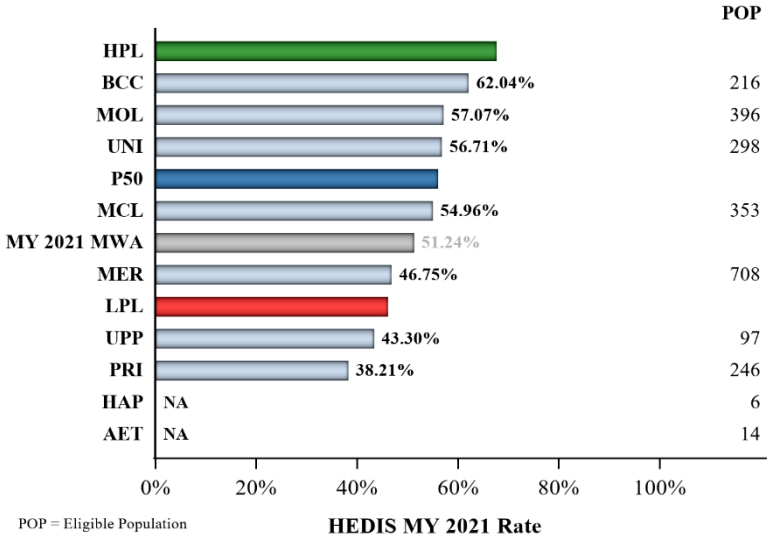
Figure 3–27—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

Figure 3–28—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase
Health Plan Ranking



NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Three MHPs ranked above the 50th percentile, but fell below the HPL. Two MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 23 percentage points.

4. Women—Adult Care

Introduction

The Women—Adult Care domain encompasses the following HEDIS measures:

- *Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years,* and *Total*
- *Cervical Cancer Screening*
- *Breast Cancer Screening*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 4-1 presents the Michigan MWA performance for the measure indicators under the Women—Adult Care domain. The table lists the HEDIS MY 2021 MWA rates and performance levels, a comparison of the HEDIS MY 2020 MWA to the HEDIS MY 2021 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2020 MWA to HEDIS MY 2021 MWA.

Table 4-1—HEDIS MY 2021 MWA Performance Levels and Trend Results for Women—Adult Care

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Chlamydia Screening in Women				
Ages 16 to 20 Years	58.09%	+0.79	2	0
Ages 21 to 24 Years	64.15%	+0.47	2	0
Total	61.00%	**+0.80⁺**	4	0
Cervical Cancer Screening				
Cervical Cancer Screening	58.01%	**-2.52⁺⁺**	0	3
Breast Cancer Screening				
Breast Cancer Screening	52.30%	**-4.01⁺⁺**	0	8

[1] *HEDIS MY 2021 performance levels were based on comparisons of the HEDIS MY 2021 MWA rates to national Medicaid Quality Compass HEDIS MY 2020 MWA benchmarks. HEDIS MY 2021 performance levels represent the following percentile comparisons:*

≤25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] *HEDIS MY 2020 MWA to HEDIS MY 2021 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.*

Green Shading[+] *Indicates that the HEDIS MY 2021 MWA demonstrated a significant improvement from the HEDIS MY 2020 MWA.*

Red Shading[++] *Indicates that the HEDIS MY 2021 MWA demonstrated a significant decline from the HEDIS MY 2020 MWA.*

Table 4-1 shows that for the Women—Adult Care domain, the *Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years*, and *Total* measure indicators were an area of strength. All measure indicators ranked above the 50th percentile with the *Chlamydia Screening in Women—Total* measure indicator demonstrating significant improvement from the HEDIS MY 2020 MWA. Priority and Blue Cross ranked above the 50th percentile for the most measure indicators within the Women—Adult Care domain.

The MWA demonstrated a significant decline for the *Cervical Cancer Screening* and *Breast Cancer Screening* measure indicators. No MHPs ranked above the HPL for any measure indicators. Additionally, Upper Peninsula fell below the LPL for all *Chlamydia Screening for Women* measure indicators, HAP fell below the LPL for the *Cervical Cancer Screening* measure, and Aetna fell below the LPL for both the *Cervical Cancer Screening* and *Breast Cancer Screening* measures. The *Cervical Cancer Screening* and *Breast Cancer Screening* measures had the highest number of MHPs that demonstrated a statistically significant decline in HEDIS MY 2021, as well as an MWA decrease of over 2 percentage points from HEDIS MY 2020. Further, the *Breast Cancer Screening* measure had the most significant MWA decrease of over 4 percentage points from HEDIS MY 2020.

MDHHS should continue to monitor the MHPs' performance on the *Cervical Cancer Screening* and *Breast Cancer Screening* measure indicators to ensure that the MHPs' performance does not continue to decline and work with the MHPs toward establishing resources to increase access to routine cancer screenings. Screening can improve outcomes and early detection, reduce the risk of dying, and lead to a greater range of treatment options and lower health care costs.[4-1] Prolonged delays in screening related to the COVID-19 pandemic may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[4-2]

4-1 National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Sept 14, 2022.

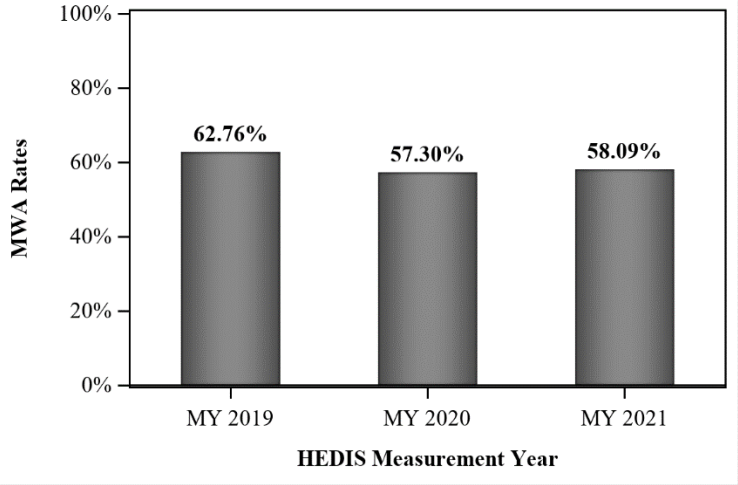
4-2 Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Sept 14, 2022.

Measure-Specific Findings

Chlamydia Screening in Women—Ages 16 to 20 Years

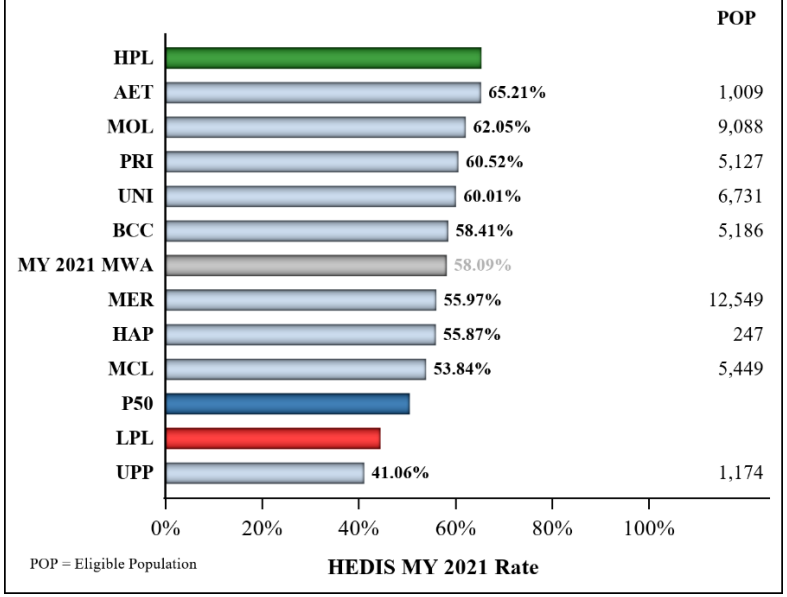
Chlamydia Screening in Women—Ages 16 to 20 Years assesses the percentage of women 16 to 20 years of age who were identified as sexually active and had at least one test for chlamydia during the MY.

Figure 4–1—Chlamydia Screening in Women—Ages 16 to 20 Years
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

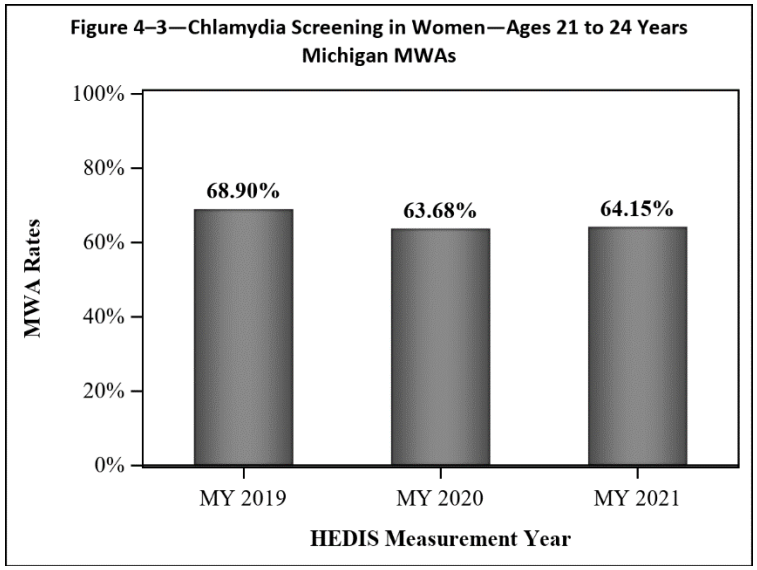
Figure 4–2—Chlamydia Screening in Women—Ages 16 to 20 Years
Health Plan Ranking



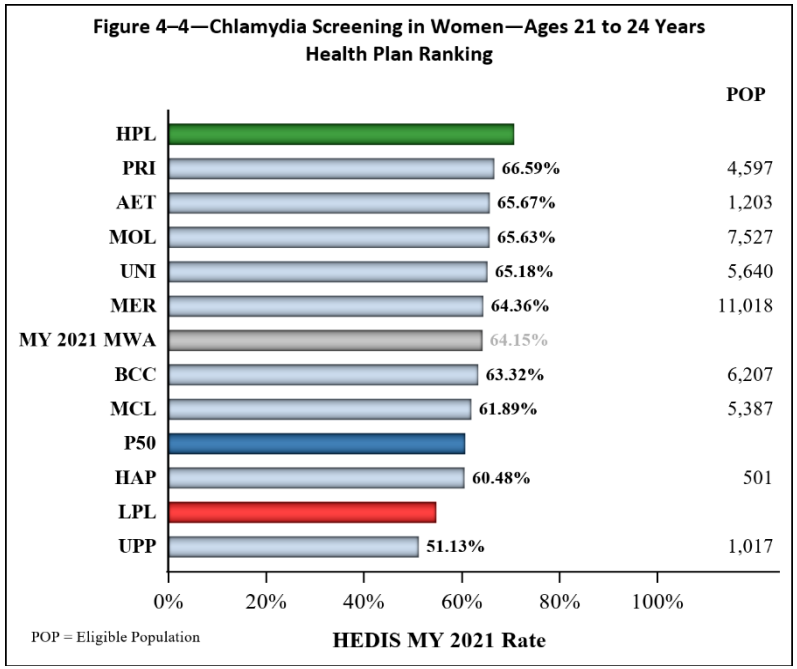
Eight MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 24 percentage points.

Chlamydia Screening in Women—21 to 24 Years

Chlamydia Screening in Women—21 to 24 Years assesses the percentage of women 21 to 24 years of age who were identified as sexually active and had at least one test for chlamydia during the MY.



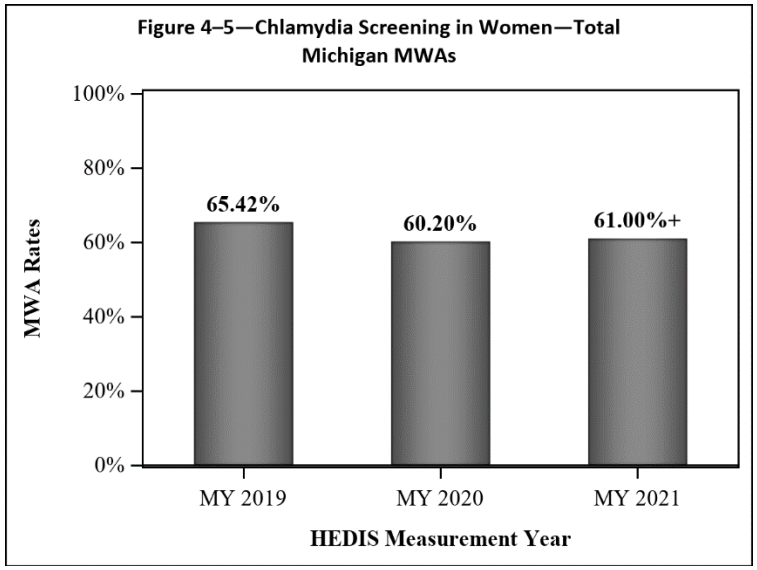
The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.



Seven MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 15 percentage points.

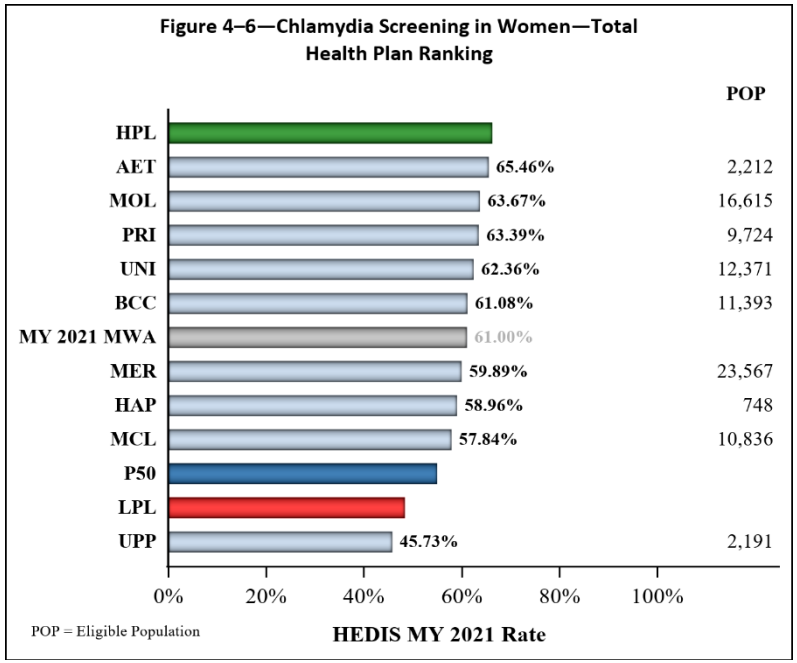
Chlamydia Screening in Women—Total

Chlamydia Screening in Women—Total assesses the percentage of women 16 to 24 years of age who were identified as sexually active and had at least one test for chlamydia during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.



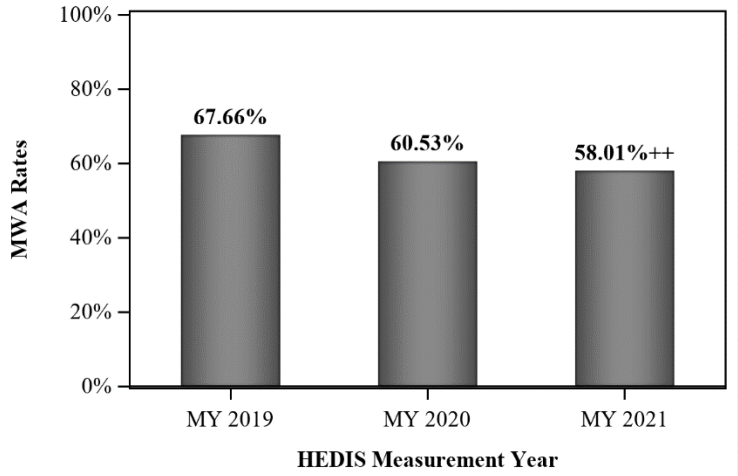
Eight MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 19 percentage points.

Cervical Cancer Screening

Cervical Cancer Screening assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 to 64 years of age who had cervical cytology performed every three years.
- Women 30 to 64 years of age who had cervical cytology/human papillomavirus co-testing performed every five years.

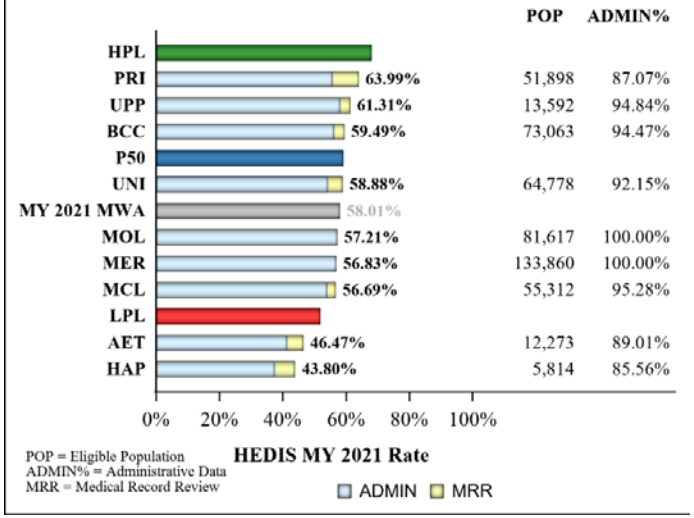
Figure 4–7—Cervical Cancer Screening
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

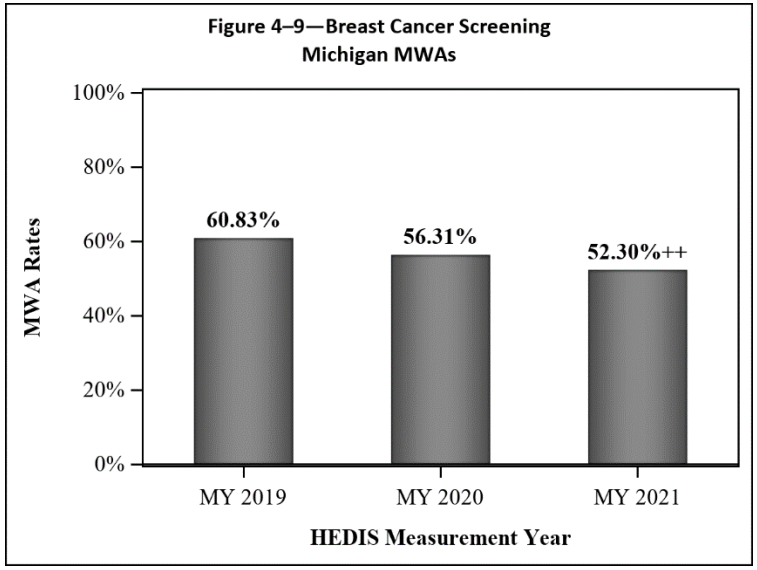
Figure 4–8—Cervical Cancer Screening—Cervical Cancer Screening
Health Plan Ranking



Three MHPs ranked above the 50th percentile, but fell below the HPL. Four MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 20 percentage points.

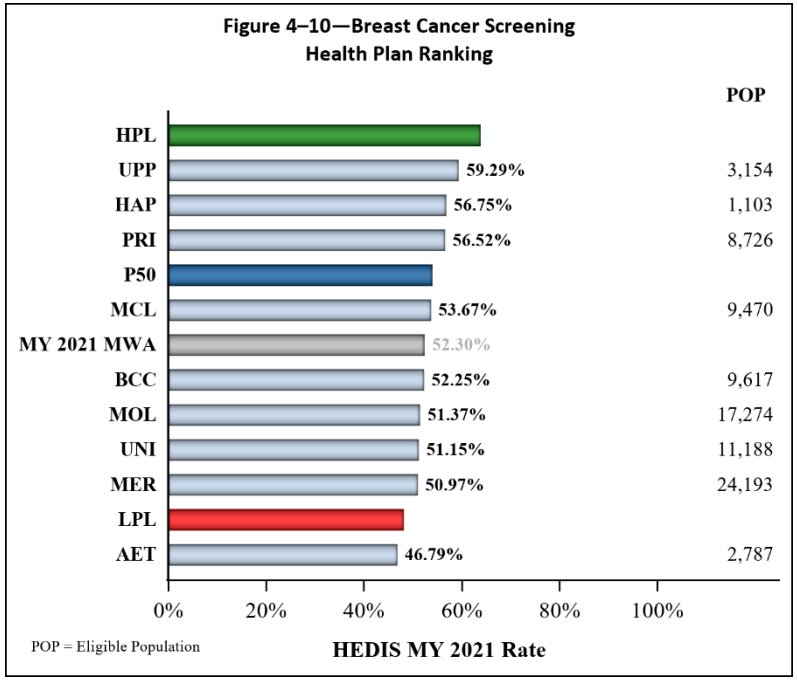
Breast Cancer Screening

Breast Cancer Screening assesses the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer on or after October 1 two years prior to the MY.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.



Three MHPs ranked above the 50th percentile, but fell below the HPL. Five MHPs ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 12 percentage points.

5. Access to Care

Introduction

The Access to Care domain encompasses the following HEDIS measures:

- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65 Years and Older,* and *Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older,* and *Total*
- *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older,* and *Total*
- *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older,* and *Total*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 5-1 presents the Michigan MWA performance for the measure indicators under the Access to Care domain. The table lists the HEDIS MY 2021 MWA rates and performance levels, a comparison of the HEDIS MY 2020 MWA to the HEDIS MY 2021 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2020 MWA to HEDIS MY 2021 MWA.

Table 5-1—HEDIS MY 2021 MWA Performance Levels and Trend Results for Access to Care

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20 to 44 Years	75.38%	**+0.78⁺**	6	2
Ages 45 to 64 Years	84.06%	+0.01	3	2
Ages 65 Years and Older	89.55%	**+0.78⁺**	5	0
Total	78.58%	**+0.36⁺**	4	3

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years	64.93%	**+3.51⁺**	2	0
Ages 18 to 64 Years	45.77%	**+6.08⁺**	6	0
Ages 65 Years and Older	40.94%	+8.07	1	0
Total	51.78%	**+1.63⁺**	3	0
Appropriate Testing for Pharyngitis				
Ages 3 to 17 Years	69.04%	**-6.30⁺⁺**	1	6
Ages 18 to 64 Years	53.55%	**-4.06⁺⁺**	0	5
Ages 65 Years and Older	14.78%	-10.22	0	0
Total	60.58%	**-7.98⁺⁺**	1	7
Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	94.11%	**+2.81⁺**	9	0
Ages 18 to 64 Years	82.21%	**+4.03⁺**	7	0
Ages 65 Years and Older	75.51%	+4.18	1	0
Total	89.59%	**+2.31⁺**	8	0

[1] 2021 performance levels were based on comparisons of the HEDIS MY 2021 MWA rates to national Medicaid Quality Compass HEDIS MY 2020 MWA benchmarks. 2021 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] HEDIS MY 2020 MWA to HEDIS MY 2021 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading⁺ *Indicates that the HEDIS MY 2021 MWA demonstrated a significant improvement from the HEDIS MY 2020 MWA.*

Red Shading⁺⁺ *Indicates that the HEDIS MY 2021 MWA demonstrated a significant decline from the HEDIS MY 2020 MWA.*

Table 5-1 shows that for the Access to Care domain, the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 65 Years and Older*, and *Total*; *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years* and *Ages 18 to 64 Years*; and *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*, *Ages 18 to 64 Years*, and *Total* measure indicators were an area of strength. All measure indicators ranked above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2020 MWA. Upper Peninsula and Meridian ranked above the 50th percentile for the most measure indicators within the Access to Care domain. Upper Peninsula ranked above the HPL for *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older*, and Aetna and Priority ranked above the HPL for *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years*.

The MWA demonstrated a significant decline for the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years*, *Ages 18 to 64 Years*, and *Total* measure indicators. *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years*, and *Total* had the highest number of MHPs that demonstrated a statistically significant decline in HEDIS MY 2021 and MWA decrease from HEDIS MY 2020. Additionally, the MWA ranked below the 25th percentile for the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years*, and *Total* measure indicators.

MDHHS should continue to monitor the MHPs' performance for the *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years*, and *Total* measure indicators to ensure that the MHPs' performance does not continue to decline. Proper testing and treatment of pharyngitis prevents the spread of sickness while reducing unnecessary use of antibiotics.[5-1]

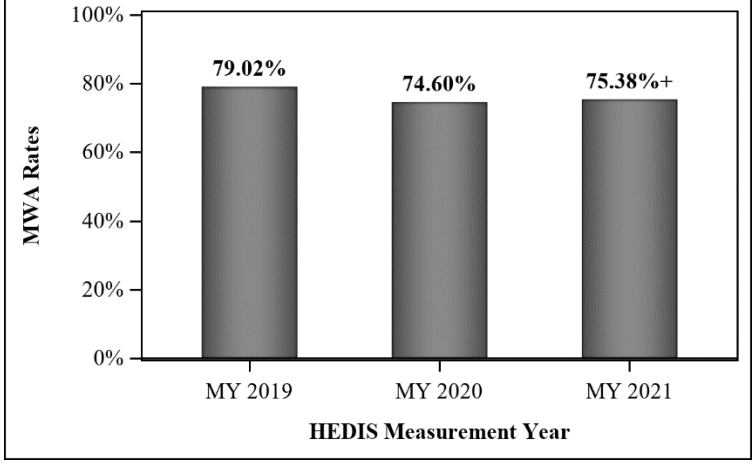
[5-1] National Committee for Quality Assurance. Appropriate Testing for Children with Pharyngitis. Available at: https://www.ncqa.org/hedis/measures/appropriate-testing-for-children-with-pharyngitis/. Accessed on: Sept 14, 2022.

Measure-Specific Findings

Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years

Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years assesses the percentage of members 20 to 44 years of age who had an ambulatory or preventive care visit during the MY.

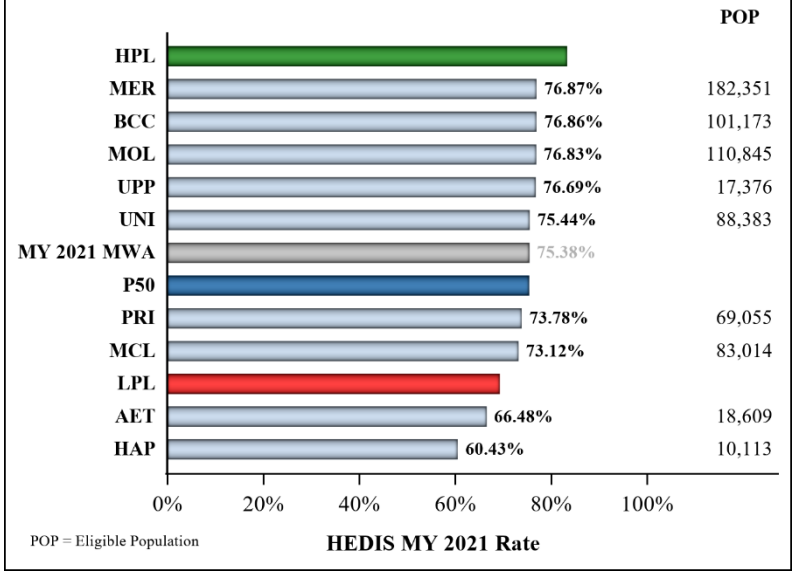
Figure 5–1—Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 5–2—Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years
Health Plan Ranking

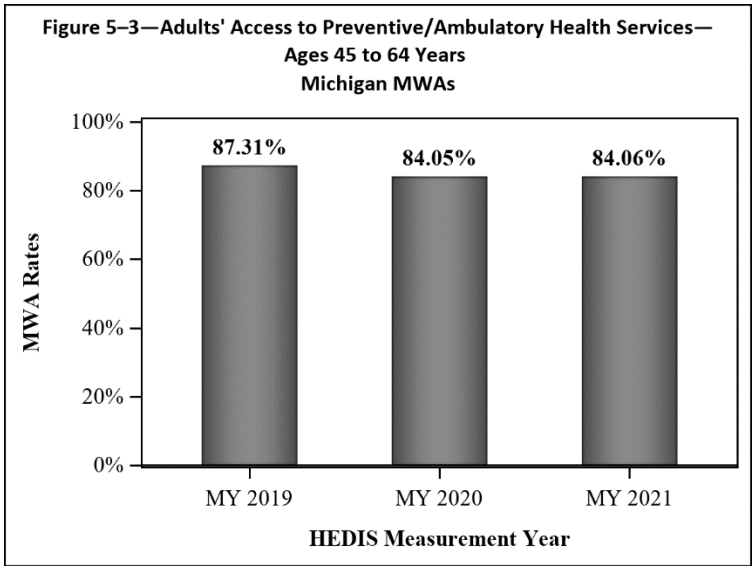


Five MHPs and the MWA ranked above 50th percentile, but fell below the HPL. Two MHPs ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 16 percentage points.

Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years

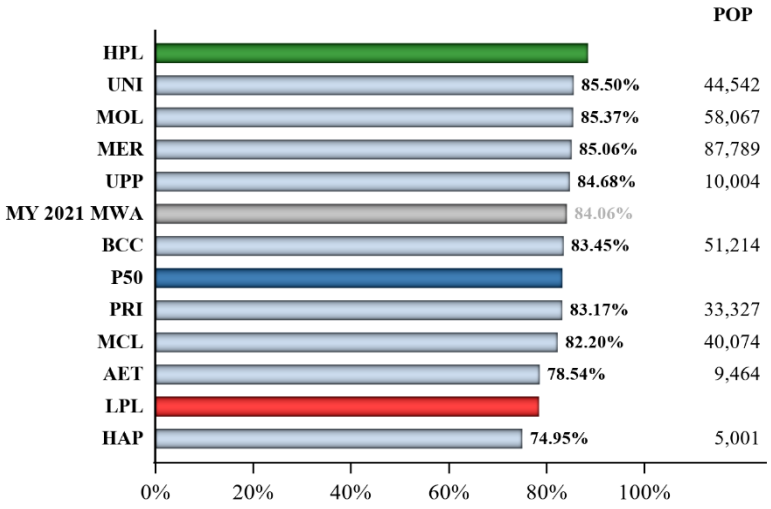
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years assesses the percentage of members 45 to 64 years of age who had an ambulatory or preventive care visit during the MY.

Figure 5–3—Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 5–4—Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years
Health Plan Ranking

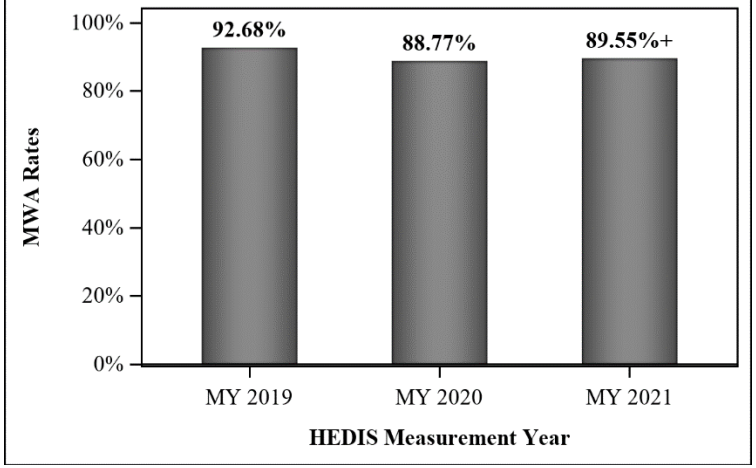


Five MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Three MHPs ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 10 percentage points.

Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older

Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who had an ambulatory or preventive care visit during the MY.

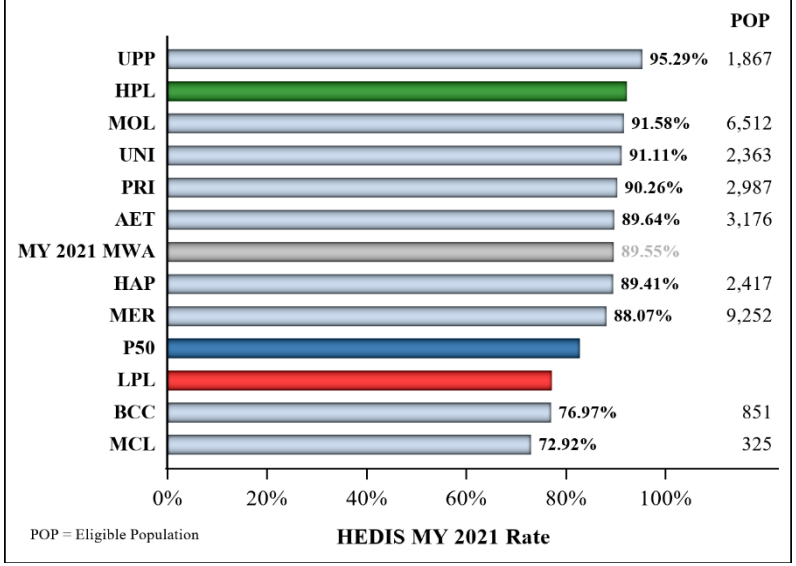
Figure 5–5—Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

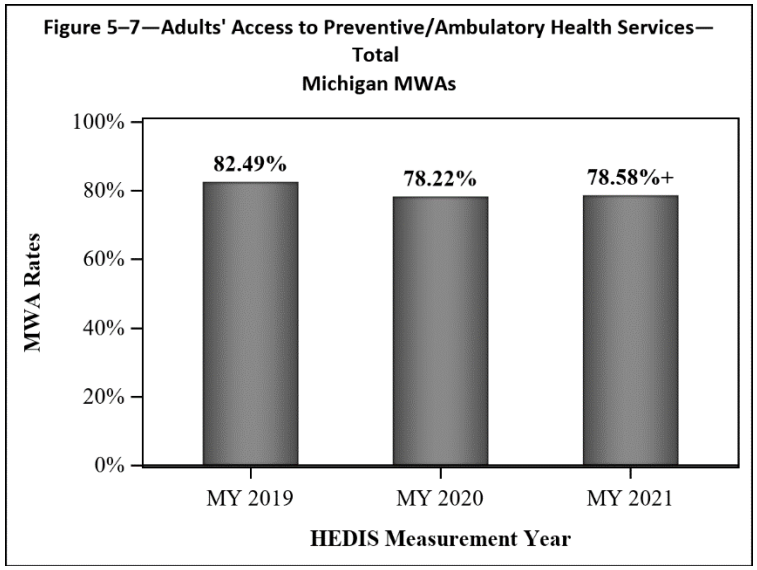
Figure 5–6—Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older
Health Plan Ranking



One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs fell below the LPL. MHP performance varied by over 22 percentage points.

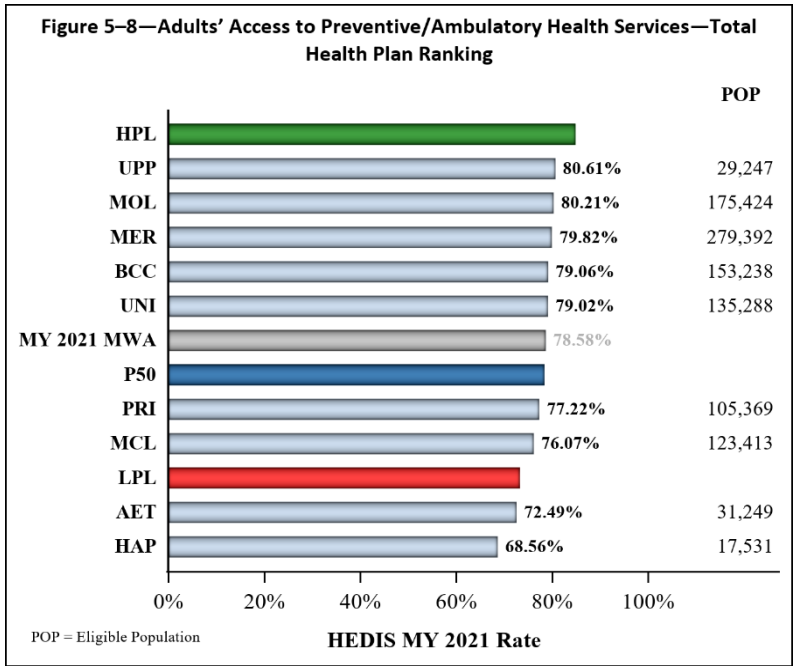
Adults' Access to Preventive/Ambulatory Health Services—Total

Adults' Access to Preventive/Ambulatory Health Services—Total assesses the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

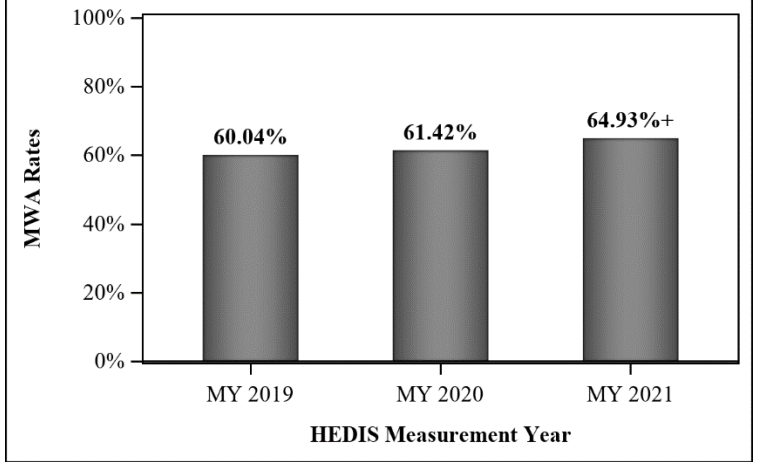


Five MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 12 percentage points.

Avoidance of Antibiotic Treatment in for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years assesses the percentage of members 3 months to 17 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

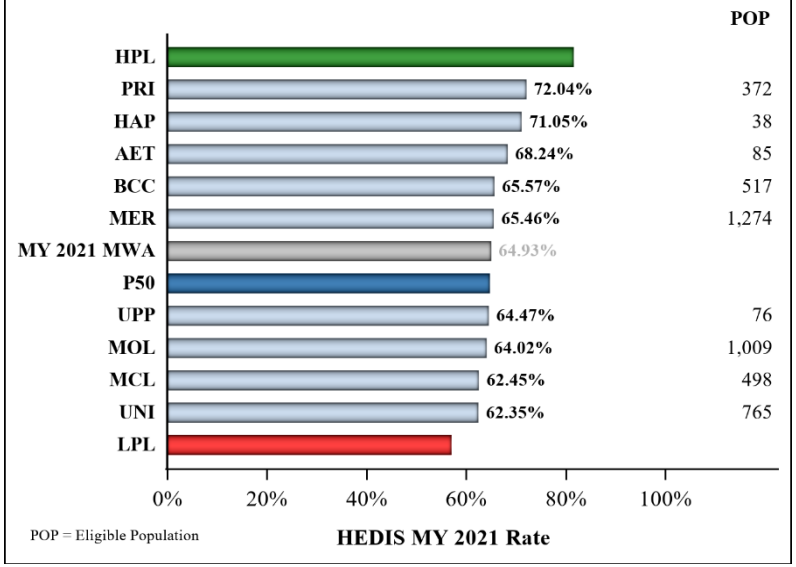
Figure 5–9—Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 5–10—Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years
Health Plan Ranking

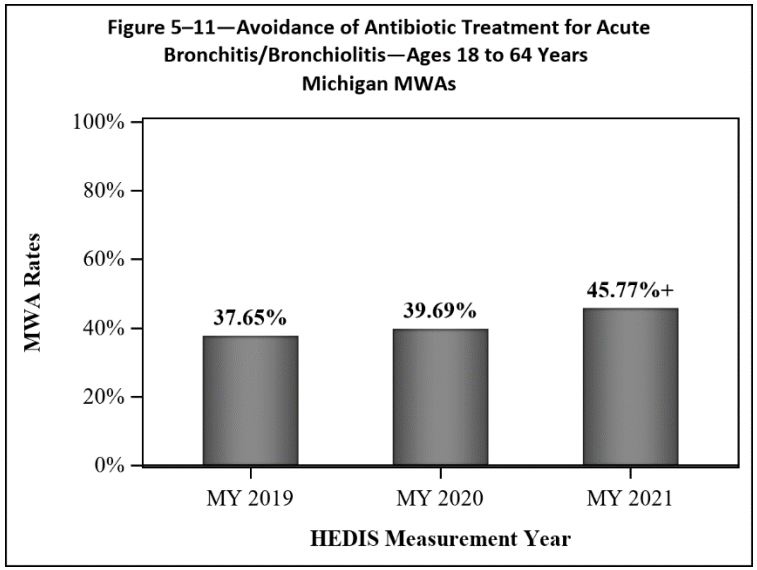


Five MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Four MHPs ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 9 percentage points.

Avoidance of Antibiotic Treatment in for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

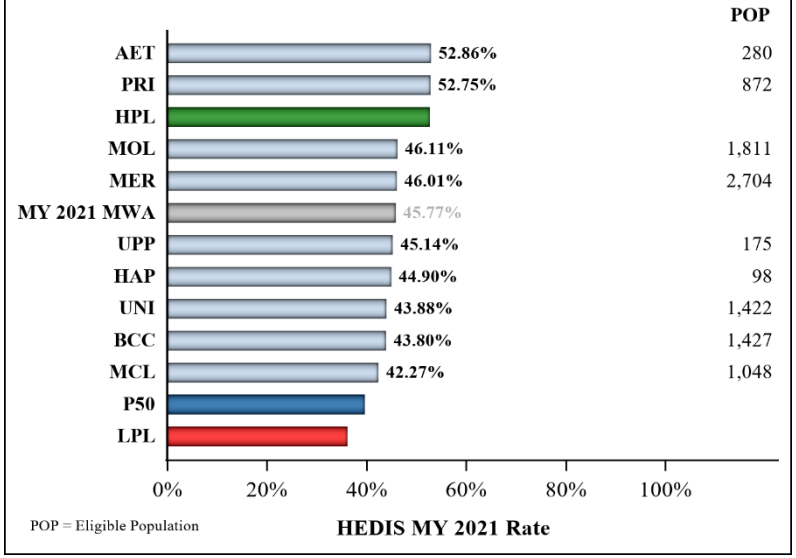
Figure 5–11—Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 5–12—Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years
Health Plan Ranking

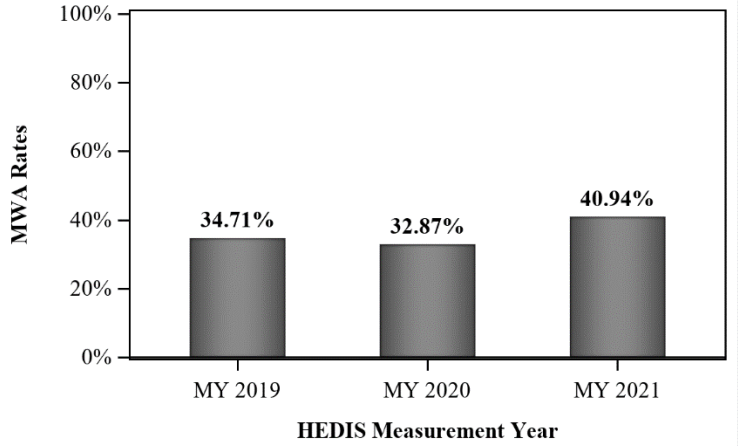


Two MHPs ranked above the HPL. Seven MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. MHP performance varied by over 10 percentage points.

Avoidance of Antibiotic Treatment in for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older

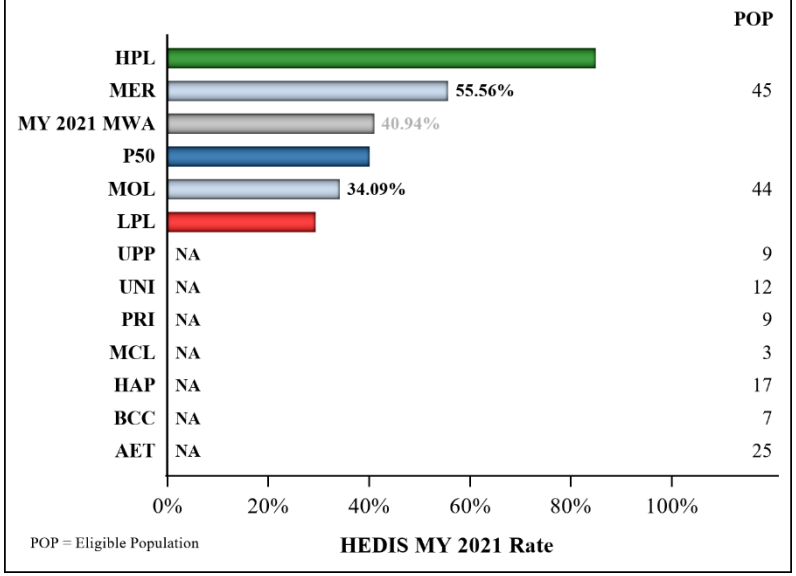
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older assesses the percentage of members 65 years of age and older with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Figure 5–13—Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 5–14—Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years And Older Health Plan Ranking



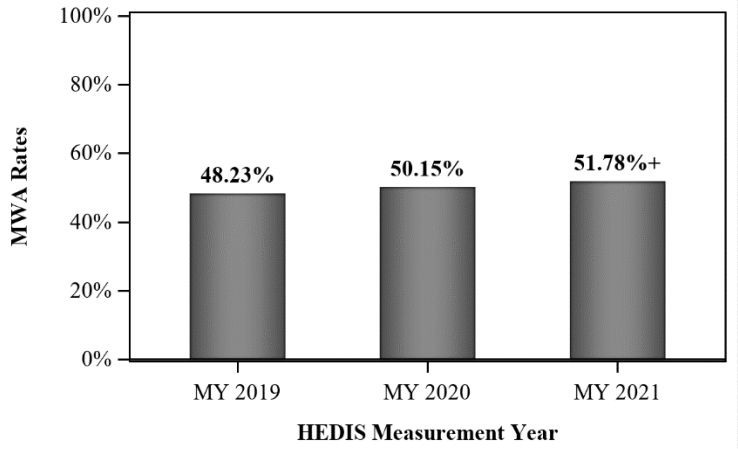
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MHP and the MWA ranked above the 50th percentile, fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 21 percentage points.

Avoidance of Antibiotic Treatment in for Acute Bronchitis/Bronchiolitis—Total

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total assesses the percentage of members 3 months of age or older with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

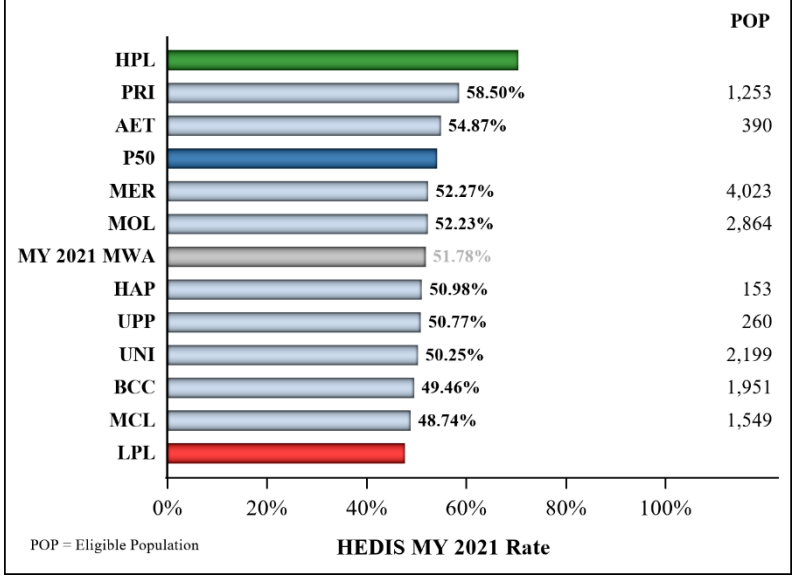
Figure 5–15—Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

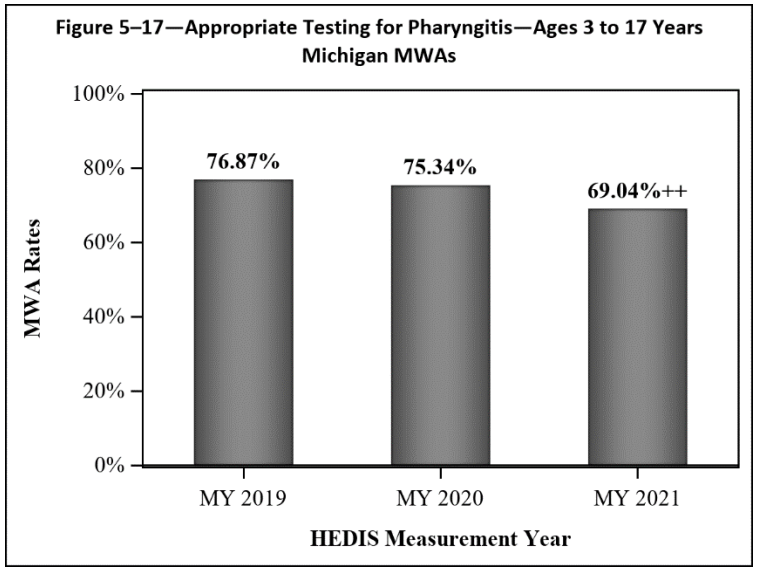
Figure 5–16—Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total
Health Plan Ranking



Two MHPs ranked above 50th percentile, but fell below the HPL. Seven MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 9 percentage points.

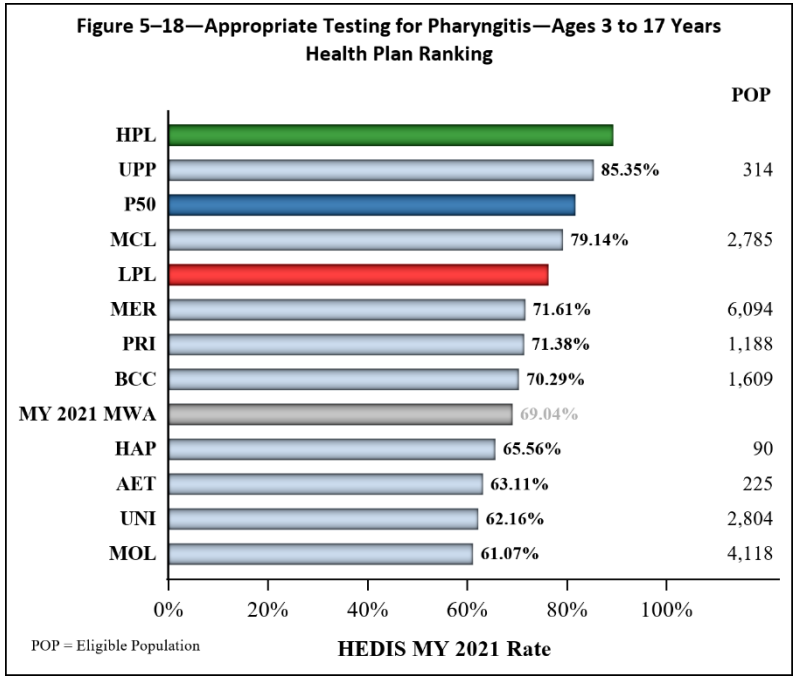
Appropriate Testing for Pharyngitis—Ages 3 Months to 17 Years

Appropriate Testing for Pharyngitis—Ages 3 Months to 17 Years assesses the percentage of members 3 months to 17 years of age who were diagnosed with pharyngitis, were dispensed an antibiotic, and received a group A streptococcus test for the episode.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020 MWA.

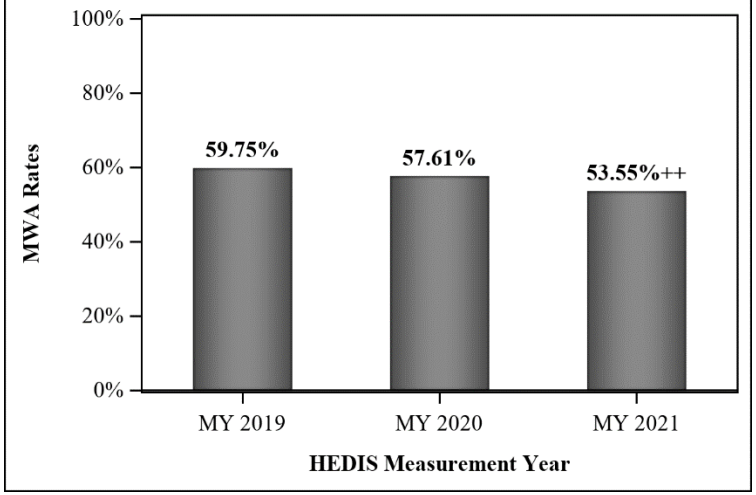


One MHP ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. Seven MHPs fell below the LPL. MHP performance varied by over 24 percentage points.

Appropriate Testing for Pharyngitis—Ages 18 to 64 Years

Appropriate Testing for Pharyngitis—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age who were diagnosed with pharyngitis, were dispensed an antibiotic, and received a group A streptococcus test for the episode.

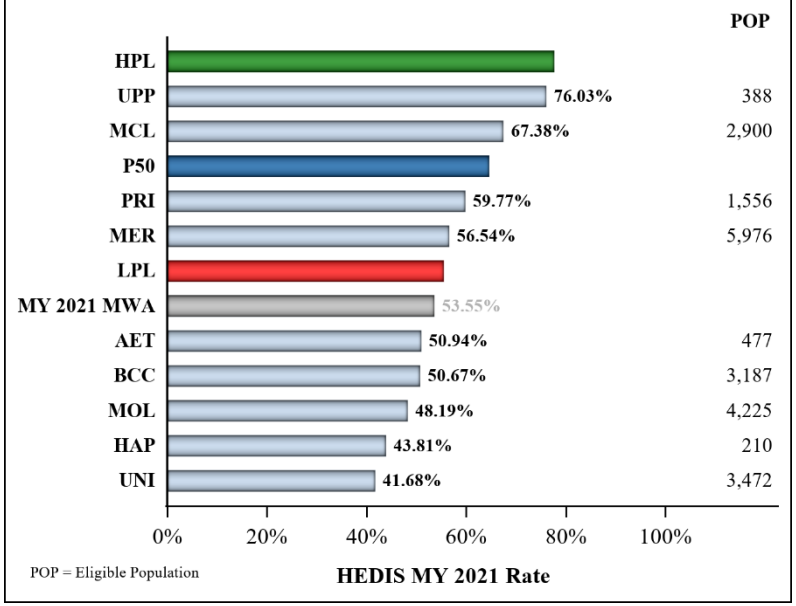
Figure 5–19—Appropriate Testing for Pharyngitis—Ages 18 to 64 Years
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020 MWA.

Figure 5–20—Appropriate Testing for Pharyngitis—Ages 18 to 64 Years
Health Plan Ranking

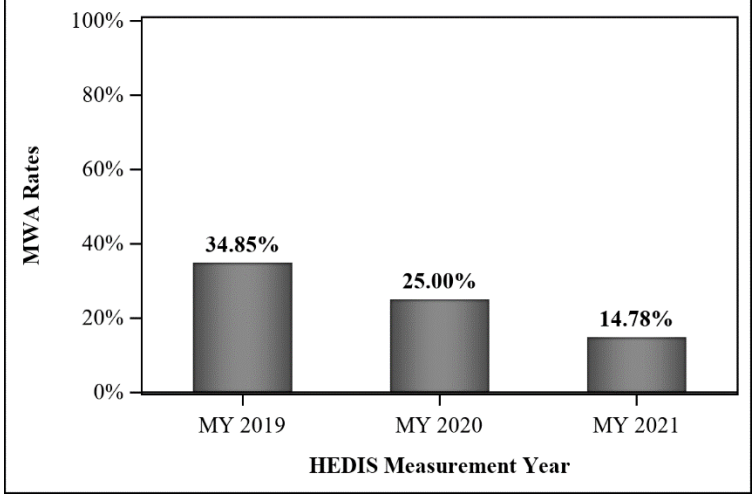


Two MHPs ranked above 50th percentile, but fell below the HPL. Two MHPs ranked above the LPL, but fell below the 50th percentile. Five MHPs and the MWA fell below the LPL. MHP performance varied by over 34 percentage points.

Appropriate Testing for Pharyngitis—Ages 65 Years and Older

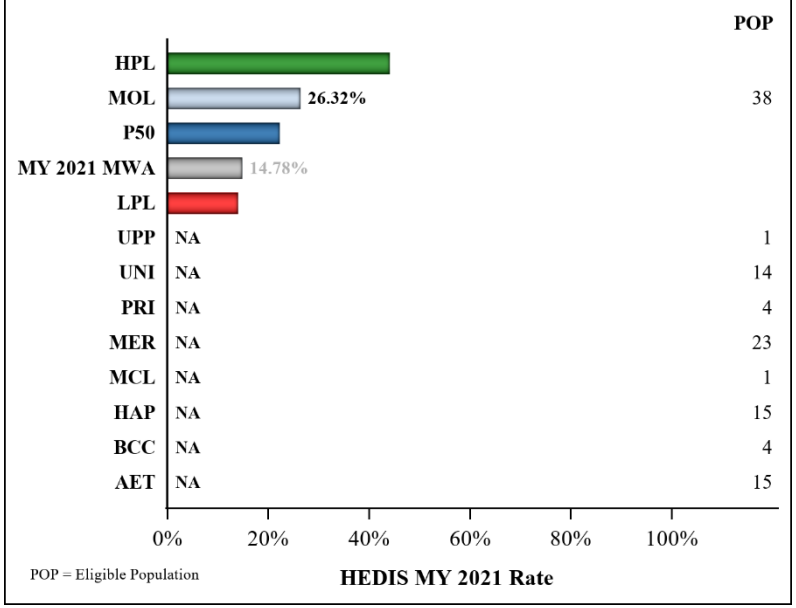
Appropriate Testing for Pharyngitis—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who were diagnosed with pharyngitis, were dispensed an antibiotic, and received a group A streptococcus test for the episode.

Figure 5–21—Appropriate Testing for Pharyngitis—Ages 65 Years and Older Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 5–22—Appropriate Testing for Pharyngitis—Ages 65 Years And Older Health Plan Ranking

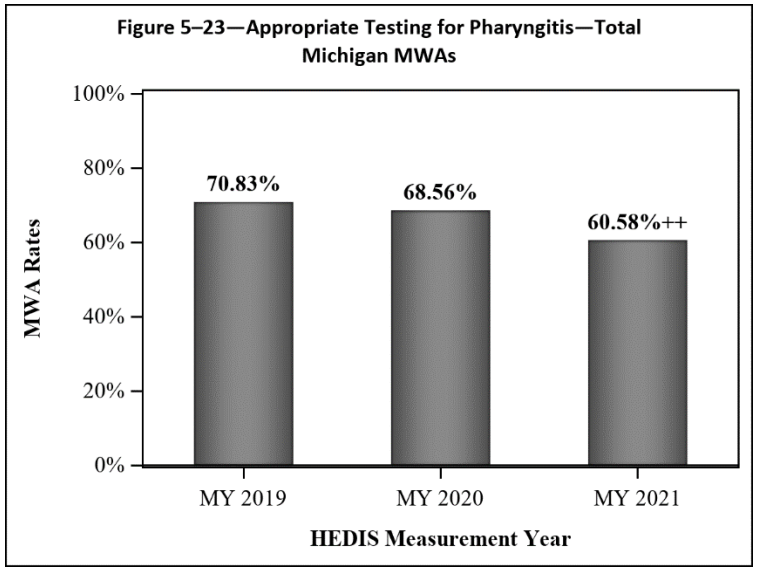


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MHP ranked above the 50th percentile, but fell below the HPL. The MWA ranked above the LPL, but fell below the 50th percentile.

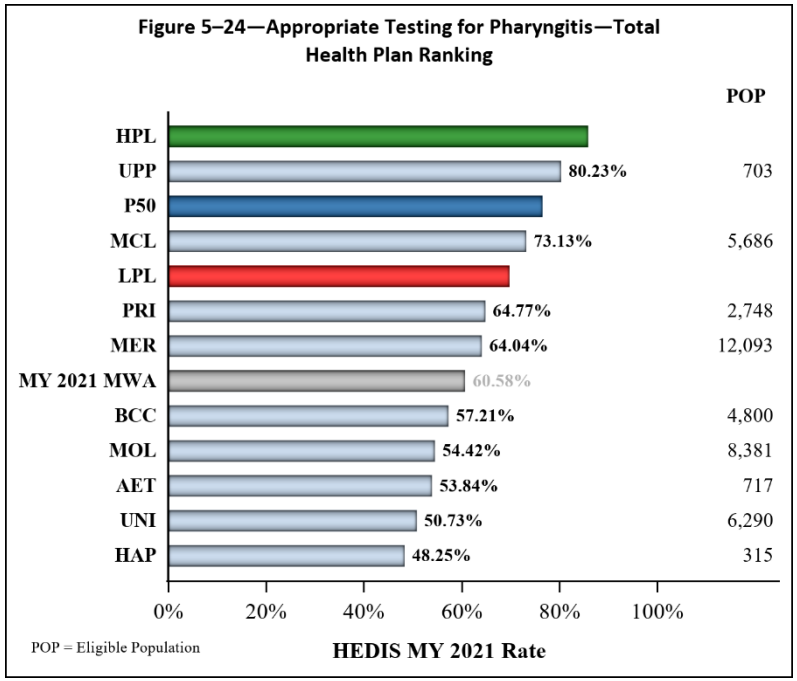
Appropriate Testing for Pharyngitis—Total

Appropriate Testing for Pharyngitis—Total assesses the percentage of members who were diagnosed with pharyngitis, were dispensed an antibiotic, and received a group A streptococcus test for the episode.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

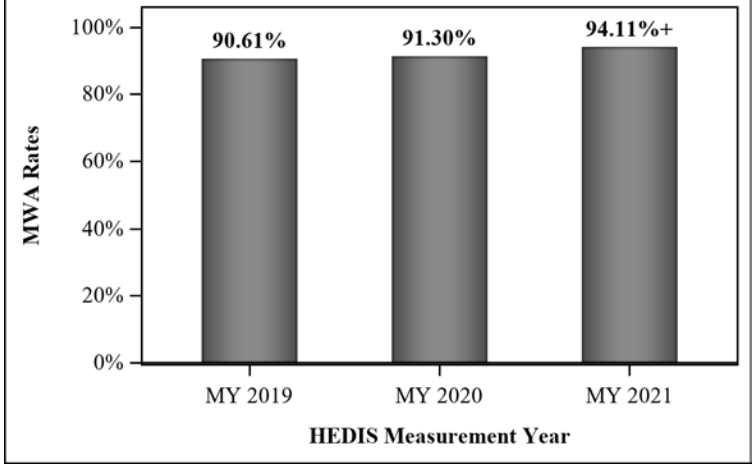


One MHP ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. Seven MHPs and the MWA fell below the LPL. MHP performance varied by over 31 percentage points.

Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years

Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years assesses the percentage of members 3 months to 17 years of age with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event.

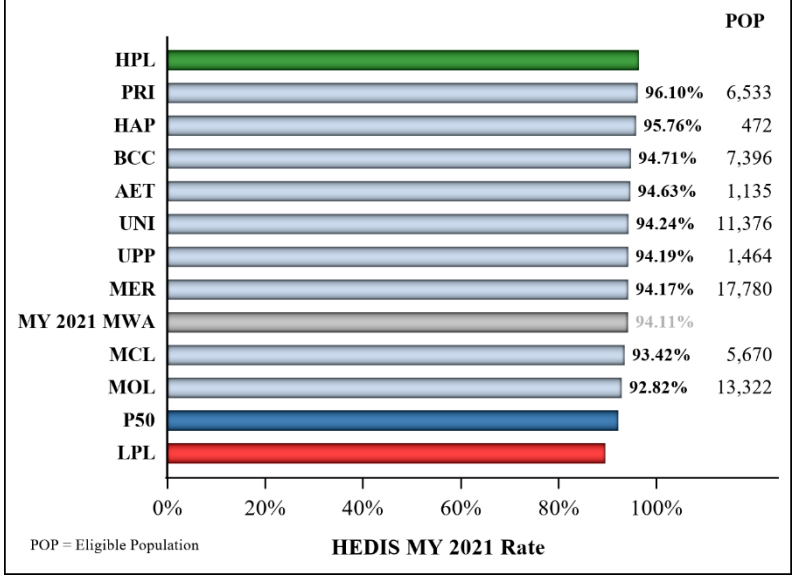
Figure 5–25—Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 5–26—Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years
Health Plan Ranking

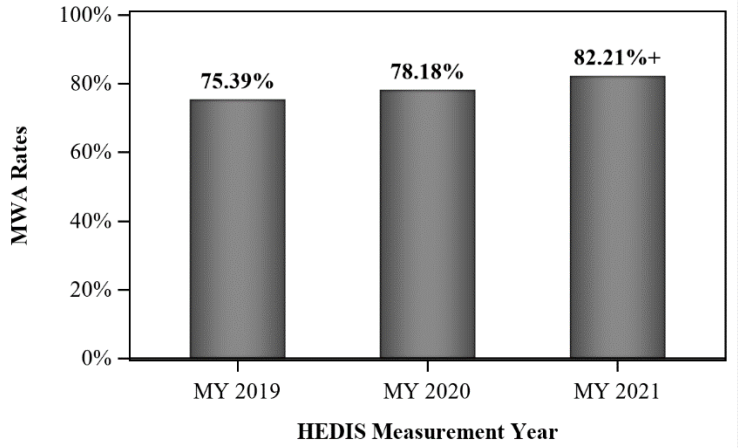


All MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. MHP performance varied by over 3 percentage points.

Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years

Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event.

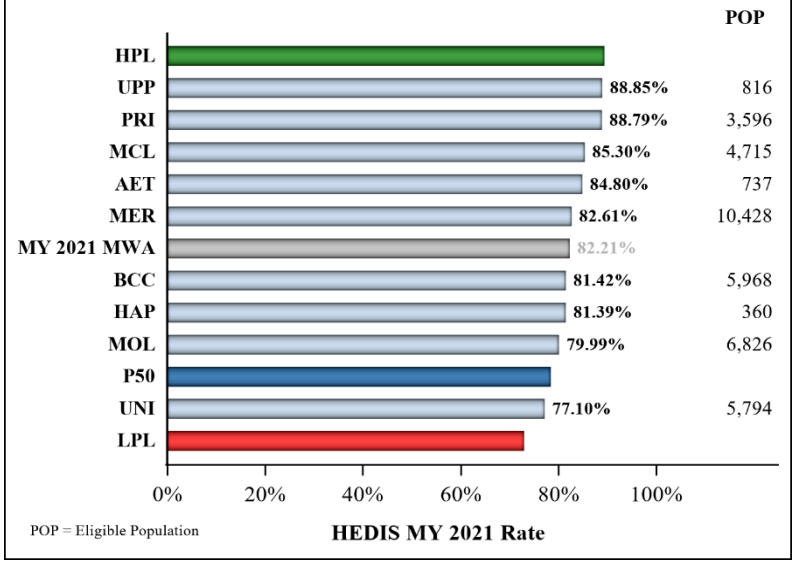
Figure 5–27—Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 5–28—Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years
Health Plan Ranking

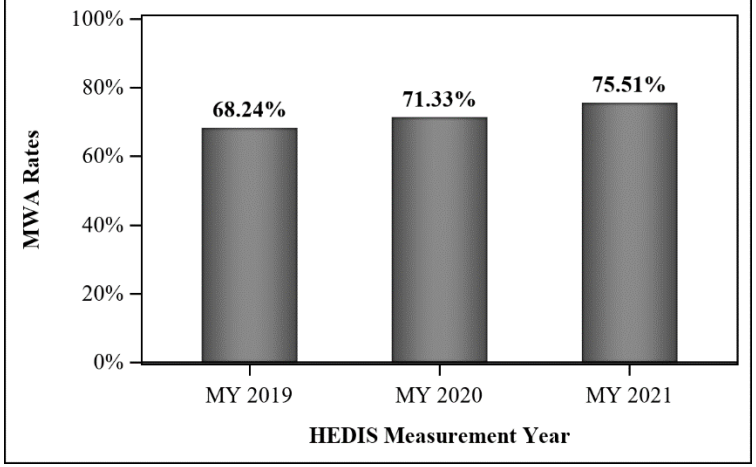


Eight MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 11 percentage points.

Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older

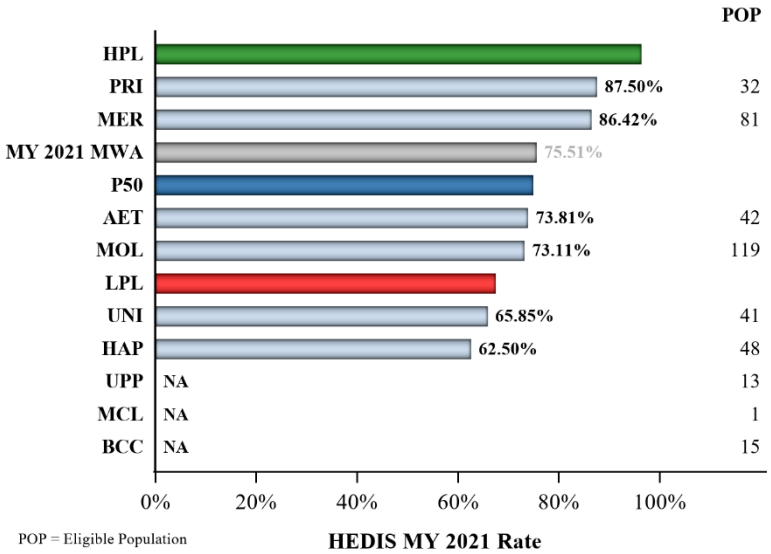
Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older assesses the percentage of members 65 years of age and older with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event.

Figure 5–29—Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 5–30—Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years And Older
Health Plan Ranking



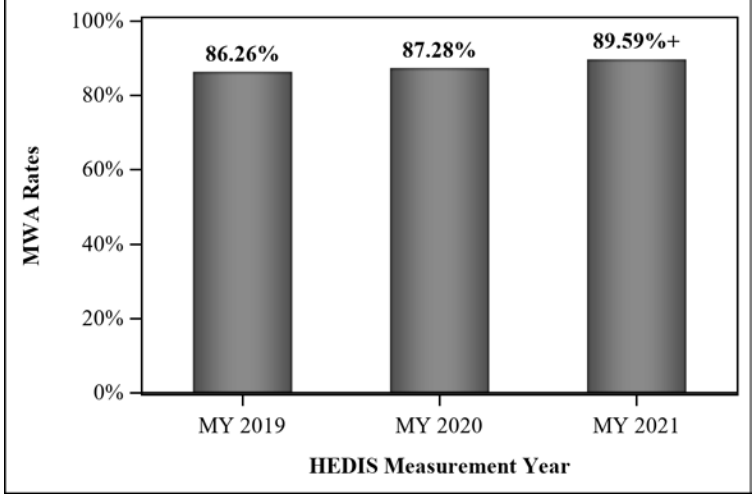
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Two MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 25 percentage points.

Appropriate Treatment for Upper Respiratory Infection—Total

Appropriate Treatment for Upper Respiratory Infection—Total assesses the percentage of members with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event.

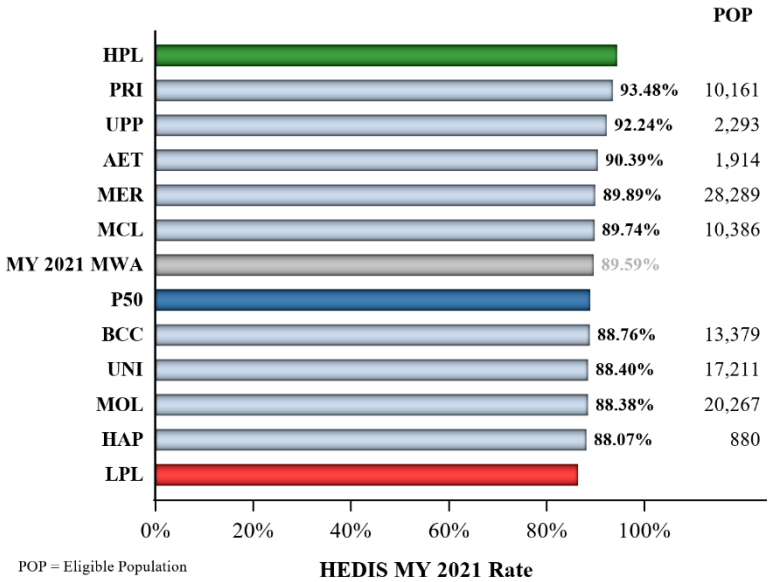
Figure 5–31—Appropriate Treatment for Upper Respiratory Infection—Total
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 5–32—Appropriate Treatment for Upper Respiratory Infection—Total
Health Plan Ranking



Five MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Four MHPs ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 5 percentage points.

6. Obesity

Introduction

The Obesity domain encompasses the following HEDIS measures:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 6-1 presents the Michigan MWA performance for the measure indicators under the Obesity domain. The table lists the HEDIS MY 2021 MWA rates and performance levels, a comparison of the HEDIS MY 2020 MWA to the HEDIS MY 2021 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2020 MWA to HEDIS MY 2021 MWA.

Table 6-1—HEDIS MY 2021 MWA Performance Levels and Trend Results for Obesity

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	76.87%	**-1.66^{++}**	0	0
Counseling for Nutrition—Total	70.12%	**+0.61^{+}**	1	0
Counseling for Physical Activity—Total	68.90%	**+1.30^{+}**	1	0

[1] HEDIS MY 2021 performance levels were based on comparisons of the HEDIS MY 2021 MWA rates to national Medicaid Quality Compass HEDIS MY 2020 MWA benchmarks. HEDIS MY 2021 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] *HEDIS MY 2020 MWA to HEDIS MY 2021 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.*

Green Shading[+] *Indicates that the HEDIS MY 2021 MWA demonstrated a significant improvement from the HEDIS MY 2020 MWA.*

Red Shading[++] *Indicates that the HEDIS MY 2021 MWA demonstrated a significant decline from the HEDIS MY 2020 MWA.*

Table 6-1 shows that for the Obesity domain, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* were an area of strength. Both measure indicators ranked above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2020 MWA. Additionally, Upper Peninsula, Blue Cross, Priority, UnitedHealthcare, Aetna, and HAP ranked above the 50th percentile for the most measure indicators within the Obesity domain. Priority ranked above the HPL for all *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, and Upper Peninsula ranked above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator.

The MWA demonstrated a significant decline for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator. McLaren ranked below the LPL for all three measure indicators.

MDHHS should continue to monitor the MHPs' performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator and work with the MHPs and providers to strategize the best way to utilize every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, MDHHS should continue to monitor McLaren's performance for this measure to ensure the MHP performance does not continue to decline and encourage higher performing MHPs to share and discuss best practices. Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases. Obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.[6-1]

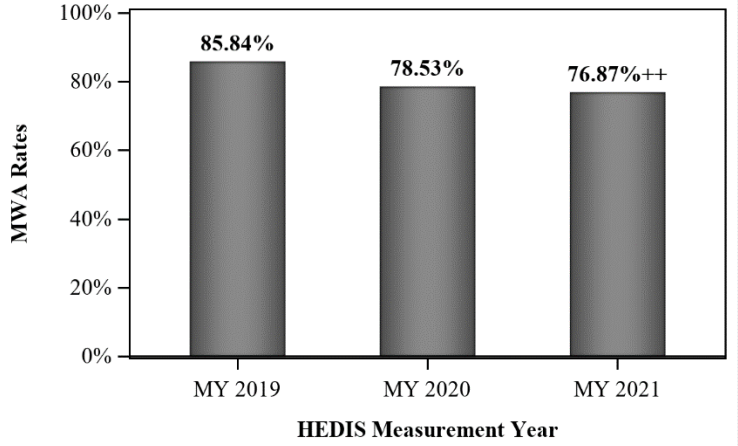
[6-1] National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. Available at: https://www.ncqa.org/hedis/measures/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents/. Accessed on: Sept 14, 2022.

Measure-Specific Findings

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile documentation during the MY.

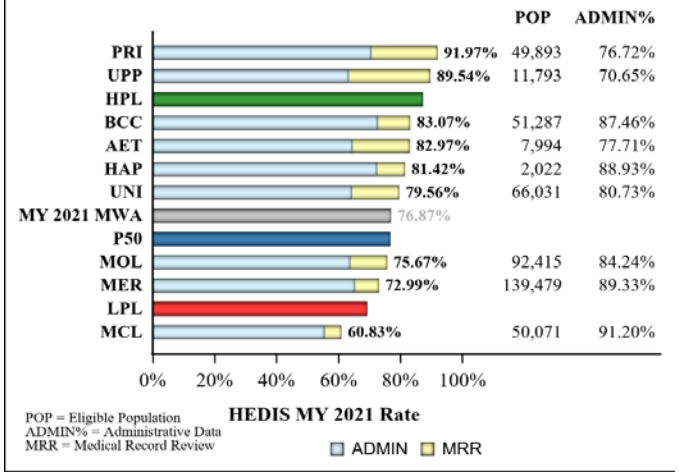
Figure 6–1—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

Figure 6–2—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total
Health Plan Ranking

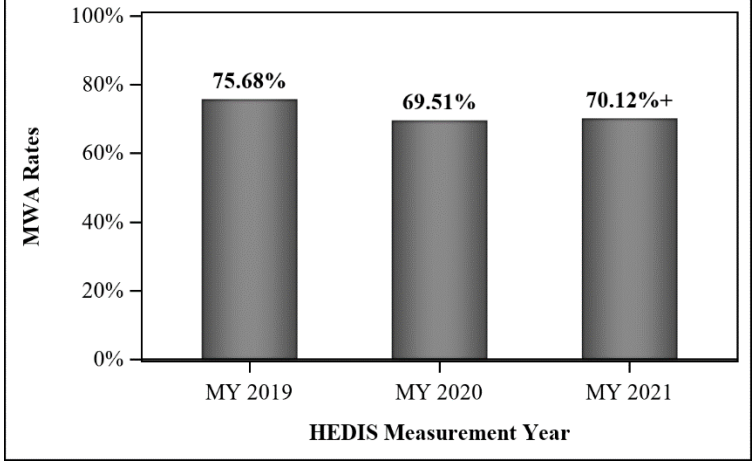


Two MHPs ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 31 percentage points.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of counseling for nutrition during the MY.

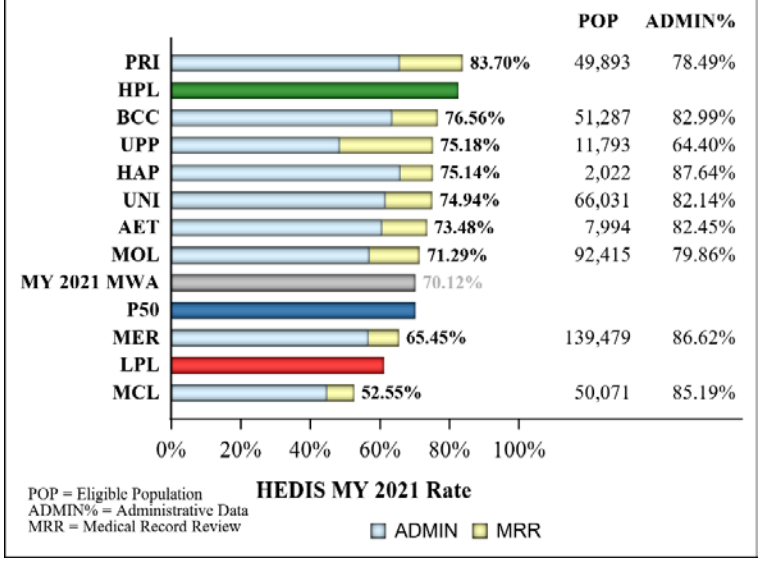
Figure 6–3—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 6–4—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total Health Plan Ranking

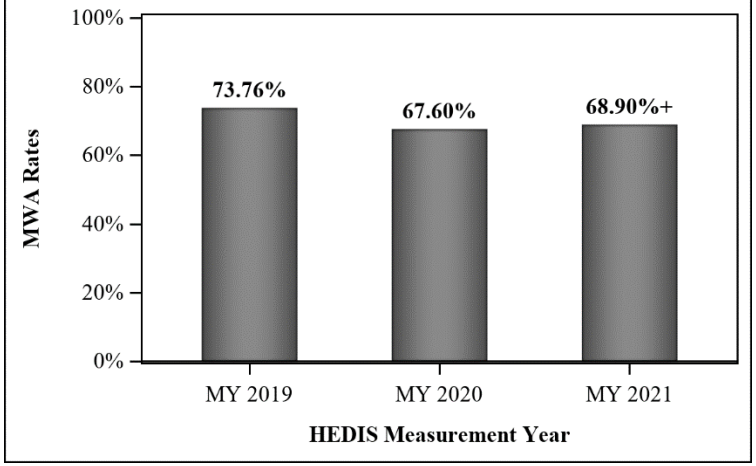


One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 31 percentage points.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of counseling for physical activity during the MY.

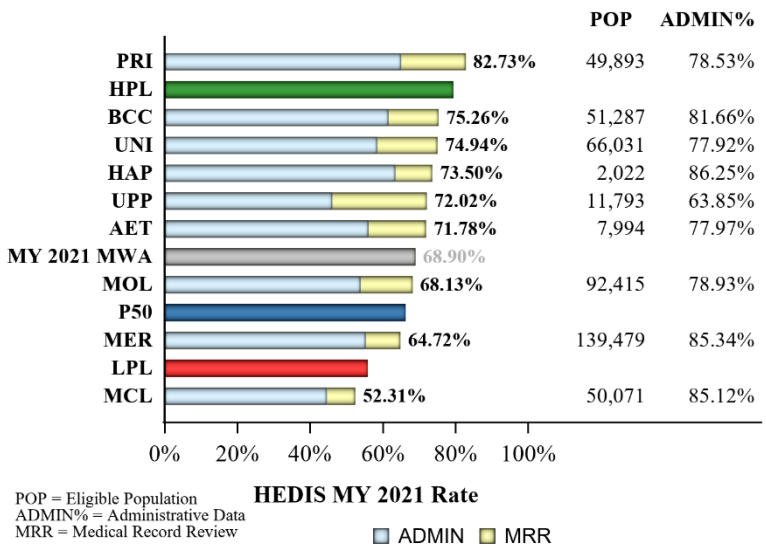
Figure 6–5—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 6–6—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total Health Plan Ranking



One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 30 percentage points.

7. Pregnancy Care

Introduction

The Pregnancy Care domain encompasses the following HEDIS measure:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 7-1 presents the Michigan MWA performance for the measure indicators under the Pregnancy Care domain.

Table 7-1—HEDIS MY 2021 MWA Performance Levels and Trend Results for Pregnancy Care

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	79.45%	-0.09	2	1
Postpartum Care	73.36%	**+3.23**[+]	2	0

[1] HEDIS MY 2021 performance levels were based on comparisons of the HEDIS MY 2021 MWA rates to national Medicaid Quality Compass HEDIS MY 2020 MWA benchmarks. HEDIS MY 2021 performance levels represent the following percentile comparisons:

≤25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] HEDIS MY 2020 MWA to HEDIS MY 2021 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading[+] *Indicates that the HEDIS MY 2021 MWA demonstrated a significant improvement from the HEDIS MY 2020 MWA.*

Table 7-1 shows that for the Pregnancy Care domain, *Prenatal and Postpartum Care—Postpartum Care* was an area of strength, as the measure indicator demonstrated significant improvement from the HEDIS MY 2020 MWA. Additionally, Upper Peninsula and Blue Cross ranked above the 50th percentile for the most measure indicators within the Pregnancy Care domain. Upper Peninsula ranked above the HPL for both *Prenatal and Postpartum Care* measure indicators.

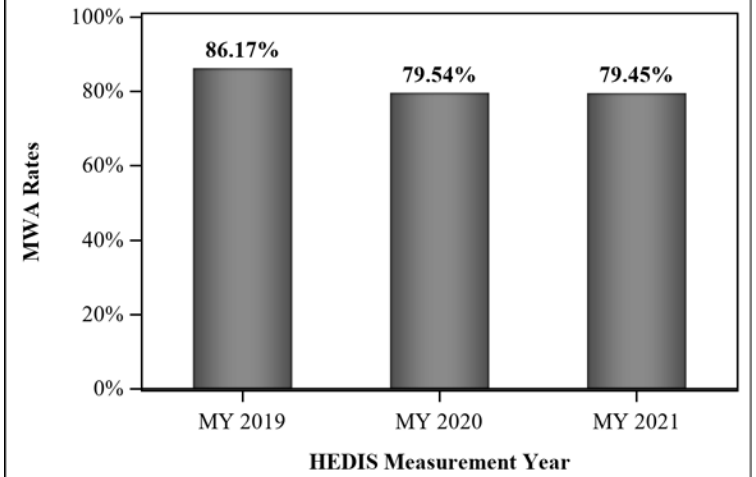
Molina, Meridian, McLaren, Aetna, HAP all fell below the LPL for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and Molina, McLaren, HAP, and Aetna all fell below the LPL for *Prenatal and Postpartum Care—Postpartum Care*. MDHHS is encouraged to work with the higher performing MHPs to identify best practices for ensuring women's access to prenatal and postpartum care, which can then be shared with the lower performing MHPs to improve overall access.

Measure-Specific Findings

Prenatal and Postpartum Care—Timeliness of Prenatal Care

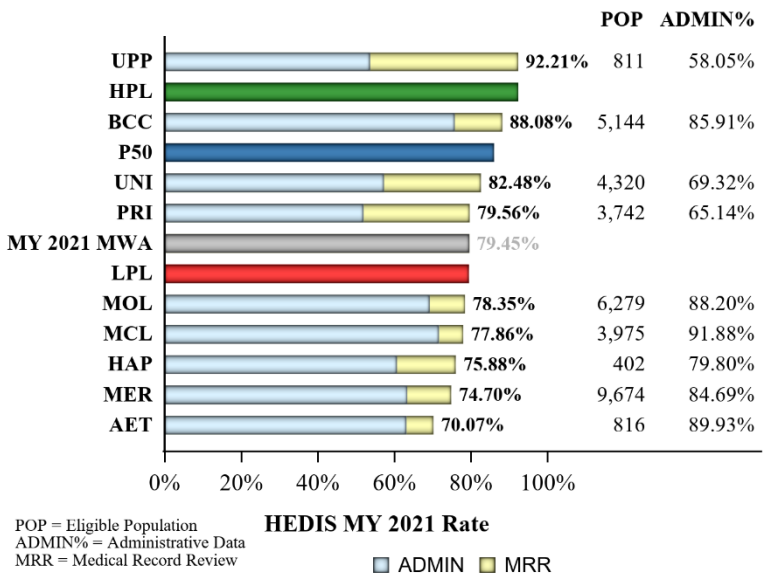
Prenatal and Postpartum Care—Timeliness of Prenatal Care assesses the percentage of deliveries of live births that received a prenatal care visit as a member of the MHP in the first trimester or within 42 days of enrollment in the MHP.

Figure 7–1—Prenatal and Postpartum Care—Timeliness of Prenatal Care
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 7–2—Prenatal and Postpartum Care—Timeliness of Prenatal Care
Health Plan Ranking



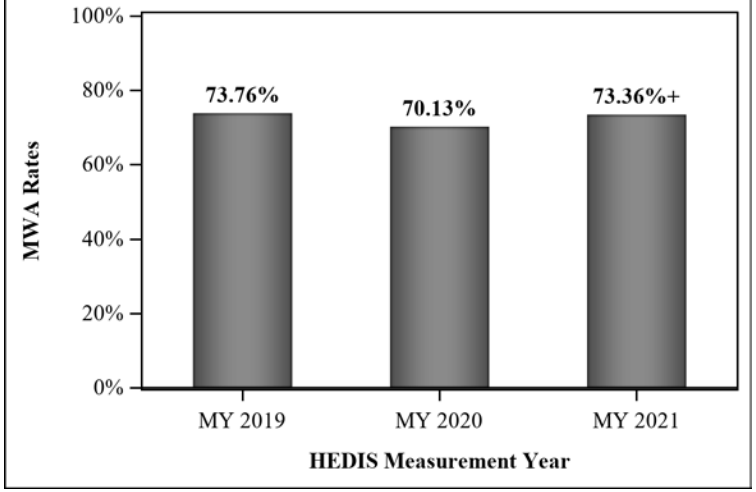
POP = Eligible Population
ADMIN% = Administrative Data
MRR = Medical Record Review

One MHP ranked above the HPL. One MHP ranked above the 50th percentile, but fell below the HPL. Two MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. Five MHPs fell below the LPL. MHP performance varied by over 22 percentage points.

Prenatal and Postpartum Care—Postpartum Care

Prenatal and Postpartum Care—Postpartum Care assesses the percentage of deliveries of live births that had a postpartum visit on or between 21 and 56 days after delivery.

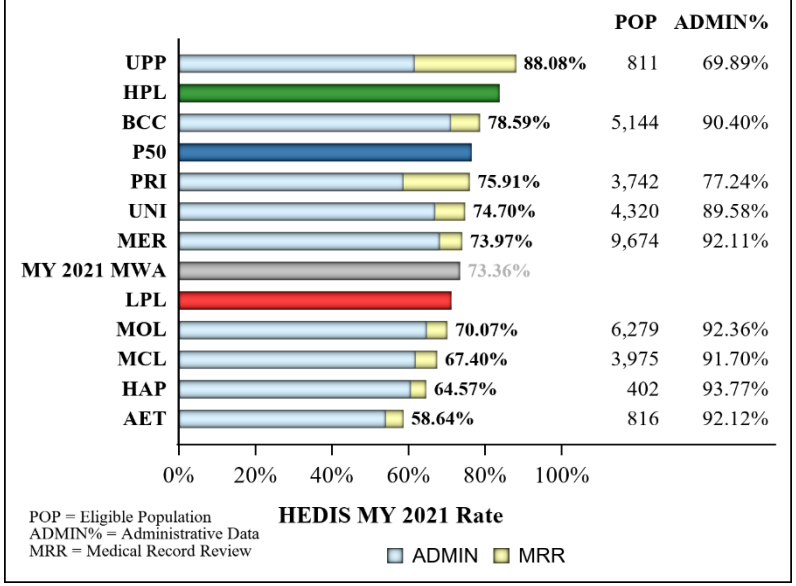
Figure 7–3—Prenatal and Postpartum Care—Postpartum Care
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 7–4—Prenatal and Postpartum Care—Postpartum Care
Health Plan Ranking



POP = Eligible Population
ADMIN% = Administrative Data
MRR = Medical Record Review

One MHP ranked above the HPL. One MHP ranked above the 50th percentile, but fell below the HPL. Three MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. Four MHPs fell below the LPL. MHP performance varied by over 29 percentage points.

8. Living With Illness

Introduction

The Living With Illness domain encompasses the following HEDIS measures:

- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years*, *Ages 65 to 74 Years*, *Ages 75 to 85 Years*, and *Total*
- *Asthma Medication Ratio—Total*
- *Controlling High Blood Pressure*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessations Strategies*
- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 8-1 presents the Michigan MWA performance for the measure indicators under the Living With Illness domain. The table lists the HEDIS MY 2021 MWA rates and performance levels, a comparison of the HEDIS MY 2020 MWA to the HEDIS MY 2021 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2020 MWA to HEDIS MY 2021 MWA.

Table 8-1—HEDIS MY 2021 MWA Performance Levels and Trend Results for Living With Illness

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Comprehensive Diabetes Care				
Hemoglobin A1C (HbA1c) Testing	85.92%	**+2.79⁺**	2	0
*HbA1c Poor Control (>9.0%)**	43.04%	+0.01	1	1
HbA1c Control (<8.0%)	48.26%	**+0.80⁺**	1	1
Eye Exam (Retinal) Performed	54.56%	**+0.91⁺**	0	0
BP Control (<140/90 mm Hg)	59.61%	**+1.23⁺**	0	2
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	30.62%	-0.01	4	3
Ages 65 to 74 Years	29.92%	-2.11	1	1
Ages 75 to 85 Years	30.27%	+0.30	1	1
Total	30.57%	-0.11	4	3
Asthma Medication Ratio				
Total	56.36%	-0.47	0	1
Controlling High Blood Pressure				
Controlling High Blood Pressure	56.14%	**+1.66⁺**	2	1
Medical Assistance With Smoking and Tobacco Use Cessation[3]				
Advising Smokers and Tobacco Users to Quit	75.48%	**-1.50⁺⁺**	0	0
Discussing Cessation Medications	54.91%	**-2.06⁺⁺**	0	0
Discussing Cessation Strategies	47.35%	**-2.66⁺⁺**	0	0
Antidepressant Medication Management				
Effective Acute Phase Treatment	65.68%	**+6.40⁺**	7	0
Effective Continuation Phase Treatment	49.31%	**+6.33⁺**	8	0
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.95%	**+2.94⁺**	4	0
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	65.67%	**+3.69⁺**	1	0

Measure	HEDIS MY 2021 MWA and Performance Level[1]	HEDIS MY 2020 MWA–HEDIS MY 2021 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2021	Number of MHPs With Statistically Significant Decline in HEDIS MY 2021
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	66.39%	+1.44	0	0
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.80%	**-2.37**++	0	3

[1] HEDIS MY 2021 performance levels were based on comparisons of the HEDIS MY 2020 MWA rates to national Medicaid Quality Compass HEDIS MY 2020 MWA benchmarks. HEDIS MY 2021 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] HEDIS MY 2020 MWA to HEDIS MY 2021 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

[3] To align with calculations from prior years, the weighted average for this measure used the eligible population for the survey rather than the number of people who responded as being smokers.

** For this indicator, a lower rate indicates better performance.*

Green Shading+ *Indicates that the HEDIS MY 2021 MWA demonstrated a significant improvement from the HEDIS MY 2020 MWA.*

Red Shading++ *Indicates that the HEDIS MY 2021 MWA demonstrated a significant decline from the HEDIS MY 2020 MWA.*

Table 8-1 shows that for the Living With Illness domain, *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*; *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*; and *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure indicators were an area of strength. All measure indicators ranked above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2020 MWA. Upper Peninsula and UnitedHealthcare ranked above the 50th percentile and the HPL for the most measure indicators within the Living With Illness domain.

The MWA demonstrated a significant decline for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessations Strategies*, and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure indicators. *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* had the highest number of MHPs that demonstrated a significantly significant decline in HEDIS MY 2021.

MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessations Strategies* measure indicators. Smoking and tobacco use are the largest causes of preventable disease and death in the United States. Comprehensive cessation interventions that motivate and help users to quit tobacco use can be very effective. Health care providers also play an important role in supporting tobacco users and their efforts to quit.[8-1] Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*. Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Medication non-adherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization.[8-2] If the decline in receipt of these services is determined to be related to the COVID-19 public health emergency, MDHHS is encouraged to work with other state Medicaid agencies facing similar barriers to identify safe methods for adults to have access to these important services.

[8-1] National Committee for Quality Assurance. Medical Assistance With Smoking and Tobacco Use Cessation. Available at: https://www.ncqa.org/hedis/measures/medical-assistance-with-smoking-and-tobacco-use-cessation/. Accessed on: Sept 15, 2022.

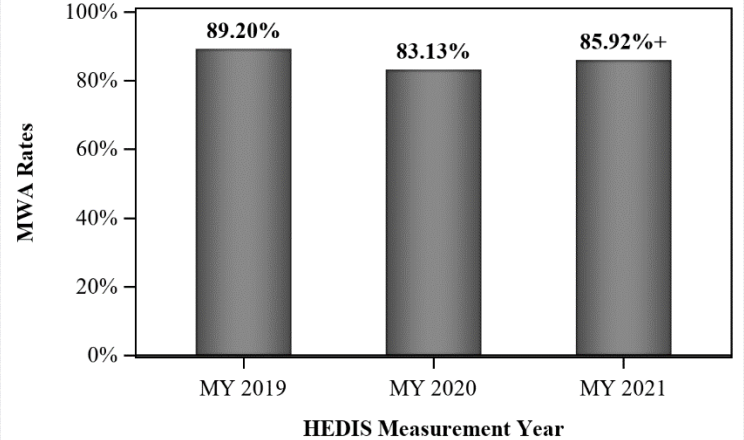
[8-2] National Committee for Quality Assurance. Adherence to Antipsychotic Medications for Individuals With Schizophrenia. Available at: https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/. Accessed on: Sept 15, 2022.

Measure-Specific Findings

Comprehensive Diabetes Care—HbA1c Testing

Comprehensive Diabetes Care—HbA1c Testing assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c testing.

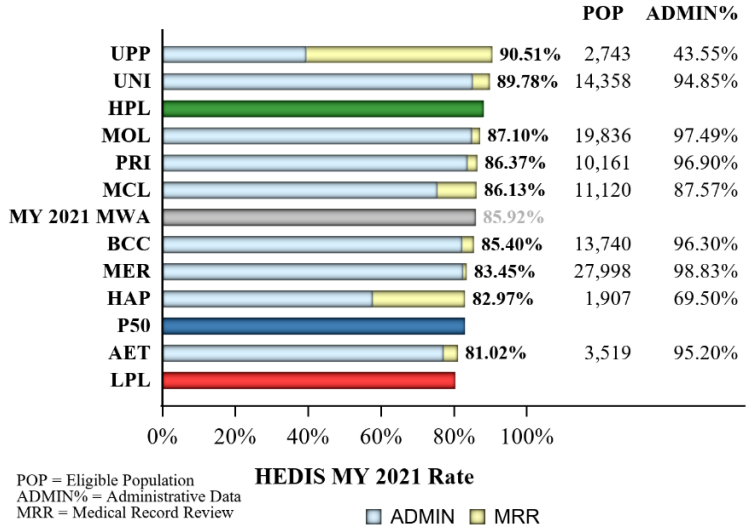
Figure 8–1—Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 8–2—Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing
Health Plan Ranking

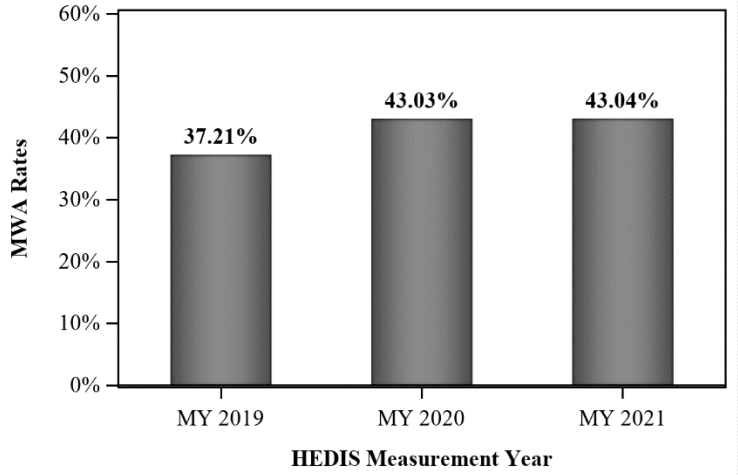


Two MHPs ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 9 percentage points.

Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)

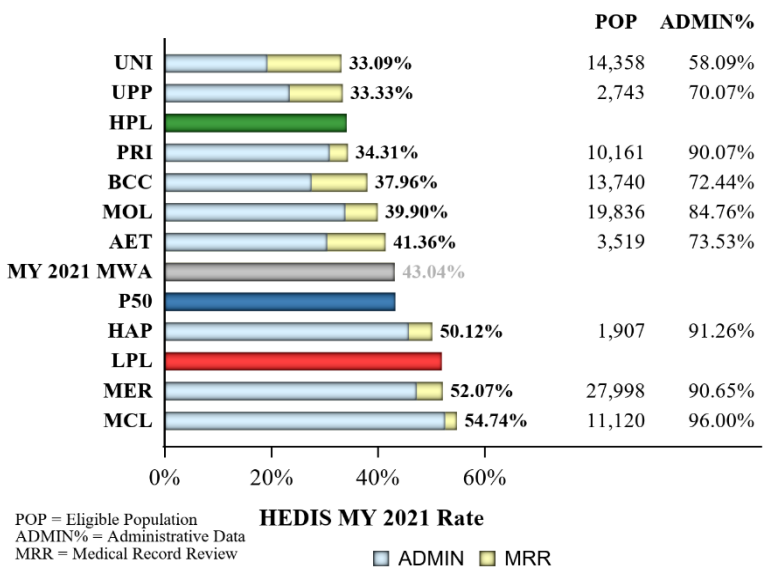
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recently documented HbA1c level was greater than 9.0 percent. For this measure, a lower rate indicates better performance.

Figure 8–3—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 8–4—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)
Health Plan Ranking



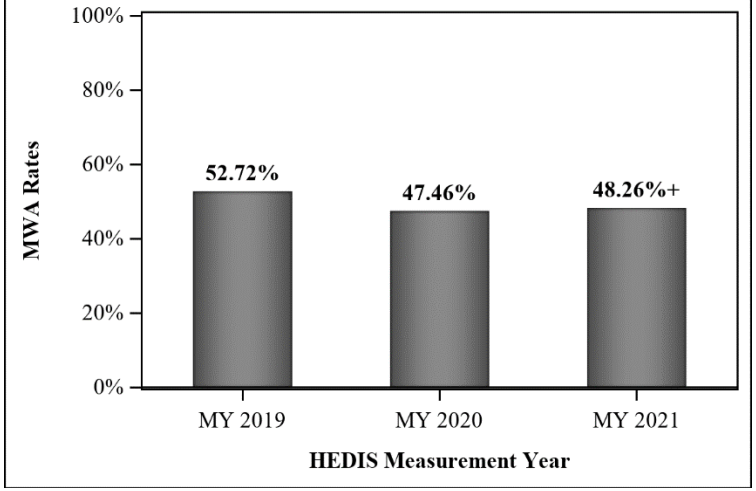
POP = Eligible Population
ADMIN% = Administrative Data
MRR = Medical Record Review

Two MHPs ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 21 percentage points.

Comprehensive Diabetes Care—HbA1c Control (<8.0%)

Comprehensive Diabetes Care—HbA1c Control (<8.0%) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recently documented HbA1c level was less than 8.0 percent.

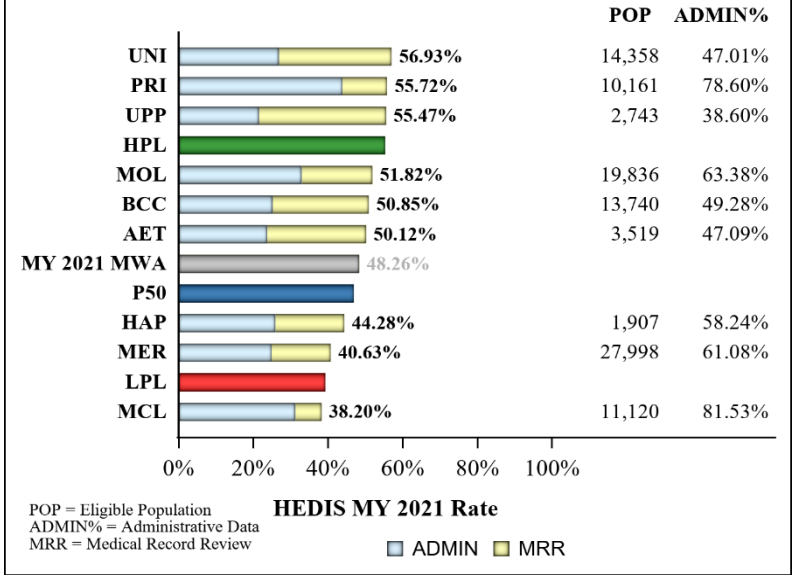
Figure 8–5—Comprehensive Diabetes Care—HbA1c Control (<8.0%)
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 8–6—Comprehensive Diabetes Care—HbA1c Control (<8.0%)
Health Plan Ranking

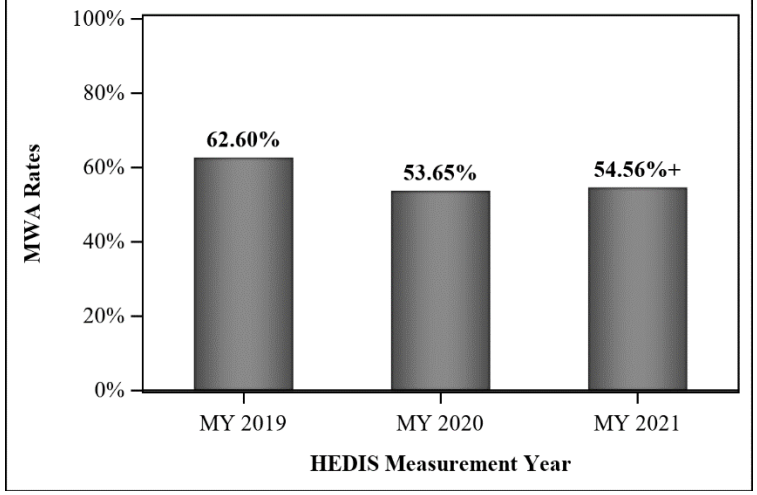


Three MHPs ranked above the HPL. Three MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 18 percentage points.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had screening or monitoring for diabetic retinal disease.

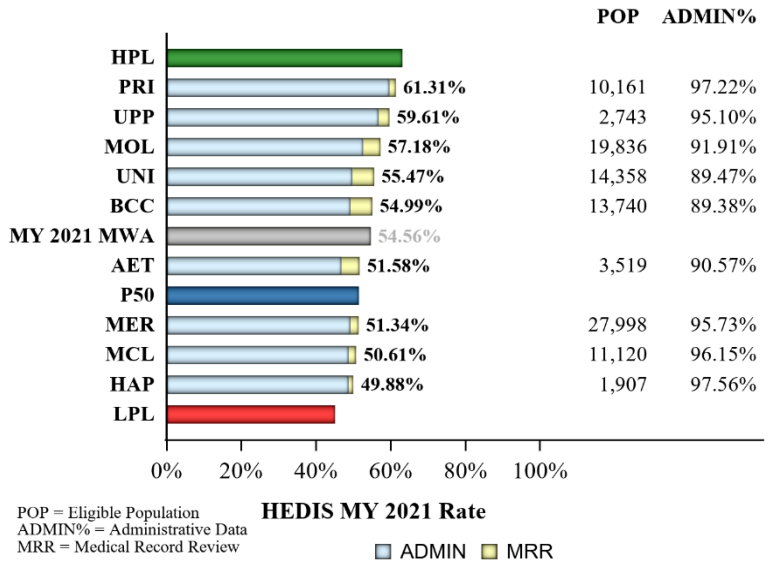
Figure 8–7—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 8–8—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed
Health Plan Ranking

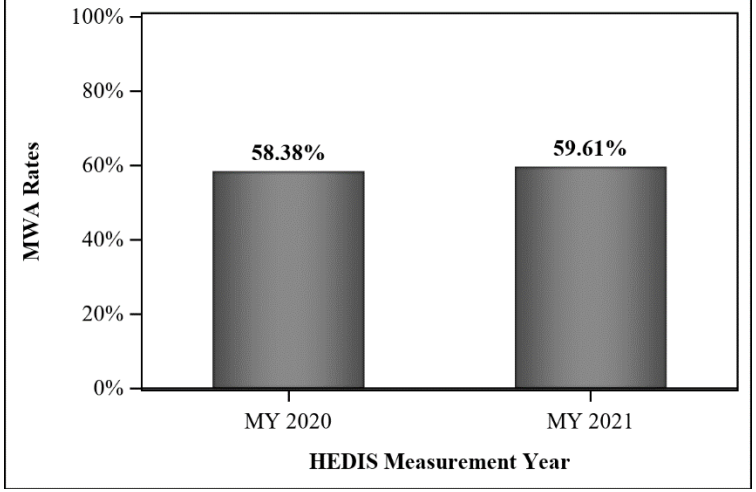


Six MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Three MHPs ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 11 percentage points.

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

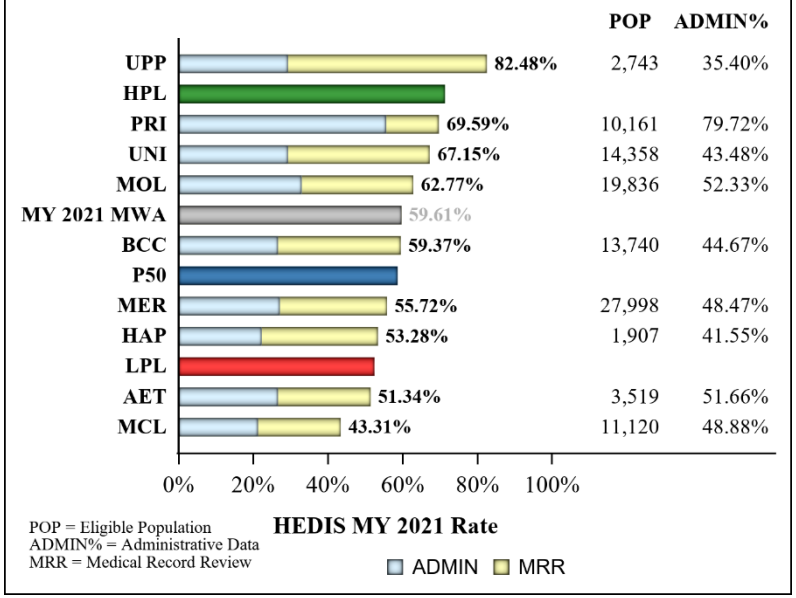
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure reading was less than 140/90 mm Hg.

Figure 8–9—Comprehensive Diabetes Care—BP Control (<140/90 mm Hg)
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 8–10—Comprehensive Diabetes Care—BP Control (<140/90 mm Hg)
Health Plan Ranking

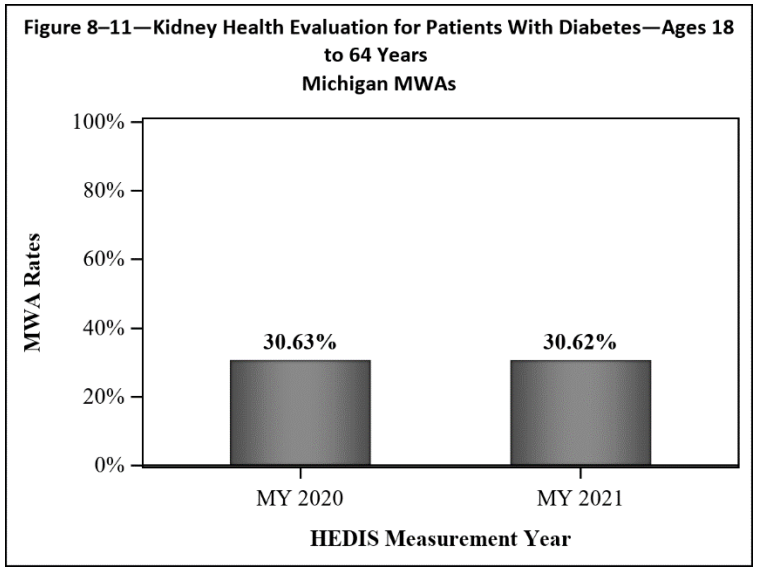


POP = Eligible Population
ADMIN% = Administrative Data
MRR = Medical Record Review

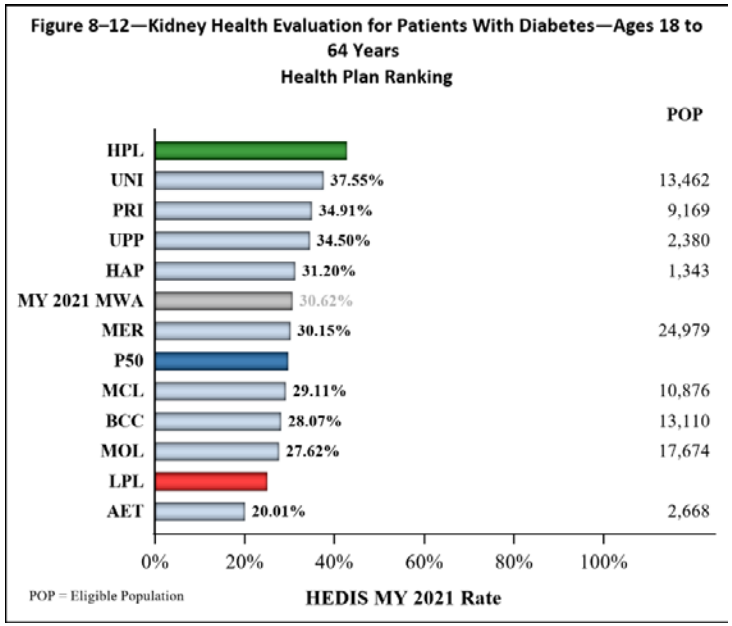
One MHP ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 39 percentage points.

Kidney Health Evaluation for People With Diabetes—Ages 18 to 64 Years

Kidney Health Evaluation for Patients With Diabetes assesses the percentage of members 18 to 64 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the MY.



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.



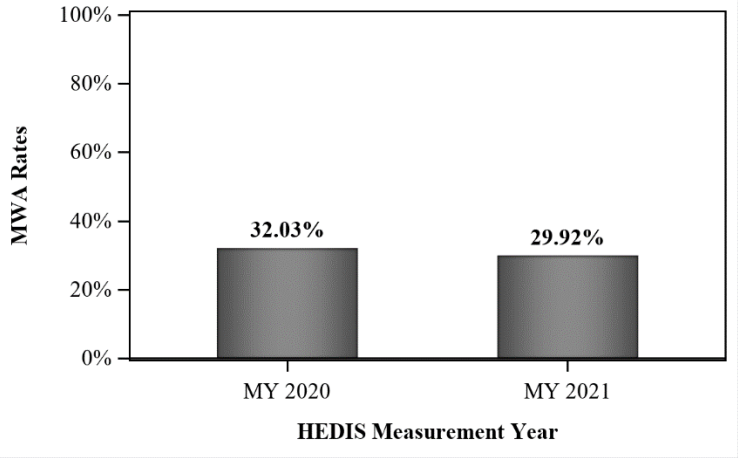
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Five MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Three MHPs ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 17 percentage points.

Kidney Health Evaluation for People With Diabetes—Ages 65 to 74 Years

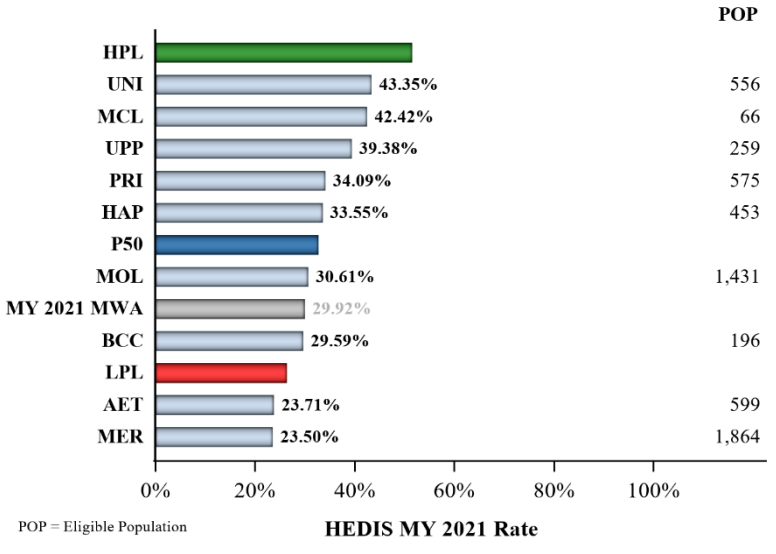
Kidney Health Evaluation for Patients With Diabetes assesses the percentage of members 65 to 74 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an eGFR and an uACR, during the MY.

Figure 8–13—Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 8–14—Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years
Health Plan Ranking

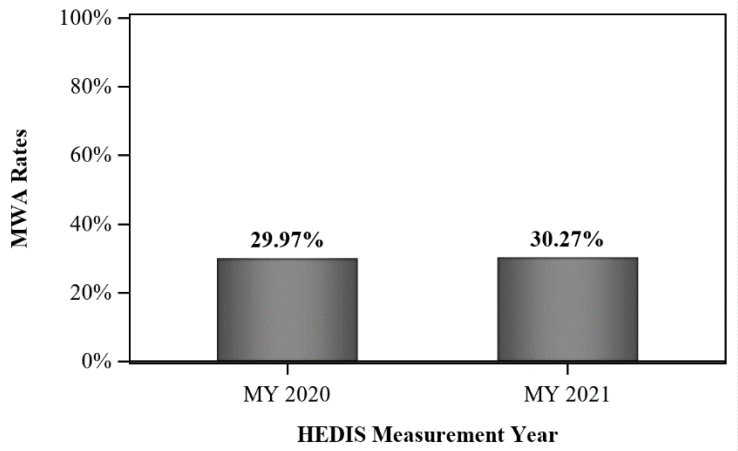


Five MHPs ranked above the 50th percentile, but fell below the HPL. Two MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 19 percentage points.

Kidney Health Evaluation for People With Diabetes—Ages 75 to 85 Years

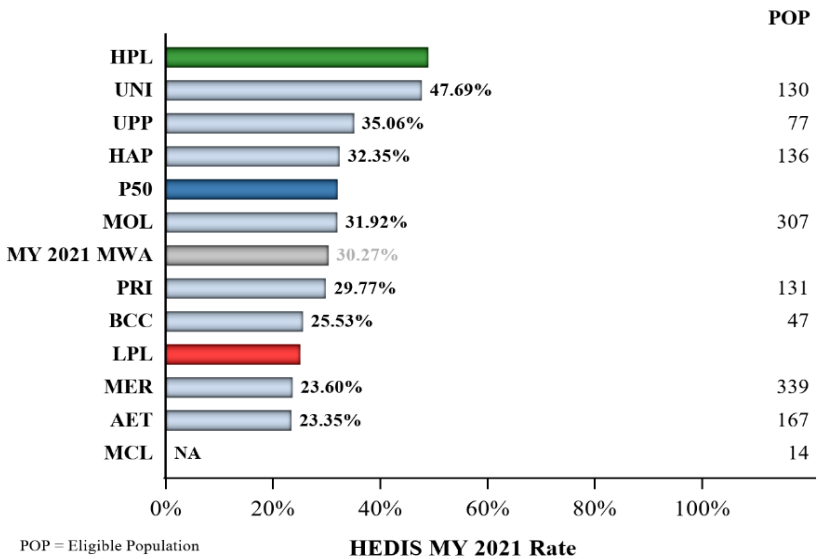
Kidney Health Evaluation for Patients With Diabetes assesses the percentage of members 75 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the MY.

Figure 8–15—Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 8–16—Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years
Health Plan Ranking

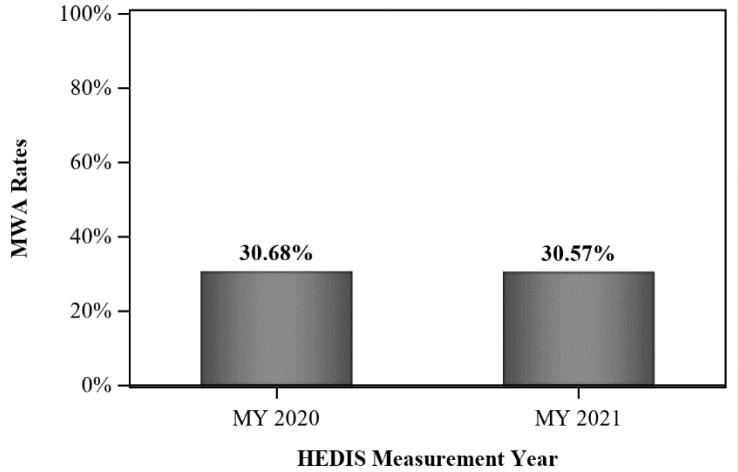


Three MHPs ranked above the 50th percentile, but fell below the HPL. Three MHPs ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 24 percentage points.

Kidney Health Evaluation for People With Diabetes—Total

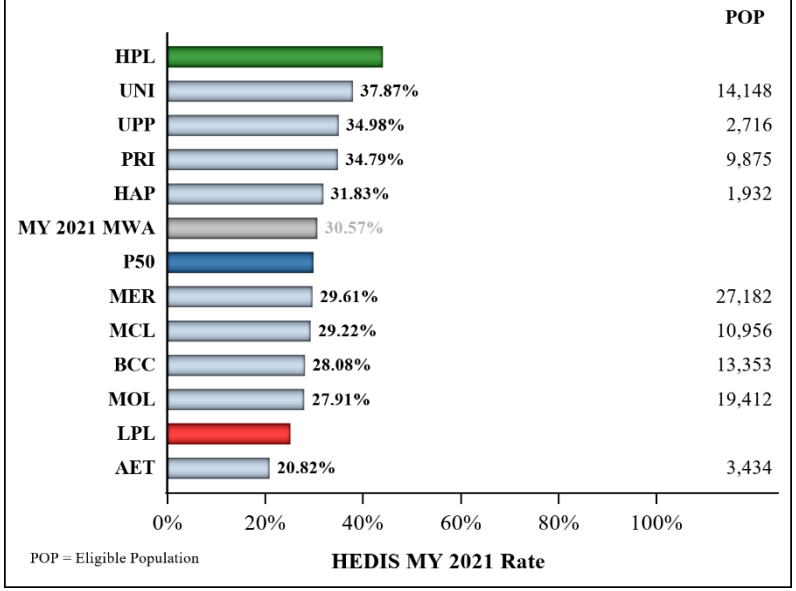
Kidney Health Evaluation for Patients With Diabetes—Total assesses the percentage of members 18 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the MY.

Figure 8–17—Kidney Health Evaluation for Patients With Diabetes—Total Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

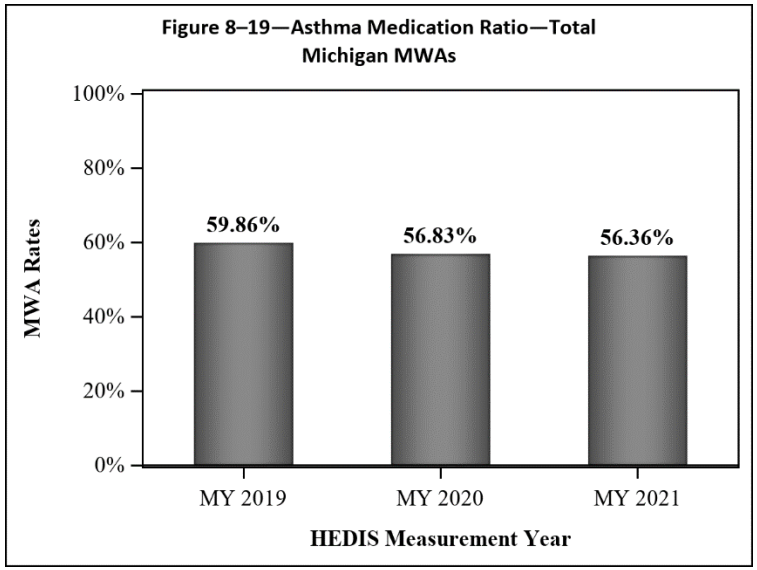
Figure 8–18—Kidney Health Evaluation for Patients With Diabetes—Total Health Plan Ranking



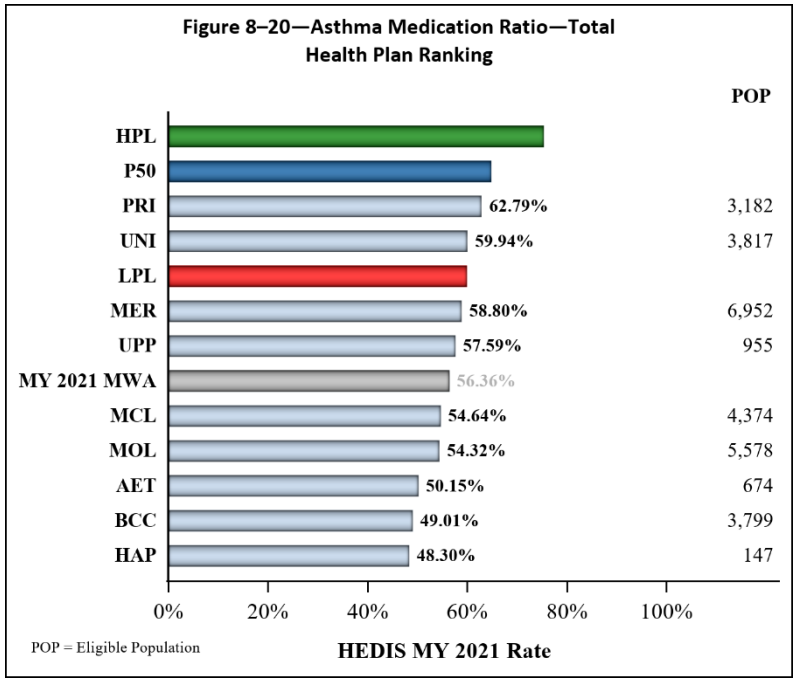
Four MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Four MHPs ranked above the LPL, but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 17 percentage points.

Asthma Medication Ratio—Total

Asthma Medication Ratio—Total assesses the percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY.



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

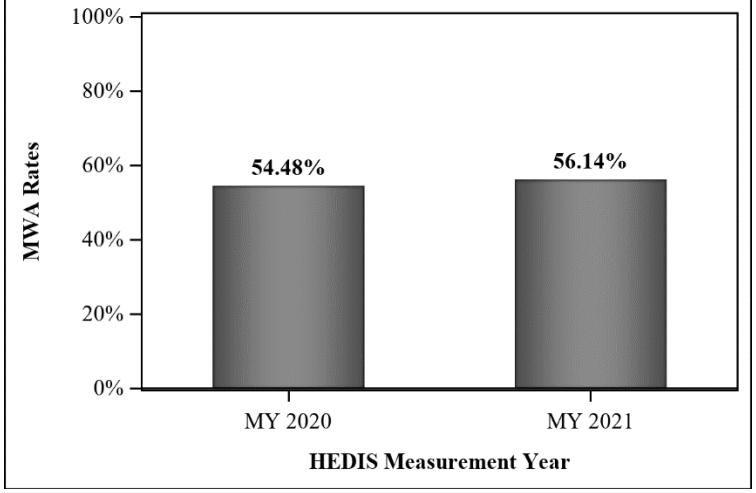


Two MHPs ranked above the LPL, but fell below the 50th percentile and the HPL. Seven MHPs and the MWA fell below the LPL. MHP performance varied by over 14 percentage points.

Controlling High Blood Pressure

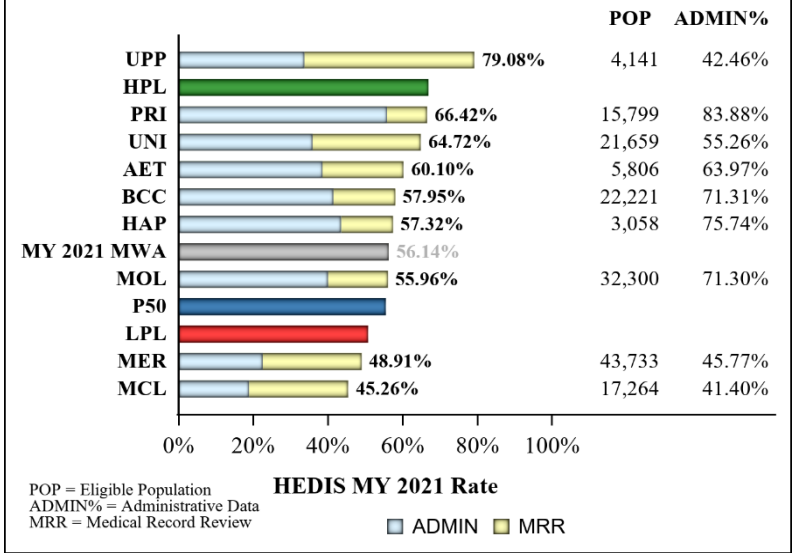
Controlling High Blood Pressure assesses the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the MY.

Figure 8–21—Controlling High Blood Pressure
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 8–22—Controlling High Blood Pressure—Controlling High Blood Pressure
Health Plan Ranking

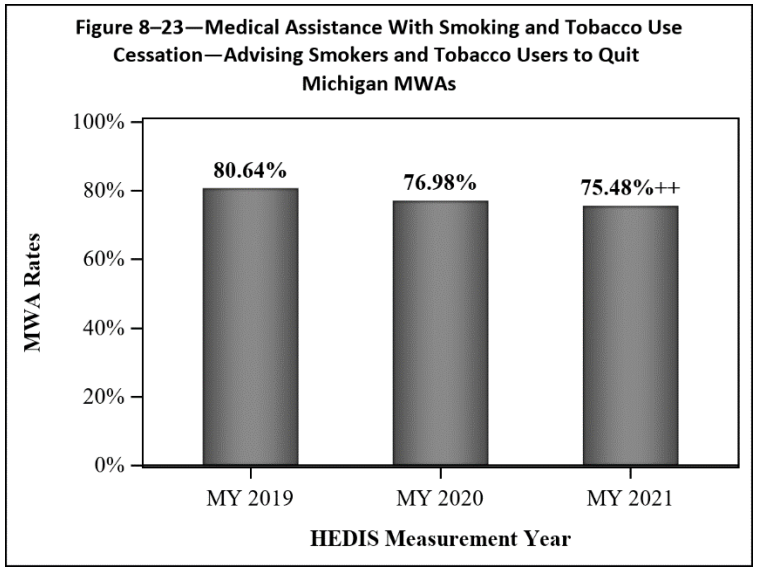


POP = Eligible Population
ADMIN% = Administrative Data
MRR = Medical Record Review

One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs fell below the LPL. MHP performance varied by over 33 percentage points.

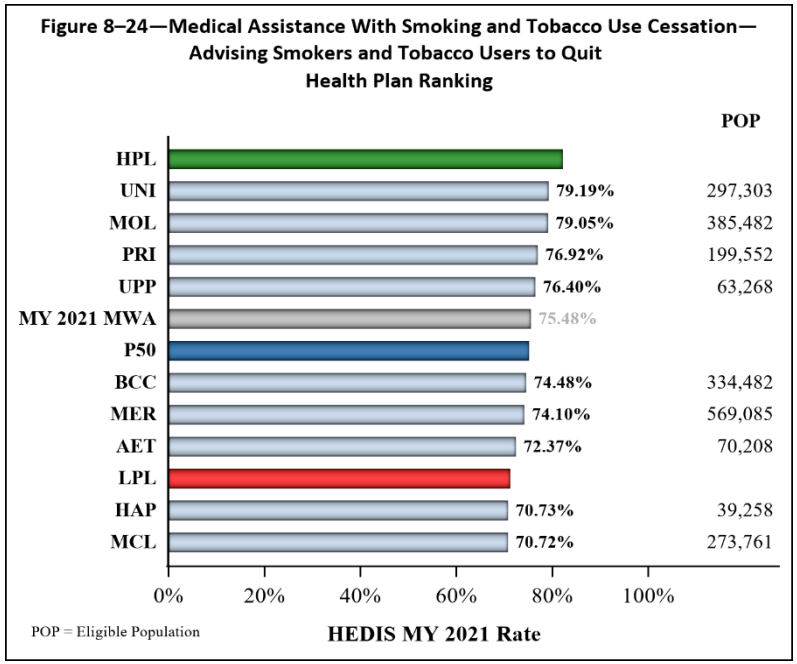
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit

Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit assesses the percentage of members 18 years of age and older who are current smokers or tobacco users and received cessation advice during the MY.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

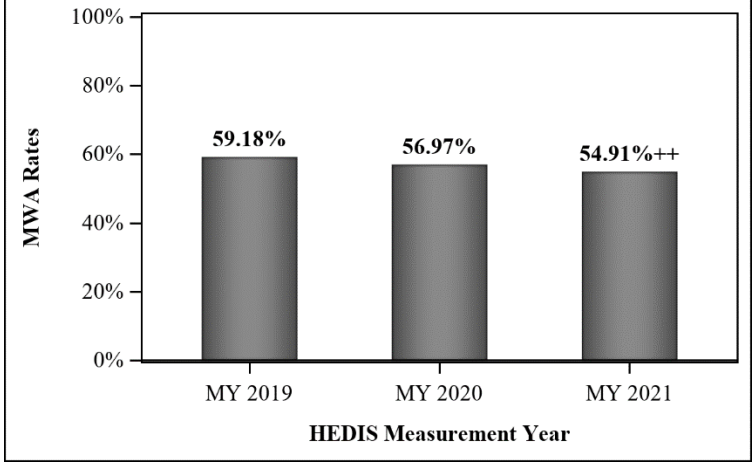


Four MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Three MHPs ranked above the LPL, but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 8 percentage points.

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications assesses the percentage of members 18 years of age and older who are current smokers or tobacco users and discussed or were recommended cessation medications during the MY.

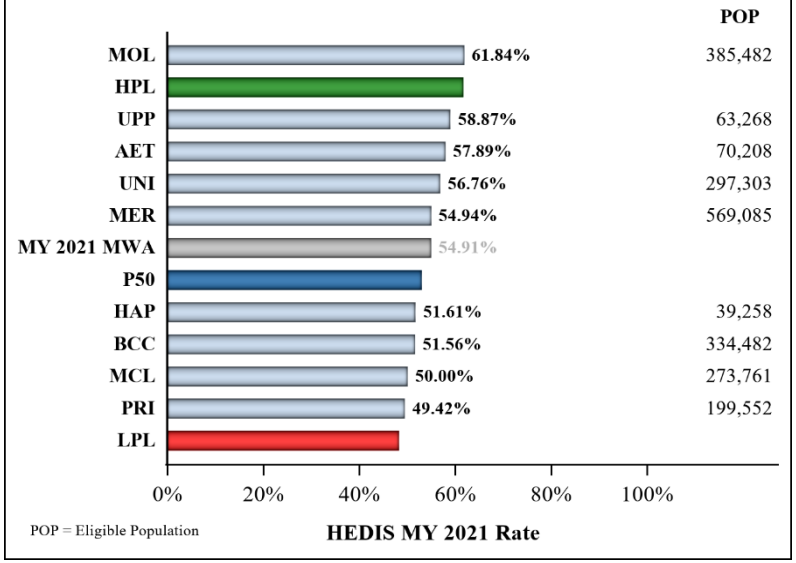
Figure 8–25—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

Figure 8–26—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications
Health Plan Ranking

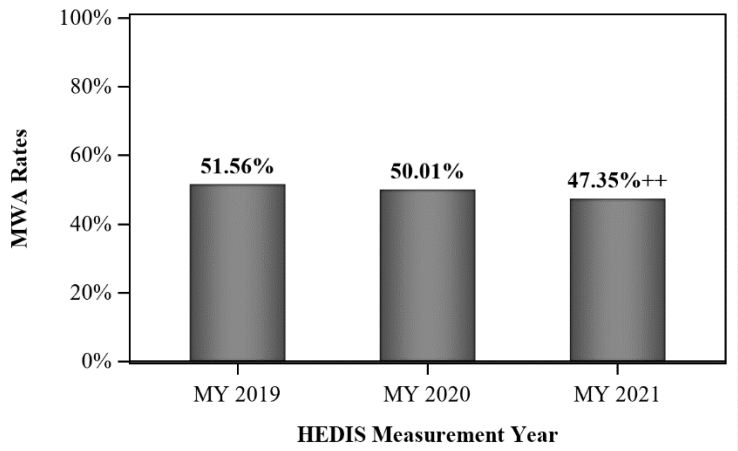


One MHP ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Four MHPs ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 12 percentage points.

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies assesses the percentage of members 18 years of age or older who are current smokers or tobacco users and discussed or were provided cessation methods or strategies during the MY.

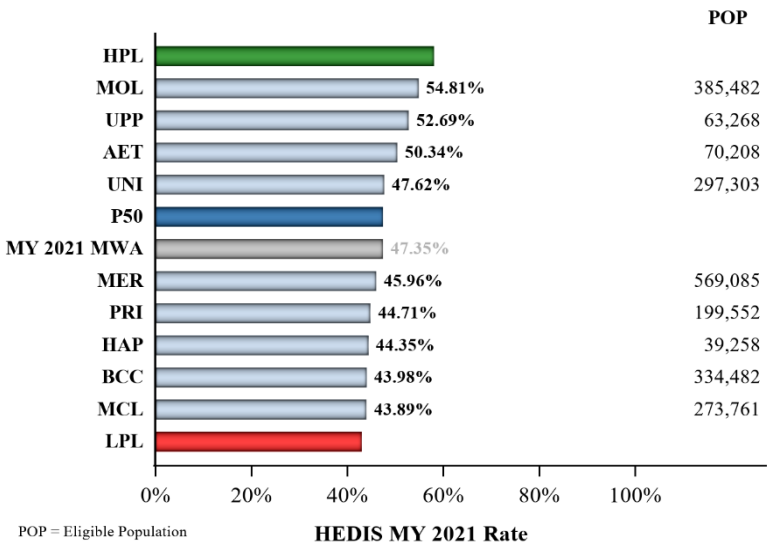
Figure 8–27—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

Figure 8–28—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies
Health Plan Ranking

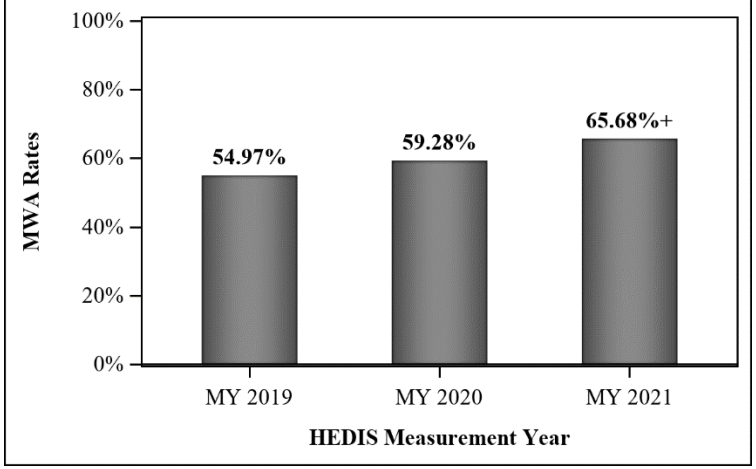


Four MHPs ranked above the 50th percentile, but fell below the HPL. Five MHPs and the MWA ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 10 percentage points.

Antidepressant Medication Management—Effective Acute Phase Treatment

Antidepressant Medication Management—Effective Acute Phase Treatment assesses the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment for at least 84 days (12 weeks).

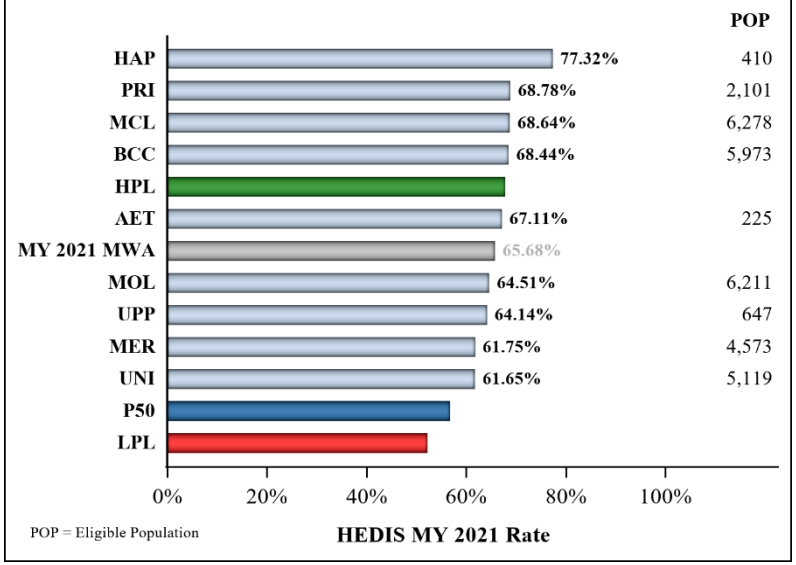
Figure 8–29—Antidepressant Medication Management—Effective Acute Phase Treatment
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 8–30—Antidepressant Medication Management—Effective Acute Phase Treatment
Health Plan Ranking

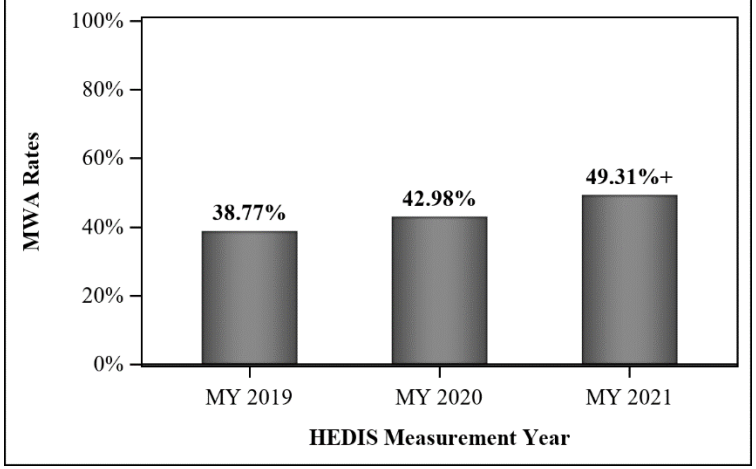


Four MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. MHP performance varied by over 15 percentage points.

Antidepressant Medication Management—Effective Continuation Phase Treatment

Antidepressant Medication Management—Effective Continuation Phase Treatment assesses the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment for at least 180 days (6 months).

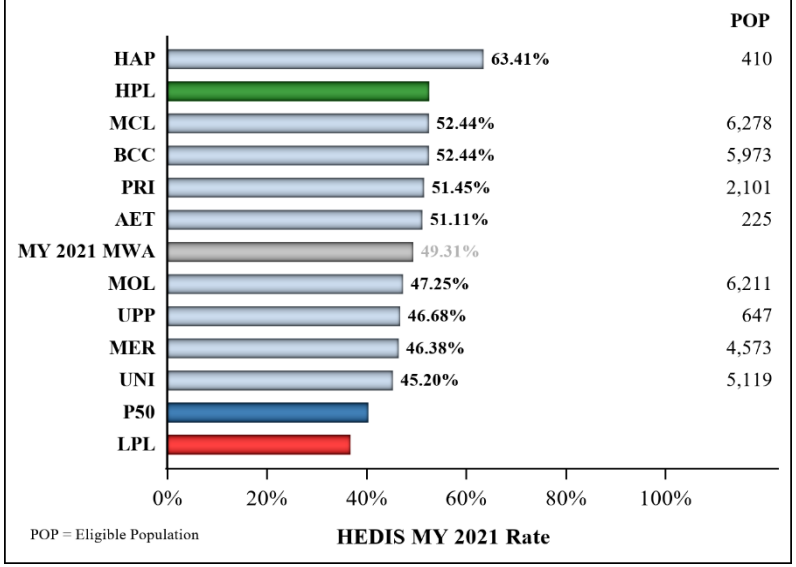
Figure 8–31—Antidepressant Medication Management—Effective Continuation Phase Treatment
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 8–32—Antidepressant Medication Management—Effective Continuation Phase Treatment
Health Plan Ranking

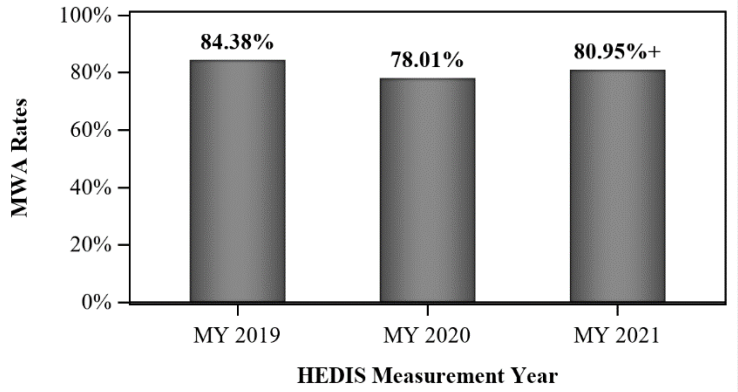


One MHP ranked above the HPL. Eight MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. MHP performance varied by over 18 percentage points.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the MY.

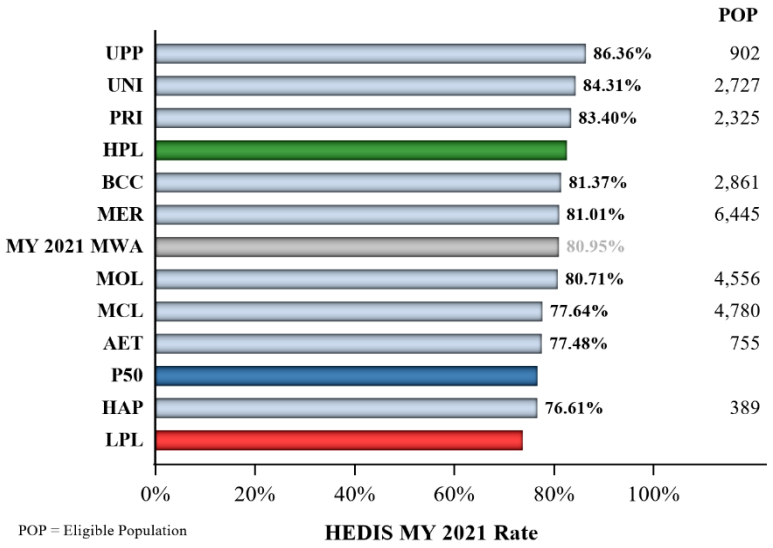
Figure 8–33—Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 8–34—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Health Plan Ranking

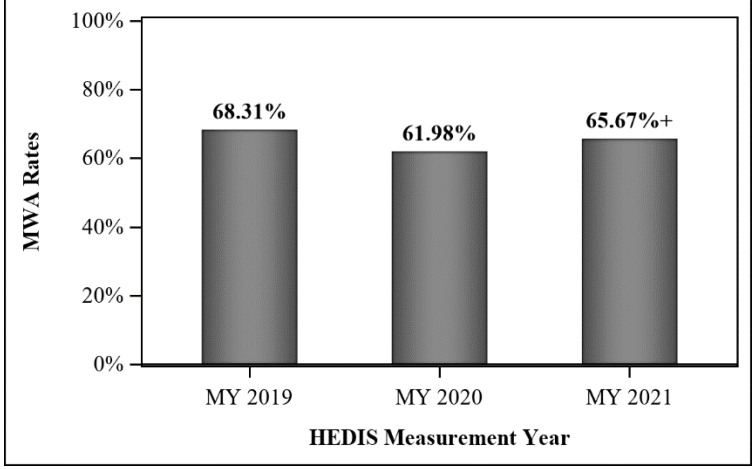


Three MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. One MHP ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 9 percentage points.

Diabetes Monitoring for People With Diabetes and Schizophrenia

Diabetes Monitoring for People With Diabetes and Schizophrenia assesses the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and diabetes, who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the MY.

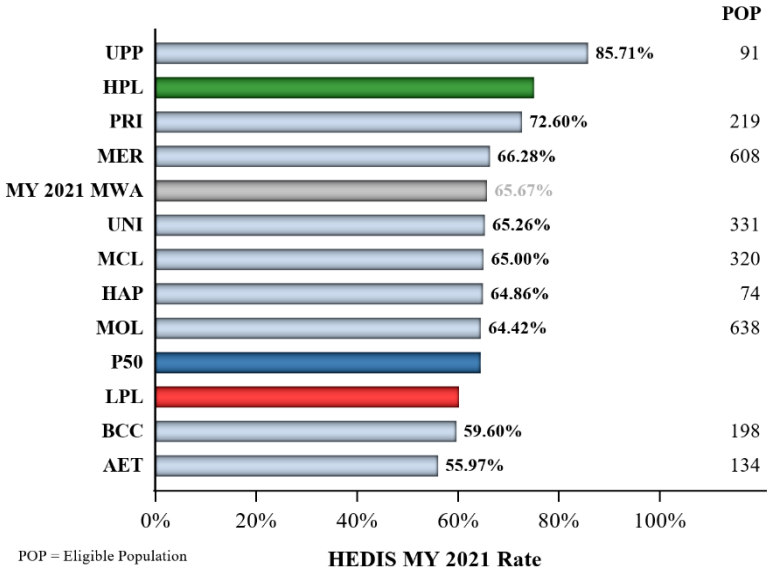
Figure 8–35—Diabetes Monitoring for People With Diabetes and Schizophrenia
Michigan MWAs



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly improved from HEDIS MY 2020.

Figure 8–36—Diabetes Monitoring for People With Diabetes and Schizophrenia
Health Plan Ranking

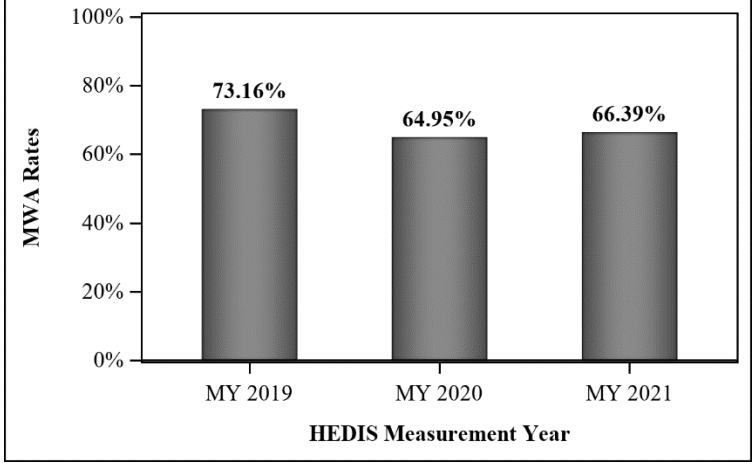


One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Two MHPs fell below the LPL. MHP performance varied by over 29 percentage points.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

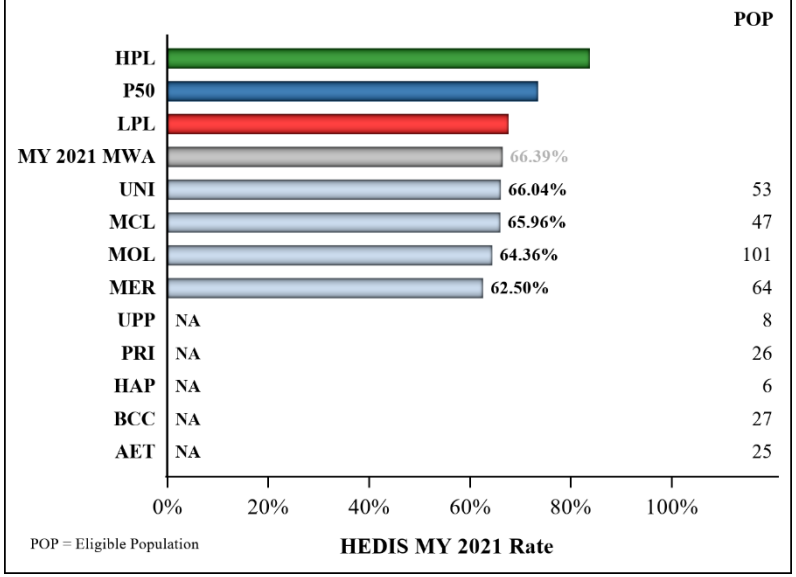
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia assesses the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease who had an LDL-C test during the MY.

Figure 8–37—Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
Michigan MWAs



The HEDIS MY 2021 MWA rate did not demonstrate a significant change from HEDIS MY 2020.

Figure 8–38—Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
Health Plan Ranking



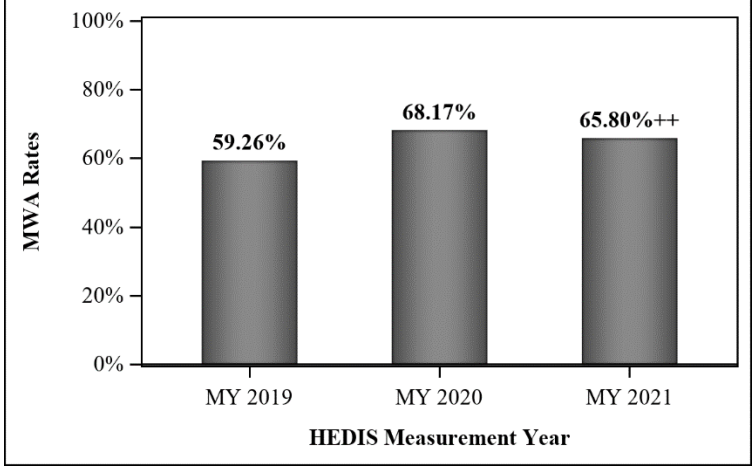
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

All MHPs and the MWA fell below the 50th percentile, HPL, and LPL. MHP performance varied by over 3 percentage points.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Adherence to Antipsychotic Medications for Individuals With Schizophrenia assesses the percentage of members 19 to 64 years of age with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

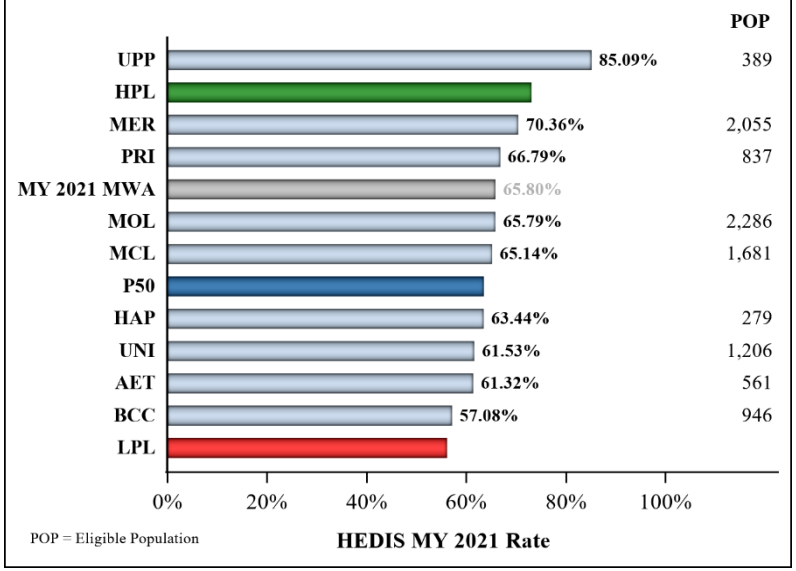
Figure 8–39—Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Michigan MWAs



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2021 MWA rate significantly declined from HEDIS MY 2020.

Figure 8–40—Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Health Plan Ranking



One MHP ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile, but fell below the HPL. Four MHPs ranked above the LPL, but fell below the 50th percentile. MHP performance varied by over 28 percentage points.

9. Health Plan Diversity

Introduction

The Health Plan Diversity domain encompasses the following HEDIS measures:

- *Race/Ethnicity Diversity of Membership*
- *Language Diversity of Membership—Spoken Language Preferred for Health Care, Preferred Language for Written Materials,* and *Other Language Needs*

Summary of Findings

Although measures under this domain are not performance measures and are not compared to percentiles, changes observed in the results may provide insight into how select member characteristics affect the MHPs' provision of services and care. The *Race/Ethnicity Diversity of Membership* measure shows that the HEDIS MY 2021 MWA rates for different racial/ethnic groups were fairly stable across years, with less than four percentage points difference between MY 2020 and MY 2021 for all racial/ethnic groups.

For the *Language Diversity of Membership* measure, MY 2021 rates remained similar to prior years, with Michigan members reporting English as the preferred spoken language for healthcare and preferred language for written materials, with nearly three percentage points difference between MY 2020 and MY 2021.

Race/Ethnicity Diversity of Membership

Measure Definition

Race/Ethnicity Diversity of Membership is an unduplicated count and percentage of members enrolled at any time during the MY, by race and ethnicity.

Results

Table 9-1a and b show that the statewide rates for reported racial/ethnic groups remained similar to prior years.

Table 9-1a—MHP and MWA Results for Race/Ethnicity Diversity of Membership

MHP	Eligible Population	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian and Other Pacific Islander
AET	69,168	34.86%	53.11%	0.39%	0.99%	0.09%
BCC	343,247	50.27%	34.93%	1.39%	1.72%	2.94%
HAP	39,350	41.61%	45.63%	0.50%	1.35%	0.07%
MCL	274,184	68.31%	21.23%	1.06%	0.69%	0.11%
MER	628,753	65.87%	23.86%	0.88%	0.83%	0.10%
MOL	418,037	46.75%	34.09%	0.36%	0.24%	<0.01%
PRI	268,261	59.24%	26.40%	0.78%	0.92%	0.11%
UNI	335,254	55.96%	30.84%	0.60%	1.79%	0.10%
UPP	63,177	87.82%	1.77%	3.70%	0.28%	0.13%
HEDIS MY 2021 MWA		**57.88%**	**28.72%**	**0.88%**	**0.98%**	**0.49%**
HEDIS MY 2020 MWA		**53.44%**	**28.03%**	**0.54%**	**1.61%**	**0.50%**
HEDIS MY 2019 MWA		**53.27%**	**27.45%**	**0.49%**	**1.87%**	**0.44%**

Table 9-1b—MHP and MWA Results for Race/Ethnicity Diversity of Membership (Continued)

MHP	Eligible Population	Some Other Race	Two or More Races	Unknown	Declined	Hispanic or Latino*
AET	69,168	0.00%	0.00%	3.99%	6.57%	0.83%
BCC	343,247	0.00%	0.03%	8.73%	0.00%	2.90%
HAP	39,350	1.67%	0.00%	9.13%	0.04%	0.91%
MCL	274,184	0.41%	0.00%	8.19%	0.00%	0.41%
MER	628,753	<0.01%	0.00%	8.46%	0.00%	<0.01%
MOL	418,037	0.00%	0.00%	18.56%	0.00%	5.99%
PRI	268,261	0.01%	<0.01%	12.09%	0.46%	0.62%
UNI	335,254	0.00%	0.00%	10.70%	0.00%	1.23%
UPP	63,177	0.19%	0.00%	0.00%	6.11%	0.19%
HEDIS MY 2021 MWA		**0.08%**	**0.00%**	**10.57%**	**0.40%**	**1.76%**
HEDIS MY 2020 MWA		**0.80%**	**0.00%**	**14.33%**	**0.74%**	**4.47%**
HEDIS MY 2019 MWA		**0.69%**	**0.00%**	**12.90%**	**2.89%**	**6.02%**

** Starting from HEDIS 2011, the rates associated with members of Hispanic origin were not based on the total number of members in the health plan. Therefore, the rates presented here were calculated by HSAG using the total number of members reported from the Hispanic or Latino column divided by the total number of members in the health plan reported in the MHP IDSS files.*

Language Diversity of Membership

Measure Definition

Language Diversity of Membership is an unduplicated count and percentage of members enrolled at any time during the MY by spoken language preferred for healthcare, the preferred language for written materials, and the preferred language for other language needs.

Results

Table 9-2 shows that the percentage of Michigan members using English as the preferred spoken language for healthcare decreased slightly (over 2 percentage points) when compared to MY 2020 but remains the preferred spoken language for healthcare at the statewide level.

Table 9-2—MHP and MWA Results for Language Diversity of Membership—Spoken Language Preferred for Healthcare

MHP	Eligible Population	Declined	English	Non-English	Unknown
AET	69,168	0.00%	0.00%	0.00%	100.00%
BCC	343,247	0.00%	98.33%	1.66%	0.01%
HAP	39,350	0.00%	99.10%	0.00%	0.90%
MCL	274,184	0.00%	47.65%	0.35%	52.00%
MER	628,753	0.00%	98.39%	0.68%	0.93%
MOL	418,037	0.00%	98.47%	1.51%	0.02%
PRI	268,261	0.00%	1.09%	<0.01%	98.91%
UNI	335,254	0.00%	96.20%	3.80%	<0.01%
UPP	63,177	0.00%	99.88%	0.10%	0.02%
HEDIS MY 2021 MWA		**0.00%**	**78.95%**	**1.23%**	**19.82%**
HEDIS MY 2020 MWA		**0.00%**	**81.23%**	**1.26%**	**17.51%**
HEDIS MY 2019 MWA		**0.00%**	**83.19%**	**1.48%**	**15.33%**

Table 9-3 shows that for each MHP, Michigan members who reported a language reported English as the language preferred for written materials. At the statewide level, English remained the preferred language for written materials for most (over 73 percent) Michigan members from MY 2019 to MY 2021.

Table 9-3—MHP and MWA Results for Language Diversity of Membership—Preferred Language for Written Materials

MHP	Eligible Population	English	Non-English	Unknown	Declined
AET	69,168	0.00%	0.00%	100.00%	0.00%
BCC	343,247	98.33%	1.67%	0.01%	0.00%
HAP	39,350	99.10%	0.00%	0.90%	0.00%
MCL	274,184	0.00%	0.00%	100.00%	0.00%
MER	628,753	98.39%	0.68%	0.93%	0.00%
MOL	418,037	98.47%	1.51%	0.02%	0.00%
PRI	268,261	1.09%	<0.01%	98.91%	0.00%
UNI	335,254	96.20%	3.80%	<0.01%	0.00%
UPP	63,177	99.88%	0.10%	0.02%	0.00%
HEDIS MY 2021 MWA		**73.60%**	**1.19%**	**25.21%**	**0.00%**
HEDIS MY 2020 MWA		**75.16%**	**1.22%**	**23.62%**	**0.00%**
HEDIS MY 2019 MWA		**76.52%**	**1.44%**	**22.04%**	**0.00%**

Table 9-4 shows that at the statewide level, Michigan members reported English as their preferred language for other language needs, and the Michigan members that listed Unknown as their preferred language for other language needs remained fairly constant from the prior year. Please note that *Language Diversity of Membership—Other Language Needs* captures data collected from questions that cannot be mapped to any other category (e.g., What is the primary language spoken at home?).

Table 9-4—MHP and MWA Results for Language Diversity of Membership—Other Language Needs

MHP	Eligible Population	English	Non-English	Unknown	Declined
AET	69,168	96.60%	1.10%	2.30%	0.00%
BCC	343,247	98.72%	1.27%	0.01%	0.00%
HAP	39,350	99.10%	0.00%	0.90%	0.00%
MCL	274,184	0.00%	0.00%	100.00%	0.00%
MER	628,753	96.75%	0.65%	2.60%	0.00%
MOL	418,037	98.47%	1.51%	0.02%	0.00%
PRI	268,261	1.09%	<0.01%	98.91%	0.00%
UNI	335,254	96.20%	3.80%	<0.01%	0.00%
UPP	63,177	0.00%	0.00%	100.00%	0.00%
HEDIS MY 2021 MWA		**73.38%**	**1.16%**	**25.46%**	**0.00%**
HEDIS MY 2020 MWA		**75.32%**	**1.19%**	**23.50%**	**0.00%**
HEDIS MY 2019 MWA		**76.58%**	**1.41%**	**22.01%**	**0.00%**

10. Utilization

Introduction

The Utilization domain encompasses the following HEDIS measures:

- *Ambulatory Care—Total (Per 1,000 Member Months)—ED Visits—Total* and *Outpatient Visits—Total*
- *Inpatient Utilization—General Hospital/Acute Care—Total*; *Inpatient—Discharges per 1,000 Member Months—Total* and *Average Length of Stay—Total*; *Maternity—Discharges per 1,000 Member Months—Total* and *Average Length of Stay—Total*; *Surgery—Discharges per 1,000 Member Months—Total* and *Average Length of Stay—Total*; and *Medicine—Discharges per 1,000 Member Months—Total* and *Average Length of Stay—Total*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*, *Multiple Pharmacies*, and *Multiple Prescribers and Multiple Pharmacies*
- *Use of Opioids at High Dosage*
- *Risk of Continued Opioid Use—At Least 15 Days Covered—Total* and *At Least 31 Days Covered—Total*
- *Plan All-Cause Readmissions—Index Admissions—Total*, *Observed Readmissions Rate—Total*, *Expected Readmissions Rate—Total*, and *O/E Ratio—Total*

The following tables present the HEDIS MY 2021 MHP-specific rates as well as the MWA or Michigan Medicaid Average (MA) for HEDIS MY 2021, HEDIS MY 2020, and HEDIS MY 2019, where applicable. To align with calculations from prior years, HSAG calculated traditional averages for the *Ambulatory Care—Total (Per 1,000 Member Months)* and *Inpatient Utilization—General Hospital/Acute Care—Total* measure indicators in the Utilization domain; therefore, the MA is presented for those two measures rather than the MWA, which was calculated and presented for all other measures. The *Ambulatory Care* and *Inpatient Utilization* measures are designed to describe the frequency of specific services provided by the MHPs and are not risk adjusted. Therefore, it is important to assess utilization supplemented by information on the characteristics of each MHP's population.

Summary of Findings

Reported rates for the MHPs and MWA rates for the *Ambulatory Care* and *Inpatient Utilization* measures do not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on these measures. For the *Plan All-Cause Readmissions* measure, four MHPs had an O/E ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on patient mix. The remaining five MHPs O/E ratio is more than one indicating they had more readmissions.

Measure-Specific Findings

Ambulatory Care—Total (Per 1,000 Member Months)

The *Ambulatory* Care—*Total (Per 1,000 Member Months)* measure summarizes use of ambulatory care for *ED Visits—Total* and *Outpatient Visits—Total*. In this section, the results for the total age group are presented.

Results

Table 10-1 shows *ED Visits—Total* and *Outpatient Visits—Total* per 1,000 member months for ambulatory care for the total age group.

Table 10-1—Ambulatory Care—Total (Per 1,000 Member Months) for Total Age Group

MHP	Member Months	ED Visits—Total*	Outpatient Visits including telehealth—Total
AET	675,576	59.14	349.02
BCC	3,479,223	45.19	374.56
HAP	360,031	51.10	386.91
MCL	2,886,751	55.59	682.98
MER	6,793,445	47.97	427.01
MOL	4,412,799	49.45	379.92
PRI	2,741,600	52.19	318.56
UNI	3,462,404	49.35	355.48
UPP	660,724	48.47	343.99
HEDIS MY 2021 MA		**50.94**	**402.05**
HEDIS MY 2020 MA		**48.10**	**361.46**
HEDIS MY 2019 MA		**66.05**	**433.13**

** Awareness is advised when interpreting results for this indicator as a lower rate is a higher percentile.*

For the *ED Visits—Total* measure indicator, the MWA decreased by 15.11 visits per 1,000 member months from HEDIS MY 2019 to HEDIS MY 2021. The MWA for the *Outpatient Visits—Total* measure indicator decreased from HEDIS MY 2019 to HEDIS MY 2021 by 31.08 visits per 1,000 member months.

Inpatient Utilization—General Hospital/Acute Care—Total

The *Inpatient Utilization—General Hospital/Acute Care—Total* measure summarizes use of acute inpatient care and services in four categories: *Total Inpatient*, *Maternity*, *Surgery*, and *Medicine*.

Results

Table 10-2 shows the member months for all ages and the *Total Discharges per 1,000 Member Months* for the total age group. The values in the table below are presented for informational purposes only.

Table 10-2—Inpatient Utilization—General Hospital/Acute Care: Total Discharges per 1,000 Member Months for Total Age Group

MHP	Member Months	Total Inpatient	Maternity*	Surgery	Medicine
AET	675,576	8.23	2.01	2.16	4.57
BCC	3,479,223	6.86	2.27	1.51	3.57
HAP	360,031	9.03	1.82	2.33	5.31
MCL	2,886,751	7.35	2.17	1.76	3.92
MER	6,793,445	6.14	2.14	1.40	3.17
MOL	4,412,799	6.70	2.29	1.45	3.55
PRI	2,741,600	5.78	2.15	1.36	2.83
UNI	3,462,404	4.90	1.84	1.19	2.32
UPP	660,724	6.06	1.83	1.81	2.88
HEDIS MY 2021 MA		**6.78**	**2.06**	**1.66**	**3.57**
HEDIS MY 2020 MA		**7.31**	**2.35**	**1.72**	**3.85**
HEDIS MY 2019 MA		**8.63**	**2.53**	**2.18**	**4.62**

** The Maternity measure indicators were calculated using member months for members 10 to 64 years of age.*

Table 10-3 displays the *Total Average Length of Stay* for all ages and are presented for informational purposes only.

Table 10-3—Inpatient Utilization—General Hospital/Acute Care: Total Average Length of Stay for Total Age Group

MHP	Member Months	Total Inpatient	Maternity	Surgery	Medicine
AET	675,576	5.59	2.42	9.16	4.94
BCC	3,479,223	4.69	2.77	7.99	4.24
HAP	360,031	6.08	2.45	9.55	5.51
MCL	2,886,751	4.21	1.71	7.00	4.02
MER	6,793,445	4.78	2.76	8.15	4.30
MOL	4,412,799	5.08	2.83	9.16	4.49
PRI	2,741,600	4.72	2.88	7.59	4.38
UNI	3,462,404	5.11	2.46	8.56	4.94
UPP	660,724	4.65	2.61	6.80	4.27
HEDIS MY 2021 MA		**4.99**	**2.54**	**8.22**	**4.57**
HEDIS MY 2020 MA		**4.65**	**2.49**	**7.62**	**4.33**
HEDIS MY 2019 MA		**4.43**	**2.54**	**7.00**	**4.00**

Use of Opioids From Multiple Providers

The *Use of Opioids From Multiple Providers* summarizes use of prescription opioids for at least 15 days received from four or more providers. Three rates are reported: *Multiple Prescribers*, *Multiple Pharmacies*, and *Multiple Prescribers and Multiple Pharmacies.* Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2021 and prior years be considered with caution.

Results

Table 10-4 shows the HEDIS MY 2021 rates for receiving prescription opioids. The values in the table below are presented for informational purposes only.

Table 10-4—Use of Opioids From Multiple Providers*

MHP	Use of Opioids From Multiple Providers—Eligible Population	Use of Opioids From Multiple Providers—Multiple Prescribers	Use of Opioids From Multiple Providers—Multiple Pharmacies	Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies
AET	2,470	15.63%	2.31%	1.78%
BCC	8,949	17.63%	2.96%	2.09%
HAP	1,266	17.30%	2.92%	2.37%
MCL	8,500	14.19%	2.13%	1.21%
MER	18,246	14.26%	1.94%	1.16%
MOL	15,614	13.12%	2.11%	1.43%
PRI	7,150	17.20%	2.38%	1.34%
UNI	9,099	15.22%	1.70%	1.15%
UPP	2,358	17.73%	6.83%	5.17%
HEDIS MY 2021 MWA		**15.03%**	**2.32%**	**1.52%**
HEDIS MY 2020 MWA		**14.60%**	**3.03%**	**1.88%**
HEDIS MY 2019 MWA		**15.48%**	**4.21%**	**2.13%**

**For this measure, a lower rate indicates better performance.*

Use of Opioids at High Dosage

The *Use of Opioids at High Dosage* summarizes use of prescription opioids received at a high dosage for at least 15 days. Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2021 and prior years be considered with caution.

Results

Table 10-5 shows the HEDIS MY 2021 rates for members receiving prescription opioids at a high dosage. The values in the table below are presented for informational purposes only.

Table 10-5—Use of Opioids at High Dosage*

MHP	Eligible Population	Rate
AET	2,110	2.65%
BCC	8,003	1.31%
HAP	1,033	1.94%
MCL	7,586	2.43%
MER	16,504	1.98%
MOL	14,037	6.68%
PRI	6,296	11.32%
UNI	8,138	2.76%
UPP	2,101	2.38%
HEDIS MY 2021 MWA		**3.98%**
HEDIS MY 2020 MWA		**2.86%**
HEDIS MY 2019 MWA		**3.36%**

** For this measure, a lower rate indicates better performance.*

Risk of Continued Opioid Use

The *Risk of Continued Opioid Use* summarizes new episodes of opioid use that puts members at risk for continued opioid use. Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2021 and prior years be considered with caution.

Results

Table 10-6 shows the HEDIS MY 2021 rates for members whose new episode lasted at least 15 days in a 30-day period and at least 31 days in a 62-day period. The values in the table below are presented for informational purposes only.

Table 10-6—Risk of Continued Opioid Use*

MHP	Eligible Population	At Least 15 Days Covered—Total	At Least 31 Days Covered—Total
AET	3,171	9.59%	7.13%
BCC	18,079	8.14%	5.78%
HAP	1,666	11.94%	6.84%
MCL	14,821	7.22%	5.20%
MER	31,459	8.04%	5.51%
MOL	21,084	19.58%	12.07%
PRI	11,658	14.30%	8.23%
UNI	15,626	9.06%	6.51%
UPP	3,774	7.87%	5.30%
HEDIS MY 2021 MWA		**10.78%**	**7.10%**
HEDIS MY 2020 MWA		**10.66%**	**6.72%**
HEDIS MY 2019 MWA		**14.41%**	**7.54%**

** For this measure, a lower rate indicates better performance.*

Plan All-Cause Readmissions

The *Plan All-Cause Readmissions* measure summarizes the percentage of inpatient hospital admissions that result in an unplanned readmission for any diagnosis within 30 days. This measure is risk-adjusted, so an O/E ratio is also calculated that indicates whether an MHP had more readmissions (O/E ratio greater than 1.0) or fewer readmissions (O/E ratio less than 1.0) than expected based on population mix.

Results

Table 10-7 shows the HEDIS MY 2021 observed rates, expected rates, and the O/E ratio for inpatient hospital admissions that were followed by an unplanned readmission for any diagnosis within 30 days.

Table 10-7—Plan All-Cause Readmissions*

MHP	Index Admissions	Observed Readmissions—Total	Expected Readmissions—Total	O/E Ratio—Total
AET	1,560	11.99%	10.74%	1.1158
BCC	8,748	9.98%	9.88%	1.0096
HAP	771	9.86%	9.76%	1.0099
MCL	10,622	9.60%	9.71%	0.9891
MER	21,280	8.43%	9.53%	0.8844
MOL	14,662	8.98%	9.76%	0.9205
PRI	7,619	8.51%	9.75%	0.8721
UNI	6,162	10.76%	10.75%	1.0007
UPP	1,390	9.06%	9.99%	0.9076
HEDIS MY 2021 MWA		**9.21%**	**9.81%**	**0.94**
HEDIS MY 2020 MWA		**9.65%**	**9.90%**	**0.98**
HEDIS MY 2019 MWA		**9.09%**	**9.90%**	**0.92**

** For this measure, a lower rate indicates better performance.*

The rates of observed readmissions ranged from 8.43 percent for Meridian to 11.99 percent for Aetna; however, four of the nine MHPs had an O/E ratio greater than 1.0 indicating these MHPs had more readmissions. The remaining five MHPs had an O/E ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on patient mix.

HEDIS Reporting Capabilities—Information Systems Findings

NCQA's IS standards are the guidelines used by certified HEDIS compliance auditors to assess an MHP's ability to report HEDIS data accurately and reliably.[11-1] Compliance with the guidelines also helps an auditor to understand an MHP's HEDIS reporting capabilities. For HEDIS MY 2021, MHPs were assessed on six IS standards. To assess an MHP's adherence to the IS standards, HSAG reviewed several documents for the MHPs. These included the MHPs' final audit reports (FARs), IS compliance tools, and the IDSS files approved by their respective NCQA-licensed audit organization (LO).

All 10 of the Michigan MHPs that underwent NCQA HEDIS Compliance Audits™ in Michigan in 2021 contracted with the same LOs in 2022.[11-2] The MHPs were able to select the LO of their choice. Overall, the Michigan MHPs consistently maintain the same LOs across reporting years.

For HEDIS MY 2021, all but two MHPs contracted with external software vendors for HEDIS measure production and rate calculation. HSAG reviewed the MHPs' FARs and ensured that these software vendors participated in and passed the NCQA's Measure Certification process. MHPs could purchase the software with certified measures and generate HEDIS measure results internally or provide all data to the software vendor to generate HEDIS measures for them. Either way, using software with NCQA-certified measures may reduce the MHPs' burden for reporting and help ensure rate validity. For the MHP that calculated its rate using internally developed source code, the auditor selected a core set of measures and manually reviewed the programming codes to verify accuracy and compliance with HEDIS MY 2021 technical specifications.

HSAG found that, in general, all MHPs' IS and processes were compliant with the applicable IS standards and the HEDIS determination reporting requirements related to the measures for HEDIS MY 2021. The following sections present NCQA's IS standards and summarize the audit findings related to each IS standard for the MHPs.

11-1 National Committee for Quality Assurance. *HEDIS® MY 2021, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C.

11-2 NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry

This standard assesses whether:

- Industry standard codes are used and all characters are captured.
- Principal codes are identified and secondary codes are captured.
- Nonstandard coding schemes are fully documented and mapped back to industry standard codes.
- Standard submission forms are used and capture all fields relevant to measure reporting; all proprietary forms capture equivalent data; and electronic transmission procedures conform to industry standards.
- Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure the accurate entry and processing of submitted data in transaction files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 1.0, Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry*. The auditors confirmed that the MHPs captured all necessary data elements appropriately for HEDIS reporting. A majority of the MHPs accepted industry standard codes on industry standard forms. Any nonstandard code that was used for measure reporting was mapped to industry standard code appropriately. Adequate validation processes such as built-in edit checks, data monitoring, and quality control audits were in place to ensure that only complete and accurate claims and encounter data were used for HEDIS reporting.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- The organization has procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of membership data have necessary procedures to ensure accuracy.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs, except for McLaren, were fully compliant with *IS 2.0, Enrollment Data—Data Capture, Transfer, and Entry*. Data fields required for HEDIS measure reporting were captured appropriately. Based on the auditors' review, all MHPs processed eligibility files in a timely manner. Enrollment information housed in the MHPs' systems was reconciled against the enrollment files provided by the

State. Sufficient data validations were in place to ensure that only accurate data were used for HEDIS reporting.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- Provider specialties are fully documented and mapped to HEDIS provider specialties necessary for measure reporting.
- The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of practitioner data are checked to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 3.0, Practitioner Data—Data Capture, Transfer, and Entry.* MHPs had sufficient processes in place to capture all data elements required for HEDIS reporting. Primary care practitioners and specialists were appropriately identified by all MHPs. Provider specialties were fully and accurately mapped to HEDIS-specified provider types. Adequate validation processes were in place to ensure that only accurate provider data were used for HEDIS reporting.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

This standard assesses whether:

- Forms capture all fields relevant to measure reporting and whether electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).
- Retrieval and abstraction of data from medical records are reliably and accurately performed.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 4.0, Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight*. Medical record data were used by all MHPs to report HEDIS hybrid measures. Medical record abstraction tools were reviewed and approved by the MHPs' auditors for HEDIS reporting. Contracted vendor staff or internal staff used by the MHPs had sufficient qualification and training in the current year's HEDIS technical specifications and the use of MHP-specific

abstraction tools to accurately conduct medical record reviews. Sufficient validation processes and edit checks were in place to ensure data completeness and data accuracy.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- The organization has effective procedures for submitting measure-relevant information for data entry and whether electronic transmissions of data have validation procedures to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.
- Data approved for electronic clinical data system (ECDS) reporting met reporting requirements.

All MHPs were fully compliant with *IS 5.0, Supplemental Data—Capture, Transfer, and Entry*. Supplemental data sources used by the MHPs were verified and approved by the auditors. The auditors performed primary source verification of a sample of records selected from each nonstandard supplemental database used by the MHPs. In addition, the auditors reviewed the supplemental data impact reports provided by the MHPs for reasonability. Validation processes such as reconciliation between original data sources and MHP-specific data systems, edit checks, and system validations ensured data completeness and data accuracy. There were no issues noted regarding how the MHPs managed the collection, validation, and integration of the various supplemental data sources. The auditors continued to encourage the MHPs to explore ways to maximize the use of supplemental data.

IS 6.0—Data Production Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.
- Data transfers to HEDIS repository from transaction files are accurate.
- File consolidations, extracts, and derivations are accurate.
- Repository structure and formatting is suitable for measures and enable required programming efforts.
- Report production is managed effectively and operators perform appropriately.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 6.0—Data Production Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity*.

All but two MHPs contracted with external software vendors for HEDIS measure production and rate calculation. Measures were benchmarked to assess potential for bias. Cross measure checks were performed to determine appropriate relationships exist. Confirmed data logic for code mapping was applied consistently. When non-standard coding schemes were used, mapping documents showed that code systems were identified and mapped according to the requirements in the specifications. Data source identifiers were clear and documented.

IS 7.0—Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

This standard assesses whether:

- Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate.
- Report production is managed effectively and operators perform appropriately.
- Measure reporting software is managed properly with regard to development, methodology, documentation, revision control, and testing.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 7.0, Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity.* For the MHP that did not use a software vendor, the auditor requested, reviewed, and approved source code for a selected core set of HEDIS measures. For all MHPs, the auditors determined that data mapping, data transfers, and file consolidations were sufficient. Adequate validation processes were in place for all MHPs to ensure that only accurate and complete data were used for HEDIS reporting. The auditors did not document any issues with the MHPs' data integration and report production processes. Sufficient vendor oversight was in place for each MHP using a software vendor.

Glossary

Table 12-1 provides definitions of terms and acronyms used throughout this report.

Table 12-1—Definition of Terms

Term	Description
ADHD	Attention-deficit/hyperactivity disorder.
Audit Result	The HEDIS auditor's final determination, based on audit findings, of the appropriateness of the MHP to publicly report its HEDIS measure rates. Each measure indicator rate included in the HEDIS audit receives an audit result of *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR)*, *No Benefit (NB)*, *Not Required (NQ)*, *Not Reported (NR)*, and *Un-Audited (UN)*.
ADMIN%	Percentage of the rate derived using administrative data (e.g., claims data and immunization registry).
BMI	Body mass index.
BR	Biased Rate; indicates that the MHP's reported rate was invalid, therefore, the rate was not presented.
CDC	Centers for Disease Control and Prevention.
CLPPP	Childhood Lead Poisoning Prevention Program.
COVID-19	Coronavirus disease 2019.
Data Completeness	The degree to which occurring services/diagnoses appear in the MHP's administrative data systems.
Denominator	The number of members who meet all criteria specified in a measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.
DTaP	Diphtheria, tetanus, and acellular pertussis vaccine.
ECDS	Electronic clinical data system. A structured, electronic version of a patient's comprehensive medical experiences maintained over time that may include some or all key administrative clinical data relevant to care (e.g., demographics, progress notes, problems, medications, vital signs, past medical history, social history, immunizations, laboratory data, radiology reports).
ED	Emergency department.
EDI	Electronic data interchange; the direct computer-to-computer transfer of data.
eGFR	Estimated Glomerular Filtration Rate.

Term	Description
Encounter Data	Billing data received from a capitated provider. (Although the MHP does not reimburse the provider for each encounter, submission of encounter data allows the MHP to collect the data for future HEDIS reporting.)
FAR	Following the MHP's completion of any corrective actions, an auditor completes the final audit report (FAR), documenting all final findings and results of the HEDIS audit. The FAR includes a summary report, IS capabilities assessment, medical record review validation findings, measure results, and the auditor's audit opinion (the final audit statement).
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.
HEDIS Repository	The data warehouse where all data used for HEDIS reporting are stored.
HepA	Hepatitis A vaccine.
HepB	Hepatitis B vaccine.
HiB Vaccine	Haemophilus influenza type B vaccine.
HMO	Health maintenance organization.
HPL	High performance level. (For most performance measures, MDHHS defined the HPL as the most recent national Medicaid 90th percentile. For measures such as *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*, in which lower rates indicate better performance, the 10th percentile [rather than the 90th percentile] is considered the HPL.)
HPV	Human papillomavirus vaccine.
HSAG	Health Services Advisory Group, Inc., the State's external quality review organization.
Hybrid Measures	Measures that can be reported using the hybrid method.
IDSS	The Interactive Data Submission System, a tool used to submit data to NCQA.
IPV	Inactivated polio virus vaccine.
IS	Information system: an automated system for collecting, processing, and transmitting data.
IS Standards	Information System (IS) standards: an NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data.[12-1]

[12-1] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

Term	Description
LPL	Low performance level. (For most performance measures, MDHHS defined the LPL as the most recent national Medicaid 25th percentile. For measures such as *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*, in which lower rates in indicate better performance, the 75th percentile [rather than the 25th percentile] is considered the LPL).
Material Bias	For most measures reported as a rate, any error that causes a ± 5 percent difference in the reported rate is considered materially biased. For non-rate measures, any error that causes a ± 10 percent difference in the reported rate or calculation is considered materially biased.
Medical Record Validation	The process that the MHP's medical record abstraction staff uses to identify numerator positive cases.
Medicaid Percentiles	The NCQA national percentiles for each HEDIS measure for the Medicaid product line used to compare the MHP's performance and assess the reliability of the MHP's HEDIS rates.
MDHHS	Michigan Department of Health and Human Services.
MHP	Medicaid health plan.
MMR	Measles, mumps, and rubella vaccine.
MRR	Medical record review.
MY	Measurement year.
NA	Small Denominator: indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in an NA designation.
NB	No Benefit: indicates that the required benefit to calculate the measure was not offered.
NCQA	The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed healthcare delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.
NR	Not Reported: indicates that the MHP chose not to report the required HEDIS 2019 measure indicator rate. This designation was assigned to rates during previous reporting years to indicate one of the following designations: The MHP chose not to report the required measure indicator rate, or the MHP's reported rate was invalid.
Numerator	The number of members in the denominator who received all the services as specified in the measure.
NQ	Not Required: indicates that the MHP was not required to report this measure.
OB/GYN	Obstetrician/Gynecologist.
PCP	Primary care practitioner.

Term	Description
PCV	Pneumococcal conjugate vaccine.
POP	Eligible population.
Provider Data	Electronic files containing information about physicians such as type of physician, specialty, reimbursement arrangement, and office location.
RV	Rotavirus vaccine.
Software Vendor	A third party, with source code certified by NCQA, that contracts with the MHP to write source code for HEDIS measures. (For the measures to be certified, the vendor must submit programming codes associated with the measure to NCQA for automated testing of program logic, and a minimum percentage of the measures must receive a "Pass" or "Pass With Qualifications" designation.)
Tdap	Tetanus, diphtheria toxoids, and acellular pertussis vaccine.
uACR	Urine albumin-creatinine ratio.
UN	Unaudited: indicates that the organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures.
URI	Upper respiratory infection.
Quality Compass	NCQA Quality Compass benchmark.
VZV	Varicella zoster virus (chicken pox) vaccine.

Appendix A. Tabular Results

Appendix A presents tabular results for each measure indicator. Where applicable, the results provided include the eligible population and rate as well as the Michigan MWA for HEDIS MY 2019, HEDIS MY 2020, and HEDIS MY 2021. Yellow shading with one cross ($^{+}$) indicates that the HEDIS MY 2021 rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Child & Adolescent Care Performance Measure Results

Table A-1—MHP and MWA Results for Childhood Immunization Status

Plan	Eligible Population	Combination 3 Rate	Combination 7 Rate	Combination 10 Rate
AET	1,060	45.74%	35.28%	18.00%
BCC	5,987	55.96%	48.18%	30.66%
HAP	388	37.89%	29.64%	15.46%
MCL	5,359	58.88%	51.09%	29.68%
MER	13,056	54.26%	45.01%	23.36%
MOL	8,276	54.83%	46.38%	26.33%
PRI	5,059	61.26%	52.72%	35.68%
UNI	5,973	52.40%	43.81%	24.91%
UPP	1,038	60.69%	50.58%	36.32%
HEDIS MY 2021 MWA		**55.46%**	**46.83%**	**27.22%**
HEDIS MY 2020 MWA		**64.00%**	**55.64%**	**33.22%**
HEDIS MY 2019 MWA		**68.36%**	**58.44%**	**33.44%**

Table A-2—MHP and MWA Results for Well-Child Visits in the First 30 Months of Life

Plan	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Eligible Population	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Rate	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Eligible Population	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Rate
AET	736	41.30%	826	41.89%
BCC	4,665	61.80%+	5,149	62.98%
HAP	208	36.06%	304	46.05%
MCL	4,018	58.66%+	4,780	59.04%
MER	10,195	60.85%+	11,964	61.93%
MOL	6,467	55.95%+	7,709	60.53%
PRI	3,719	59.18%+	4,585	65.58%
UNI	4,522	57.52%+	5,427	58.08%
UPP	847	67.53%+	1,010	67.43%
HEDIS MY 2021 MWA		**58.84%+**		**60.99%**
HEDIS MY 2020 MWA		**61.88%**		**67.71%**
HEDIS MY 2019 MWA		—		—

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-3—MHP and MWA Results for Lead Screening in Children

Plan	Eligible Population	Rate
AET	1,060	52.31%
BCC	5,987	55.23%
HAP	389	44.59%
MCL	5,373	40.63%
MER	13,055	56.36%
MOL	8,302	59.61%
PRI	5,066	56.02%
UNI	5,982	58.88%
UPP	1,039	39.75%
HEDIS MY 2021 MWA		**54.69%**
HEDIS MY 2020 MWA		**73.44%**
HEDIS MY 2019 MWA		**78.27%**

Table A-4—MHP and MWA Results for Child and Adolescents Well-Care Visits[1]

Plan	Ages 3 to 11 Years—Eligible Population	Ages 3 to 11 Years—Rate	Ages 12 to 17 Years—Eligible Population	Ages 12 to 17 Years—Rate	Ages 18 to 21 Years—Eligible Population	Ages 18 to 21 Years—Rate	Total—Eligible Population	Total—Rate
AET	7,770	52.37%+	4,790	44.76%	3,487	24.29%	16,047	44.00%
BCC	45,929	59.20%+	25,814	49.83%+	16,411	31.08%+	88,154	51.22%+
HAP	2,760	45.80%	1,249	34.35%	1,267	19.18%	5,276	36.69%
MCL	44,063	54.63%+	26,079	44.47%	15,517	23.41%	85,659	45.88%+
MER	117,972	58.18%+	67,693	49.86%+	34,938	27.39%+	220,603	50.75%+
MOL	73,301	59.60%+	48,926	52.34%+	26,645	31.90%+	148,872	52.26%+
PRI	44,044	60.53%+	26,868	51.89%+	14,379	30.06%+	85,291	52.67%+
UNI	57,386	57.53%+	38,102	50.23%+	20,734	32.09%+	116,222	50.60%+
UPP	9,449	57.85%+	5,705	51.87%+	3,196	23.44%	18,350	49.99%+
HEDIS MY 2021 MWA		**58.13%+**		**49.93%+**		**29.01%+**		**50.49%+**
HEDIS MY 2020 MWA		**50.92%**		**42.35%**		**27.36%**		**44.59%**
HEDIS MY 2019 MWA		—		—		—		—

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-5—MHP and MWA Results for Immunizations for Adolescents

Plan	Eligible Population	Combination 1 (Meningococcal, Tdap) Rate	Combination 2 (Meningococcal, Tdap, HPV) Rate
AET	781	69.10%	29.20%
BCC	4,001	74.45%	32.12%
HAP	218	60.55%	18.81%
MCL	4,368	77.86%	29.68%
MER	11,674	73.97%	32.60%
MOL	8,483	77.32%	32.54%
PRI	4,449	81.51%	36.74%+
UNI	6,451	78.83%	34.31%
UPP	947	79.30%	34.53%
HEDIS MY 2021 MWA		**76.64%**	**32.85%**
HEDIS MY 2020 MWA		**82.68%**	**37.95%**
HEDIS MY 2019 MWA		**85.28%**	**40.40%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-6—MHP and MWA Results for Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase[1]

Plan	Initiation Phase—Eligible Population	Initiation Phase—Rate	Continuation and Maintenance Phase—Eligible Population	Continuation and Maintenance Phase—Rate
AET	34	38.24%	14	NA
BCC	808	43.94%	216	62.04%+
HAP	32	34.38%	6	NA
MCL	1,150	40.70%	353	54.96%
MER	2,352	39.12%	708	46.75%
MOL	1,564	46.10%+	396	57.07%+
PRI	801	31.21%	246	38.21%
UNI	1,304	38.96%	298	56.71%+
UPP	250	38.40%	97	43.30%
HEDIS MY 2021 MWA		**40.29%**		**51.24%**
HEDIS MY 2020 MWA		**46.03%**		**57.74%**
HEDIS MY 2019 MWA		**44.44%**		**54.65%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Women—Adult Care Performance Measure Results

Table A-7—MHP and MWA Results for Chlamydia Screening in Women

Plan	Ages 16 to 20 Years—Eligible Population	Ages 16 to 20 Years—Rate	Ages 21 to 24 Years—Eligible Population	Ages 21 to 24 Years—Rate	Total—Eligible Population	Total—Rate
AET	1,009	65.21%+	1,203	65.67%+	2,212	65.46%+
BCC	5,186	58.41%+	6,207	63.32%+	11,393	61.08%+
HAP	247	55.87%+	501	60.48%	748	58.96%+
MCL	5,449	53.84%+	5,387	61.89%+	10,836	57.84%+
MER	12,549	55.97%+	11,018	64.36%+	23,567	59.89%+
MOL	9,088	62.05%+	7,527	65.63%+	16,615	63.67%+
PRI	5,127	60.52%+	4,597	66.59%+	9,724	63.39%+
UNI	6,731	60.01%+	5,640	65.18%+	12,371	62.36%+
UPP	1,174	41.06%	1,017	51.13%	2,191	45.73%
HEDIS MY 2021 MWA		**58.09%+**		**64.15%+**		**61.00%+**
HEDIS MY 2020 MWA		**57.30%**		**63.68%**		**60.20%**
HEDIS MY 2019 MWA		**62.76%**		**68.90%**		**65.42%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-8—MHP and MWA Results for Cervical Cancer Screening in Women[1]

Plan	Cervical Cancer Screening—Eligible Population	Cervical Cancer Screening—Rate
AET	12,273	46.47%
BCC	73,063	59.49%+
HAP	5,814	43.80%
MCL	55,312	56.69%
MER	133,860	56.83%
MOL	81,617	57.21%
PRI	51,898	63.99%+
UNI	64,778	58.88%
UPP	13,592	61.31%+
HEDIS MY 2021 MWA		**58.01%**
HEDIS MY 2020 MWA		**60.53%**
HEDIS MY 2019 MWA		**67.66%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-9—MHP and MWA Results for Breast Cancer Screening in Women[1]

Plan	Breast Cancer Screening—Eligible Population	Breast Cancer Screening—Rate
AET	2,787	46.79%
BCC	9,617	52.25%
HAP	1,103	56.75%+
MCL	9,470	53.67%
MER	24,193	50.97%
MOL	17,274	51.37%
PRI	8,726	56.52%+
UNI	11,188	51.15%
UPP	3,154	59.29%+
HEDIS MY 2021 MWA		**52.30%**
HEDIS MY 2020 MWA		**56.31%**
HEDIS MY 2019 MWA		**60.83%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Access to Care Performance Measure Results

Table A-10—MHP and MWA Results for Adults' Access to Preventive/Ambulatory Health Services

Plan	Ages 20 to 44 Years—Eligible Population	Ages 20 to 44 Years—Rate	Ages 45 to 64 Years—Eligible Population	Ages 45 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	18,609	66.48%	9,464	78.54%	3,176	89.64%+	31,249	72.49%
BCC	101,173	76.86%+	51,214	83.45%+	851	76.97%	153,238	79.06%+
HAP	10,113	60.43%	5,001	74.95%	2,417	89.41%+	17,531	68.56%
MCL	83,014	73.12%	40,074	82.20%	325	72.92%	123,413	76.07%
MER	182,351	76.87%+	87,789	85.06%+	9,252	88.07%+	279,392	79.82%+
MOL	110,845	76.83%+	58,067	85.37%+	6,512	91.58%+	175,424	80.21%+
PRI	69,055	73.78%	33,327	83.17%	2,987	90.26%+	105,369	77.22%
UNI	88,383	75.44%+	44,542	85.50%+	2,363	91.11%+	135,288	79.02%+
UPP	17,376	76.69%+	10,004	84.68%+	1,867	95.29%+	29,247	80.61%+
HEDIS MY 2021 MWA		**75.38%+**		**84.06%+**		**89.55%+**		**78.58%+**
HEDIS MY 2020 MWA		**74.60%**		**84.05%**		**88.77%**		**78.22%**
HEDIS MY 2019 MWA		**79.02%**		**87.31%**		**92.68%**		**82.49%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-11—MHP and MWA Results for Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Plan	Ages 3 Months to 17 Years—Eligible Population	Ages 3 Months to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	85	68.24%+	280	52.86%+	25	NA	390	54.87%+
BCC	517	65.57%+	1,427	43.80%+	7	NA	1,951	49.46%
HAP	38	71.05%+	98	44.90%+	17	NA	153	50.98%
MCL	498	62.45%	1,048	42.27%+	3	NA	1,549	48.74%
MER	1,274	65.46%+	2,704	46.01%+	45	55.56%+	4,023	52.27%
MOL	1,009	64.02%	1,811	46.11%+	44	34.09%	2,864	52.23%
PRI	372	72.04%+	872	52.75%+	9	NA	1,253	58.50%+
UNI	765	62.35%	1,422	43.88%+	12	NA	2,199	50.25%
UPP	76	64.47%	175	45.14%+	9	NA	260	50.77%
HEDIS MY 2021 MWA		**64.93%+**		**45.77%+**		**40.94%+**		**51.78%**
HEDIS MY 2020 MWA		**61.42%**		**39.69%**		**32.87%**		**50.15%**
HEDIS MY 2019 MWA		**60.04%**		**37.65%**		**34.71%**		**48.23%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-12—MHP and MWA Results for Appropriate Testing for Pharyngitis[1]

Plan	Ages 3 to 17 Years—Eligible Population	Ages 3 to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65+ Years—Rate	Total—Eligible Population	Total—Rate
AET	225	63.11%	477	50.94%	15	NA	717	53.84%
BCC	1,609	70.29%	3,187	50.67%	4	NA	4,800	57.21%
HAP	90	65.56%	210	43.81%	15	NA	315	48.25%
MCL	2,785	79.14%	2,900	67.38%+	1	NA	5,686	73.13%
MER	6,094	71.61%	5,976	56.54%	23	NA	12,093	64.04%
MOL	4,118	61.07%	4,225	48.19%	38	26.32%+	8,381	54.42%
PRI	1,188	71.38%	1,556	59.77%	4	NA	2,748	64.77%
UNI	2,804	62.16%	3,472	41.68%	14	NA	6,290	50.73%
UPP	314	85.35%+	388	76.03%+	1	NA	703	80.23%+
HEDIS MY 2021 MWA		**69.04%**		**53.55%**		**14.78%**		**60.58%**
HEDIS MY 2020 MWA		**75.34%**		**57.61%**		**25.00%**		**68.56%**
HEDIS MY 2019 MWA		**76.87%**		**59.75%**		**34.85%**		**70.83%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-13—MHP and MWA Results for Appropriate Treatment for Upper Respiratory Infection

Plan	Ages 3 Months to 17 Years—Eligible Population	Ages 3 Months to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	1,135	94.63%+	737	84.80%+	42	73.81%	1,914	90.39%+
BCC	7,396	94.71%+	5,968	81.42%+	15	NA	13,379	88.76%
HAP	472	95.76%+	360	81.39%+	48	62.50%	880	88.07%
MCL	5,670	93.42%+	4,715	85.30%+	1	NA	10,386	89.74%+
MER	17,780	94.17%+	10,428	82.61%+	81	86.42%+	28,289	89.89%+
MOL	13,322	92.82%+	6,826	79.99%+	119	73.11%	20,267	88.38%
PRI	6,533	96.10%+	3,596	88.79%+	32	87.50%+	10,161	93.48%+
UNI	11,376	94.24%+	5,794	77.10%	41	65.85%	17,211	88.40%
UPP	1,464	94.19%+	816	88.85%+	13	NA	2,293	92.24%+
HEDIS MY 2021 MWA		**94.11%+**		**82.21%+**		**75.51%+**		**89.59%+**
HEDIS MY 2020 MWA		**91.30%**		**78.18%**		**71.33%**		**87.28%**
HEDIS MY 2019 MWA		**90.61%**		**75.39%**		**68.24%**		**86.26%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Obesity Performance Measure Results

Table A-14—MHP and MWA Results for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Plan	Eligible Population	BMI Percentile—Total—Rate	Counseling for Nutrition—Total—Rate	Counseling for Physical Activity—Total—Rate
AET	7,994	82.97%+	73.48%+	71.78%+
BCC	51,287	83.07%+	76.56%+	75.26%+
HAP	2,022	81.42%+	75.14%+	73.50%+
MCL	50,071	60.83%	52.55%	52.31%
MER	139,479	72.99%	65.45%	64.72%
MOL	92,415	75.67%	71.29%+	68.13%+
PRI	49,893	91.97%+	83.70%+	82.73%+
UNI	66,031	79.56%+	74.94%+	74.94%+
UPP	11,793	89.54%+	75.18%+	72.02%+
HEDIS MY 2021 MWA		**76.87%+**	**70.12%+**	**68.90%+**
HEDIS MY 2020 MWA		**78.53%**	**69.51%**	**67.60%**
HEDIS MY 2019 MWA		**85.84%**	**75.68%**	**73.76%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Pregnancy Care Performance Measure Results

Table A-15—MHP and MWA Results for Prenatal and Postpartum Care[1]

Plan	Eligible Population	Timeliness of Prenatal Care—Rate	Postpartum Care—Rate
AET	816	70.07%	58.64%
BCC	5,144	88.08%+	78.59%+
HAP	402	75.88%	64.57%
MCL	3,975	77.86%	67.40%
MER	9,674	74.70%	73.97%
MOL	6,279	78.35%	70.07%
PRI	3,742	79.56%	75.91%
UNI	4,320	82.48%	74.70%
UPP	811	92.21%+	88.08%+
HEDIS MY 2021 MWA		**79.45%**	**73.36%**
HEDIS MY 2020 MWA		**79.54%**	**70.13%**
HEDIS MY 2019 MWA		**86.17%**	**73.76%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Living With Illness Performance Measure Results

Table A-16—MHP and MWA Results for Comprehensive Diabetes Care

Plan	Eligible Population	Hemoglobin A1c (HbA1c) Testing—Rate	HbA1c Poor Control (>9.0%)—Rate*	HbA1c Control (<8.0%)—Rate	Eye Exam (Retinal) Performed—Rate	BP Control (<140 90 mm Hg)—Rate
AET	3,519	81.02%	41.36%+	50.12%+	51.58%+	51.34%
BCC	13,740	85.40%+	37.96%+	50.85%+	54.99%+	59.37%+
HAP	1,907	82.97%+	50.12%	44.28%	49.88%	53.28%
MCL	11,120	86.13%+	54.74%	38.20%	50.61%	43.31%
MER	27,998	83.45%+	52.07%	40.63%	51.34%	55.72%
MOL	19,836	87.10%+	39.90%+	51.82%+	57.18%+	62.77%+
PRI	10,161	86.37%+	34.31%+	55.72%+	61.31%+	69.59%+
UNI	14,358	89.78%+	33.09%+	56.93%+	55.47%+	67.15%+
UPP	2,743	90.51%+	33.33%+	55.47%+	59.61%+	82.48%+
HEDIS MY 2021 MWA		**85.92%+**	**43.04%+**	**48.26%+**	**54.56%+**	**59.61%+**
HEDIS MY 2020 MWA		**83.13%**	**43.03%**	**47.46%**	**53.65%**	**58.38%**
HEDIS MY 2019 MWA		**89.20%**	**37.21%**	**52.72%**	**62.60%**	**—**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-17—MHP and MWA Results for Kidney Health Evaluation for People With Diabetes[1]

Plan	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 to 74 Years—Eligible Population	Ages 65 to 74 Years—Rate	Ages 75 to 85 Years—Eligible Population	Ages 75 to 85 Years—Rate	Total—Eligible Population	Total—Rate
AET	2,668	20.01%	599	23.71%	167	23.35%	3,434	20.82%
BCC	13,110	28.07%	196	29.59%	47	25.53%	13,353	28.08%
HAP	1,343	31.20%+	453	33.55%+	136	32.35%+	1,932	31.83%+
MCL	10,876	29.11%	66	42.42%+	14	NA	10,956	29.22%
MER	24,979	30.15%+	1,864	23.50%	339	23.60%	27,182	29.61%
MOL	17,674	27.62%	1,431	30.61%	307	31.92%	19,412	27.91%
PRI	9,169	34.91%+	575	34.09%+	131	29.77%	9,875	34.79%+
UNI	13,462	37.55%+	556	43.35%+	130	47.69%+	14,148	37.87%+
UPP	2,380	34.50%+	259	39.38%+	77	35.06%+	2,716	34.98%+
HEDIS MY 2021 MWA		**30.62%+**		**29.92%**		**30.27%**		**30.57%+**
HEDIS MY 2020 MWA		**30.63%**		**32.03%**		**29.97%**		**30.68%**
HEDIS MY 2019 MWA		—		—		—		—

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-18—MHP and MWA Results for Asthma Medication Ratio

Plan	Eligible Population	Total—Rate
AET	674	50.15%
BCC	3,799	49.01%
HAP	147	48.30%
MCL	4,374	54.64%
MER	6,952	58.80%
MOL	5,578	54.32%
PRI	3,182	62.79%
UNI	3,817	59.94%
UPP	955	57.59%
HEDIS MY 2021 MWA		**56.36%**
HEDIS MY 2020 MWA		**56.83%**
HEDIS MY 2019 MWA		**59.86%**

Table A-19—MHP and MWA Results for Controlling High Blood Pressure[1]

Plan	Eligible Population	Controlling High Blood Pressure—Rate
AET	5,806	60.10%+
BCC	22,221	57.95%+
HAP	3,058	57.32%+
MCL	17,264	45.26%
MER	43,733	48.91%
MOL	32,300	55.96%+
PRI	15,799	66.42%+
UNI	21,659	64.72%+
UPP	4,141	79.08%+
HEDIS MY 2021 MWA		**56.14%+**
HEDIS MY 2020 MWA		**54.48%**
HEDIS MY 2019 MWA		—

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-20—MHP and MWA Results for Medical Assistance With Smoking and Tobacco Use Cessation

Plan	Eligible Population	Advising Smokers and Tobacco Users to Quit—Rate	Discussing Cessation Medications—Rate	Discussing Cessation Strategies—Rate
AET	70,208	72.37%	57.89%+	50.34%+
BCC	334,482	74.48%	51.56%	43.98%
HAP	39,258	70.73%	51.61%	44.35%
MCL	273,761	70.72%	50.00%	43.89%
MER	569,085	74.10%	54.94%+	45.96%
MOL	385,482	79.05%+	61.84%+	54.81%+
PRI	199,552	76.92%+	49.42%	44.71%
UNI	297,303	79.19%+	56.76%+	47.62%+
UPP	63,268	76.40%+	58.87%+	52.69%+
HEDIS MY 2021 MWA		**75.48%+**	**54.91%+**	**47.35%**
HEDIS MY 2020 MWA		**76.98%**	**56.97%**	**50.01%**
HEDIS MY 2019 MWA		**80.64%**	**59.18%**	**51.56%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-21—MHP and MWA Results for Antidepressant Medication Management

Plan	Eligible Population	Effective Acute Phase Treatment—Rate	Effective Continuation Phase Treatment—Rate
AET	225	67.11%+	51.11%+
BCC	5,973	68.44%+	52.44%+
HAP	410	77.32%+	63.41%+
MCL	6,278	68.64%+	52.44%+
MER	4,573	61.75%+	46.38%+
MOL	6,211	64.51%+	47.25%+
PRI	2,101	68.78%+	51.45%+
UNI	5,119	61.65%+	45.20%+
UPP	647	64.14%+	46.68%+
HEDIS MY 2021 MWA		**65.68%+**	**49.31%+**
HEDIS MY 2020 MWA		**59.28%**	**42.98%**
HEDIS MY 2019 MWA		**54.97%**	**38.77%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-22—MHP and MWA Results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Plan	Eligible Population	Rate
AET	755	77.48%+
BCC	2,861	81.37%+
HAP	389	76.61%
MCL	4,780	77.64%+
MER	6,445	81.01%+
MOL	4,556	80.71%+
PRI	2,325	83.40%+
UNI	2,727	84.31%+
UPP	902	86.36%+
HEDIS MY 2021 MWA		**80.95%+**
HEDIS MY 2020 MWA		**78.01%**
HEDIS MY 2019 MWA		**84.38%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-23—MHP and MWA Results for Diabetes Monitoring for People With Diabetes and Schizophrenia

Plan	Eligible Population	Rate
AET	134	55.97%
BCC	198	59.60%
HAP	74	64.86%+
MCL	320	65.00%+
MER	608	66.28%+
MOL	638	64.42%+
PRI	219	72.60%+
UNI	331	65.26%+
UPP	91	85.71%+
HEDIS MY 2021 MWA		**65.67%+**
HEDIS MY 2020 MWA		**61.98%**
HEDIS MY 2019 MWA		**68.31%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Table A-24—MHP and MWA Results for Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Plan	Eligible Population	Rate
AET	25	NA
BCC	27	NA
HAP	6	NA
MCL	47	65.96%
MER	64	62.50%
MOL	101	64.36%
PRI	26	NA
UNI	53	66.04%
UPP	8	NA
HEDIS MY 2021 MWA		**66.39%**
HEDIS MY 2020 MWA		**64.95%**
HEDIS MY 2019 MWA		**73.16%**

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-25—MHP and MWA Results for Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Plan	Eligible Population	Rate
AET	561	61.32%
BCC	946	57.08%
HAP	279	63.44%
MCL	1,681	65.14%+
MER	2,055	70.36%+
MOL	2,286	65.79%+
PRI	837	66.79%+
UNI	1,206	61.53%
UPP	389	85.09%+
HEDIS MY 2021 MWA		**65.80%+**
HEDIS MY 2020 MWA		**68.17%**
HEDIS MY 2019 MWA		**59.26%**

Yellow shading with one cross (+) indicates the HEDIS MY 2021 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2020 MWA national Medicaid 50th percentile.

Health Plan Diversity and Utilization Measure Results

The Health Plan Diversity and Utilization measures' MHP and MWA results are presented in tabular format in Section 9 and Section 10 of this report.

Appendix B. Trend Tables

Appendix B includes trend tables for the MHPs. Where applicable, each measure's HEDIS MY 2019, HEDIS MY 2020, and HEDIS MY 2021 rates are presented as well as the HEDIS MY 2020 to HEDIS MY 2021 rate comparison and the HEDIS MY 2021 Performance Level. HEDIS MY 2020 and HEDIS MY 2021 rates were compared based on a Chi-square test of statistical significance with a *p* value <0.05. Values in the MY 2020–MY 2021 Comparison column that are shaded green with one cross ($^{+}$) indicate significant improvement from the previous year. Values in the MY 2020–MY 2021 Comparison column shaded red with two crosses ($^{++}$) indicate a significant decline in performance from the previous year.

Details regarding the trend analysis and performance ratings are found in Section 2.

Table B-1—AET Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	58.64%	49.38%	45.74%	-3.64	★
Combination 7	46.47%	40.63%	35.28%	-5.35	★
Combination 10	23.84%	18.13%	18.00%	-0.13	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	41.63%	41.30%	-0.33	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	52.61%	41.89%	**-10.72⁺⁺**	★
Lead Screening in Children					
Lead Screening in Children	76.40%	62.83%	52.31%	**-10.52⁺⁺**	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	41.17%	52.37%	+11.20⁺	★★★
Ages 12 to 17 Years	—	32.25%	44.76%	+12.51⁺	★★
Ages 18 to 21 Years	—	21.59%	24.29%	+2.70⁺	★★
Total	—	34.76%	44.00%	+9.24⁺	★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	88.56%	79.56%	69.10%	**-10.46⁺⁺**	★
Combination 2 (Meningococcal, Tdap, HPV)	37.96%	37.23%	29.20%	**-8.03⁺⁺**	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	27.78%	36.53%	38.24%	+1.71	★
Continuation and Maintenance Phase	52.63%	45.95%	NA	NC	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	60.39%	57.01%	65.21%	+8.20⁺	★★★★
Ages 21 to 24 Years	69.84%	63.88%	65.67%	+1.79	★★★★
Total	64.27%	60.30%	65.46%	+5.16⁺	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	60.51%	54.01%	46.47%	**-7.54⁺⁺**	★
Breast Cancer Screening					
Breast Cancer Screening	54.38%	50.35%	46.79%	**-3.56⁺⁺**	★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	72.86%	65.40%	66.48%	+1.08⁺	★
Ages 45 to 64 Years	84.44%	79.70%	78.54%	-1.16	★★
Ages 65 Years and Older	89.72%	87.72%	89.64%	+1.92⁺	★★★★
Total	79.50%	72.90%	72.49%	-0.41	★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	54.25%	61.25%	68.24%	+6.99	★★★
Ages 18 to 64 Years	35.34%	43.03%	52.86%	+9.83⁺	★★★★★
Ages 65 Years And Older	25.93%	28.36%	NA	NC	NC
Total	42.53%	48.75%	54.87%	+6.12⁺	★★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	67.21%	68.58%	63.11%	-5.47	★
Ages 18 to 64 Years	51.61%	49.81%	50.94%	+1.13	★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	60.09%	59.23%	53.84%	**-5.39⁺⁺**	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.36%	91.28%	94.63%	+3.35⁺	★★★
Ages 18 to 64 Years	74.70%	80.28%	84.80%	+4.52⁺	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	61.90%	70.00%	73.81%	+3.81	★★
Total	85.73%	87.04%	90.39%	+3.35+	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	87.23%	80.29%	82.97%	+2.68	★★★★
Counseling for Nutrition—Total	81.65%	72.02%	73.48%	+1.46	★★★
Counseling for Physical Activity—Total	78.72%	68.61%	71.78%	+3.17	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	70.07%	68.86%	70.07%	+1.21	★
Postpartum Care	63.02%	54.01%	58.64%	+4.63	★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	84.43%	80.05%	81.02%	+0.97	★★
*HbA1c Poor Control (>9.0%)**	38.93%	48.91%	41.36%	-7.55+	★★★
HbA1c Control (<8.0%)	52.31%	44.04%	50.12%	+6.08	★★★
Eye Exam (Retinal) Performed	54.50%	45.74%	51.58%	+5.84	★★★
BP Control (<140/90 mm Hg)	—	52.07%	51.34%	-0.73	★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	15.43%	20.01%	+4.58+	★
Ages 65 to 74 Years	—	19.24%	23.71%	+4.47	★
Ages 75 to 85 Years	—	15.76%	23.35%	+7.59	★
Total	—	16.15%	20.82%	+4.67+	★
Asthma Medication Ratio					
Total	50.22%	50.39%	50.15%	-0.24	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	46.23%	60.10%	+13.87+	★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	85.78%	78.68%	72.37%	-6.31	★★
Discussing Cessation Medications	60.00%	57.87%	57.89%	+0.02	★★★★
Discussing Cessation Strategies	54.05%	53.72%	50.34%	-3.38	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	49.93%	51.32%	67.11%	+15.79+	★★★★
Effective Continuation Phase Treatment	36.45%	37.48%	51.11%	+13.63+	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.64%	62.95%	77.48%	+14.53+	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	48.80%	52.49%	55.97%	+3.48	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	60.36%	63.54%	61.32%	-2.22	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	30.77%	32.58%	34.86%	+2.28	NC
Total—Black or African American	55.54%	53.80%	53.11%	-0.69	NC
Total—American–Indian and Alaska Native	0.26%	0.19%	0.39%	+0.20	NC
Total—Asian	1.82%	1.16%	0.99%	-0.17	NC
Total—Native Hawaiian and Other Pacific Islander	0.08%	0.08%	0.09%	+0.01	NC
Total—Some Other Race	0.00%	0.00%	0.00%	0.00	NC
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Total—Unknown	4.78%	6.03%	3.99%	-2.04	NC
Total—Declined	6.76%	6.16%	6.57%	+0.41	NC
Total—Hispanic or Latino	3.40%	3.62%	0.83%	-2.79	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	0.00%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	100.00%	100.00%	0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.26%	97.73%	96.60%	-1.13	NC
Other Language Needs—Non-English	0.97%	0.99%	1.10%	+0.11	NC
Other Language Needs—Unknown	0.78%	1.28%	2.30%	+1.02	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	75.36	55.97	59.14	+3.17	★
Outpatient Visits Including Telehealth—Total	590.74	550.95	349.02	-201.93	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	11.95	10.53	8.23	-2.30	NC
Total Inpatient—Average Length of Stay—Total All Ages	5.41	5.60	5.59	-0.01	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	2.39	2.32	2.01	-0.31	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	2.72	2.58	2.42	-0.16	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	2.91	2.50	2.16	-0.34	NC
Surgery—Average Length of Stay—Total All Ages	7.91	9.05	9.16	+0.11	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	7.33	6.34	4.57	-1.77	NC
Medicine—Average Length of Stay—Total All Ages	5.05	5.05	4.94	-0.11	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	15.69%	14.94%	15.63%	+0.69	★★★
Multiple Pharmacies	16.15%	3.43%	2.31%	-1.12+	★★★
Multiple Prescribers and Multiple Pharmacies	4.60%	2.23%	1.78%	-0.45	★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	3.30%	2.53%	2.65%	+0.12	★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	18.46%	16.92%	9.59%	-7.33+	★
At Least 31 Days Covered—Total	9.21%	9.03%	7.13%	-1.90+	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	10.10%	11.42%	11.99%	+0.57	★
*Expected Readmissions—Total**	9.36%	9.91%	10.74%	+0.83	★
*O/E Ratio—Total**	1.08	1.15	1.1158	-0.03	★

[1]HEDIS MY 2020 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–MY 2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Table B-2—BCC Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	67.15%	62.53%	55.96%	-6.57	★
Combination 7	59.37%	52.55%	48.18%	-4.37	★
Combination 10	34.55%	31.39%	30.66%	-0.73	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	64.39%	61.80%	-2.59++	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	66.84%	62.98%	-3.86++	★
Lead Screening in Children					
Lead Screening in Children	74.94%	71.53%	55.23%	-16.30++	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	50.56%	59.20%	+8.64+	★★★
Ages 12 to 17 Years	—	40.79%	49.83%	+9.04+	★★★
Ages 18 to 21 Years	—	27.43%	31.08%	+3.65+	★★★
Total	—	43.71%	51.22%	+7.51+	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	80.05%	82.00%	74.45%	-7.55++	★
Combination 2 (Meningococcal, Tdap, HPV)	39.42%	34.06%	32.12%	-1.94	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	45.45%	48.33%	43.94%	-4.39	★★
Continuation and Maintenance Phase	58.26%	68.62%	62.04%	-6.58	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	65.99%	58.99%	58.41%	-0.58	★★★
Ages 21 to 24 Years	69.35%	64.86%	63.32%	-1.54	★★★
Total	67.67%	61.98%	61.08%	-0.90	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	69.10%	60.73%	59.49%	-1.24	★★★
Breast Cancer Screening					
Breast Cancer Screening	59.22%	55.48%	52.25%	-3.23++	★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	77.99%	74.84%	76.86%	+2.02+	★★★
Ages 45 to 64 Years	84.70%	82.29%	83.45%	+1.16+	★★★
Ages 65 Years and Older	82.23%	71.52%	76.97%	+5.45+	★
Total	80.57%	77.48%	79.06%	+1.58+	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	61.98%	62.81%	65.57%	+2.76	★★★
Ages 18 to 64 Years	36.29%	38.45%	43.80%	+5.35+	★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	47.17%	49.46%	49.46%	0.00	★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	76.04%	75.69%	70.29%	-5.40++	★
Ages 18 to 64 Years	55.99%	54.39%	50.67%	-3.72++	★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	67.07%	65.57%	57.21%	-8.36++	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.40%	91.91%	94.71%	+2.80+	★★★
Ages 18 to 64 Years	73.71%	76.51%	81.42%	+4.91+	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	85.65%	86.34%	88.76%	+2.42+	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	87.21%	78.14%	83.07%	+4.93	★★★★
Counseling for Nutrition—Total	80.00%	64.87%	76.56%	+11.69+	★★★
Counseling for Physical Activity—Total	79.02%	63.80%	75.26%	+11.46+	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	78.83%	78.91%	88.08%	+9.17+	★★★
Postpartum Care	71.78%	71.09%	78.59%	+7.50+	★★★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	88.32%	80.29%	85.40%	+5.11	★★★
*HbA1c Poor Control (>9.0%)**	42.34%	41.61%	37.96%	-3.65	★★★★
HbA1c Control (<8.0%)	48.18%	49.15%	50.85%	+1.70	★★★
Eye Exam (Retinal) Performed	59.85%	58.64%	54.99%	-3.65	★★★
BP Control (<140/90 mm Hg)	—	56.93%	59.37%	+2.44	★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	26.81%	28.07%	+1.26+	★★
Ages 65 to 74 Years	—	32.71%	29.59%	-3.12	★★
Ages 75 to 85 Years	—	2.78%	25.53%	+22.75+	★★
Total	—	26.78%	28.08%	+1.30+	★★
Asthma Medication Ratio					
Total	57.31%	50.13%	49.01%	-1.12	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	54.99%	57.95%	+2.96	★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	85.23%	79.29%	74.48%	-4.81	★★
Discussing Cessation Medications	65.14%	54.31%	51.56%	-2.75	★★
Discussing Cessation Strategies	56.07%	49.74%	43.98%	-5.76	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	62.04%	62.35%	68.44%	+6.09+	★★★★★
Effective Continuation Phase Treatment	46.27%	47.14%	52.44%	+5.30+	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.24%	80.17%	81.37%	+1.20	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	72.16%	66.67%	59.60%	-7.07	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	56.98%	58.66%	57.08%	-1.58	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	46.23%	46.98%	50.27%	+3.29	NC
Total—Black or African American	35.41%	34.60%	34.93%	+0.33	NC
Total—American–Indian and Alaska Native	0.75%	1.01%	1.39%	+0.38	NC
Total—Asian	2.01%	1.77%	1.72%	-0.05	NC
Total—Native Hawaiian and Other Pacific Islander	3.22%	3.26%	2.94%	-0.32	NC
Total—Some Other Race	0.00%	0.00%	0.00%	0.00	NC
Total—Two or More Races	0.04%	0.04%	0.03%	-0.01	NC
Total—Unknown	12.34%	12.35%	8.73%	-3.62	NC
Total—Declined	0.00%	0.00%	0.00%	0.00	NC
Total—Hispanic or Latino	3.32%	3.11%	2.90%	-0.21	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.35%	98.39%	98.33%	-0.06	NC
Spoken Language Preferred for Health Care—Non-English	1.65%	1.61%	1.66%	+0.05	NC
Spoken Language Preferred for Health Care—Unknown	0.00%	0.01%	0.01%	0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	98.32%	98.38%	98.33%	-0.05	NC
Language Preferred for Written Materials—Non-English	1.68%	1.62%	1.67%	+0.05	NC
Language Preferred for Written Materials—Unknown	0.00%	0.01%	0.01%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.75%	98.80%	98.72%	-0.08	NC
Other Language Needs—Non-English	1.24%	1.19%	1.27%	+0.08	NC
Other Language Needs—Unknown	0.01%	0.01%	0.01%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	62.86	44.38	45.19	+0.81	★★
Outpatient Visits Including Telehealth—Total	393.07	334.57	374.56	+39.99	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	7.23	6.18	6.86	+0.68	NC
Total Inpatient—Average Length of Stay—Total All Ages	4.09	4.40	4.69	+0.29	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	2.73	2.53	2.27	-0.26	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	2.58	2.41	2.77	+0.36	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	1.65	1.20	1.51	+0.31	NC
Surgery—Average Length of Stay—Total All Ages	6.57	7.67	7.99	+0.32	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	3.48	3.03	3.57	+0.54	NC
Medicine—Average Length of Stay—Total All Ages	3.83	4.38	4.24	-0.14	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	16.58%	14.62%	17.63%	**+3.01⁺⁺**	★★★
Multiple Pharmacies	4.51%	3.00%	2.96%	-0.04	★★★
Multiple Prescribers and Multiple Pharmacies	2.57%	1.84%	2.09%	+0.25	★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.23%	1.69%	1.31%	-0.38	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	13.52%	8.40%	8.14%	-0.26	★★
At Least 31 Days Covered—Total	6.42%	5.69%	5.78%	+0.09	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	10.60%	11.00%	9.98%	-1.02⁺	★★
*Expected Readmissions—Total**	9.80%	10.23%	9.88%	-0.35	★★
*O/E Ratio—Total**	1.08	1.08	1.0096	-0.07⁺	★★

[1]HEDIS MY 2020 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. 2020–2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Table B-3—HAP Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	68.09%	44.95%	37.89%	-7.06	★
Combination 7	55.32%	37.61%	29.64%	-7.97	★
Combination 10	21.28%	20.18%	15.46%	-4.72	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	51.22%	36.06%	-15.16	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	55.36%	46.05%	-9.31	★
Lead Screening in Children					
Lead Screening in Children	80.85%	62.39%	44.59%	-17.80++	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	34.54%	45.80%	+11.26+	★★
Ages 12 to 17 Years	—	20.66%	34.35%	+13.69+	★
Ages 18 to 21 Years	—	18.28%	19.18%	+0.90	★★
Total	—	27.93%	36.69%	+8.76+	★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	NA	70.73%	60.55%	-10.18	★
Combination 2 (Meningococcal, Tdap, HPV)	NA	21.95%	18.81%	-3.14	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	NA	NA	34.38%	NC	★
Continuation and Maintenance Phase	NA	NA	NA	NC	NC
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	61.29%	51.98%	55.87%	+3.89	★★★
Ages 21 to 24 Years	57.63%	59.75%	60.48%	+0.73	★★
Total	58.89%	56.42%	58.96%	+2.54	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	56.34%	40.00%	43.80%	+3.80	★
Breast Cancer Screening					
Breast Cancer Screening	55.94%	57.02%	56.75%	-0.27	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	70.22%	57.06%	60.43%	+3.37+	★
Ages 45 to 64 Years	88.65%	74.49%	74.95%	+0.46	★
Ages 65 Years and Older	89.20%	88.16%	89.41%	+1.25	★★★★
Total	83.10%	68.81%	68.56%	-0.25	★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	NA	75.93%	71.05%	-4.88	★★★
Ages 18 to 64 Years	33.65%	40.52%	44.90%	+4.38	★★★
Ages 65 Years And Older	32.69%	29.55%	NA	NC	NC
Total	37.84%	47.20%	50.98%	+3.78	★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	83.33%	65.98%	65.56%	-0.42	★
Ages 18 to 64 Years	50.00%	47.10%	43.81%	-3.29	★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	59.31%	52.76%	48.25%	-4.51	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	89.68%	91.72%	95.76%	+4.04+	★★★★
Ages 18 to 64 Years	70.80%	79.94%	81.39%	+1.45	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	57.65%	73.75%	62.50%	-11.25	★
Total	74.68%	84.31%	88.07%	+3.76+	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	86.98%	80.67%	81.42%	+0.75	★★★
Counseling for Nutrition—Total	63.31%	69.85%	75.14%	+5.29	★★★
Counseling for Physical Activity—Total	62.13%	67.27%	73.50%	+6.23	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	90.12%	68.30%	75.88%	+7.58+	★
Postpartum Care	67.90%	52.68%	64.57%	+11.89+	★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	88.32%	84.18%	82.97%	-1.21	★★★
*HbA1c Poor Control (>9.0%)**	44.04%	46.96%	50.12%	+3.16	★★
HbA1c Control (<8.0%)	49.88%	46.47%	44.28%	-2.19	★★
Eye Exam (Retinal) Performed	56.93%	44.77%	49.88%	+5.11	★★
BP Control (<140/90 mm Hg)	—	53.28%	53.28%	0.00	★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	30.86%	31.20%	+0.34	★★★
Ages 65 to 74 Years	—	34.23%	33.55%	-0.68	★★★
Ages 75 to 85 Years	—	30.61%	32.35%	+1.74	★★★
Total	—	31.83%	31.83%	0.00	★★★
Asthma Medication Ratio					
Total	55.93%	46.27%	48.30%	+2.03	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	52.55%	57.32%	+4.77	★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	81.03%	76.13%	70.73%	-5.40	★
Discussing Cessation Medications	67.32%	59.35%	51.61%	-7.74	★★
Discussing Cessation Strategies	55.47%	53.80%	44.35%	-9.45	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	53.00%	70.59%	77.32%	+6.73	★★★★★
Effective Continuation Phase Treatment	42.00%	47.06%	63.41%	+16.35+	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.36%	71.52%	76.61%	+5.09	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	64.58%	66.67%	64.86%	-1.81	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	72.00%	65.04%	63.44%	-1.60	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	0.24%	39.22%	41.61%	+2.39	NC
Total—Black or African American	0.28%	46.62%	45.63%	-0.99	NC
Total—American–Indian and Alaska Native	0.00%	0.15%	0.50%	+0.35	NC
Total—Asian	0.03%	1.74%	1.35%	-0.39	NC
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.04%	0.07%	+0.03	NC
Total—Some Other Race	0.02%	3.98%	1.67%	-2.31	NC
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Total—Unknown	99.43%	8.24%	9.13%	+0.89	NC
Total—Declined	0.00%	0.00%	0.04%	+0.04	NC
Total—Hispanic or Latino	0.01%	3.72%	0.91%	-2.81	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	0.79%	90.36%	99.10%	+8.74	NC
Spoken Language Preferred for Health Care—Non-English	0.01%	0.74%	0.00%	-0.74	NC
Spoken Language Preferred for Health Care—Unknown	99.20%	8.91%	0.90%	-8.01	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	0.79%	90.36%	99.10%	+8.74	NC
Language Preferred for Written Materials—Non-English	0.01%	0.74%	0.00%	-0.74	NC
Language Preferred for Written Materials—Unknown	99.20%	8.91%	0.90%	-8.01	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.79%	90.36%	99.10%	+8.74	NC
Other Language Needs—Non-English	0.01%	0.74%	0.00%	-0.74	NC
Other Language Needs—Unknown	99.20%	8.91%	0.90%	-8.01	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	66.59	50.14	51.10	+0.96	★
Outpatient Visits Including Telehealth—Total	496.25	329.12	386.91	+57.79	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	13.93	10.20	9.03	-1.17	NC
Total Inpatient—Average Length of Stay—Total All Ages	5.97	5.95	6.08	+0.13	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	1.68	1.85	1.82	-0.03	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	2.79	2.57	2.45	-0.12	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	4.10	2.44	2.33	-0.11	NC
Surgery—Average Length of Stay—Total All Ages	9.24	9.44	9.55	+0.11	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	8.79	6.42	5.31	-1.11	NC
Medicine—Average Length of Stay—Total All Ages	4.82	5.33	5.51	+0.18	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	15.83%	12.95%	17.30%	+4.35++	★★★
Multiple Pharmacies	2.33%	3.34%	2.92%	-0.42	★★★
Multiple Prescribers and Multiple Pharmacies	1.23%	1.63%	2.37%	+0.74	★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.84%	2.16%	1.94%	-0.22	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	13.47%	14.45%	11.94%	-2.51	★
At Least 31 Days Covered—Total	7.92%	9.91%	6.84%	-3.07+	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	NA	13.38%	9.86%	-3.52	★★★
*Expected Readmissions—Total**	NA	9.81%	9.76%	-0.05	★★★
*O/E Ratio—Total**	NA	1.36	1.0099	-0.35	★★

[1]HEDIS MY 2020 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–MY 2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table B-4—MCL Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	63.99%	63.26%	58.88%	-4.38	★
Combination 7	52.80%	51.34%	51.09%	-0.25	★
Combination 10	27.74%	31.39%	29.68%	-1.71	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	61.22%	58.66%	-2.56++	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	67.44%	59.04%	-8.40++	★
Lead Screening in Children					
Lead Screening in Children	82.73%	74.21%	40.63%	-33.58++	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	48.09%	54.63%	+6.54+	★★★
Ages 12 to 17 Years	—	37.63%	44.47%	+6.84+	★★
Ages 18 to 21 Years	—	21.68%	23.41%	+1.73+	★★
Total	—	40.50%	45.88%	+5.38+	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	86.37%	81.75%	77.86%	-3.89	★★
Combination 2 (Meningococcal, Tdap, HPV)	34.55%	30.90%	29.68%	-1.22	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	47.72%	49.12%	40.70%	-8.42++	★★
Continuation and Maintenance Phase	57.74%	59.30%	54.96%	-4.34	★★
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	56.13%	53.49%	53.84%	+0.35	★★★
Ages 21 to 24 Years	66.14%	61.32%	61.89%	+0.57	★★★
Total	60.58%	57.22%	57.84%	+0.62	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	65.21%	59.85%	56.69%	-3.16	★★
Breast Cancer Screening					
Breast Cancer Screening	60.82%	56.20%	53.67%	-2.53++	★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	78.10%	73.17%	73.12%	-0.05	★★
Ages 45 to 64 Years	86.53%	83.28%	82.20%	-1.08++	★★
Ages 65 Years and Older	86.07%	72.67%	72.92%	+0.25	★
Total	81.33%	76.67%	76.07%	-0.60++	★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	58.97%	61.39%	62.45%	+1.06	★★
Ages 18 to 64 Years	38.43%	39.96%	42.27%	+2.31	★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	47.71%	50.05%	48.74%	-1.31	★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	82.55%	81.62%	79.14%	-2.48++	★★
Ages 18 to 64 Years	69.16%	67.58%	67.38%	-0.20	★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	77.73%	76.36%	73.13%	-3.23++	★★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	90.12%	90.52%	93.42%	+2.90+	★★★
Ages 18 to 64 Years	77.09%	79.90%	85.30%	+5.40+	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	85.77%	86.88%	89.74%	+2.86+	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	79.32%	65.21%	60.83%	-4.38	★
Counseling for Nutrition—Total	66.67%	53.53%	52.55%	-0.98	★
Counseling for Physical Activity—Total	63.26%	53.77%	52.31%	-1.46	★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	88.32%	78.59%	77.86%	-0.73	★
Postpartum Care	74.45%	70.32%	67.40%	-2.92	★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	87.83%	77.86%	86.13%	+8.27+	★★★★
*HbA1c Poor Control (>9.0%)**	42.58%	56.45%	54.74%	-1.71	★
HbA1c Control (<8.0%)	47.69%	37.71%	38.20%	+0.49	★
Eye Exam (Retinal) Performed	58.64%	54.74%	50.61%	-4.13	★★
BP Control (<140/90 mm Hg)	—	50.85%	43.31%	-7.54++	★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	26.56%	29.11%	+2.55+	★★
Ages 65 to 74 Years	—	27.87%	42.42%	+14.55	★★★
Ages 75 to 85 Years	—	NA	NA	NC	NC
Total	—	26.57%	29.22%	+2.65+	★★
Asthma Medication Ratio					
Total	57.20%	53.48%	54.64%	+1.16	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	47.20%	45.26%	-1.94	★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	79.01%	72.51%	70.72%	-1.79	★
Discussing Cessation Medications	56.67%	51.79%	50.00%	-1.79	★★
Discussing Cessation Strategies	50.28%	47.31%	43.89%	-3.42	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	63.61%	63.95%	68.64%	+4.69+	★★★★★
Effective Continuation Phase Treatment	49.09%	48.85%	52.44%	+3.59+	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.12%	74.61%	77.64%	+3.03+	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	67.20%	60.37%	65.00%	+4.63	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	70.59%	51.11%	65.96%	+14.85	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	69.10%	71.26%	65.14%	**-6.12++**	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	63.10%	64.38%	68.31%	+3.93	NC
Total—Black or African American	20.19%	20.63%	21.23%	+0.60	NC
Total—American–Indian and Alaska Native	0.52%	0.55%	1.06%	+0.51	NC
Total—Asian	1.45%	0.80%	0.69%	-0.11	NC
Total—Native Hawaiian and Other Pacific Islander	0.08%	0.09%	0.11%	+0.02	NC
Total—Some Other Race	5.82%	6.06%	0.41%	-5.65	NC
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Total—Unknown	8.84%	7.48%	8.19%	+0.71	NC
Total—Declined	0.00%	0.00%	0.00%	0.00	NC
Total—Hispanic or Latino	5.82%	6.06%	0.41%	-5.65	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	60.94%	52.87%	47.65%	-5.22	NC
Spoken Language Preferred for Health Care—Non-English	0.46%	0.40%	0.35%	-0.05	NC
Spoken Language Preferred for Health Care—Unknown	38.60%	46.73%	52.00%	+5.27	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	70.40	51.72	55.59	+3.87	★
Outpatient Visits Including Telehealth—Total	552.68	447.82	682.98	+235.16	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	9.14	8.31	7.35	-0.96	NC
Total Inpatient—Average Length of Stay—Total All Ages	3.87	3.87	4.21	+0.34	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	2.77	2.61	2.17	-0.44	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	1.77	1.69	1.71	+0.02	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	2.24	2.07	1.76	-0.31	NC
Surgery—Average Length of Stay—Total All Ages	5.81	6.00	7.00	+1.00	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	4.82	4.28	3.92	-0.36	NC
Medicine—Average Length of Stay—Total All Ages	3.86	3.86	4.02	+0.16	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	14.91%	14.77%	14.19%	-0.58	★★★★
Multiple Pharmacies	3.48%	2.60%	2.13%	-0.47+	★★★
Multiple Prescribers and Multiple Pharmacies	1.65%	1.21%	1.21%	0.00	★★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.95%	2.65%	2.43%	-0.22	★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	19.36%	12.40%	7.22%	-5.18+	★★
At Least 31 Days Covered—Total	11.64%	6.36%	5.20%	-1.16+	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	8.50%	9.63%	9.60%	-0.03	★★★
*Expected Readmissions—Total**	9.55%	9.76%	9.71%	-0.05	★★★
*O/E Ratio—Total**	0.89	0.99	0.9891	0.00	★★★

[1]HEDIS MY 2020 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–MY 2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Table B-5—MER Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	67.60%	62.53%	54.26%	**-8.27⁺⁺**	★
Combination 7	57.79%	56.20%	45.01%	**-11.19⁺⁺**	★
Combination 10	32.34%	32.85%	23.36%	**-9.49⁺⁺**	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	63.12%	60.85%	**-2.27⁺⁺**	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	68.93%	61.93%	**-7.00⁺⁺**	★
Lead Screening in Children					
Lead Screening in Children	77.51%	73.87%	56.36%	**-17.51⁺⁺**	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	52.28%	58.18%	+5.90⁺	★★★
Ages 12 to 17 Years	—	42.30%	49.86%	+7.56⁺	★★★
Ages 18 to 21 Years	—	26.22%	27.39%	+1.17⁺	★★★
Total	—	45.63%	50.75%	+5.12⁺	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	84.43%	82.73%	73.97%	**-8.76⁺⁺**	★
Combination 2 (Meningococcal, Tdap, HPV)	38.44%	36.50%	32.60%	-3.90	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	45.12%	44.59%	39.12%	**-5.47⁺⁺**	★★
Continuation and Maintenance Phase	56.80%	55.18%	46.75%	**-8.43⁺⁺**	★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	61.42%	55.53%	55.97%	+0.44	★★★
Ages 21 to 24 Years	69.18%	62.83%	64.36%	+1.53⁺	★★★
Total	64.92%	58.84%	59.89%	+1.05⁺	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	67.64%	59.41%	56.83%	**-2.58⁺⁺**	★★
Breast Cancer Screening					
Breast Cancer Screening	63.17%	56.65%	50.97%	**-5.68⁺⁺**	★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	80.91%	76.20%	76.87%	+0.67⁺	★★★
Ages 45 to 64 Years	88.76%	84.67%	85.06%	+0.39⁺	★★★
Ages 65 Years and Older	95.43%	88.91%	88.07%	-0.84	★★★
Total	84.02%	79.18%	79.82%	+0.64⁺	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	61.92%	60.82%	65.46%	+4.64⁺	★★★
Ages 18 to 64 Years	37.45%	39.00%	46.01%	+7.01⁺	★★★★
Ages 65 Years And Older	29.27%	31.25%	55.56%	+24.31⁺	★★★
Total	49.29%	50.08%	52.27%	+2.19⁺	★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	78.99%	77.32%	71.61%	**-5.71⁺⁺**	★
Ages 18 to 64 Years	63.96%	60.88%	56.54%	**-4.34⁺⁺**	★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	73.82%	71.39%	64.04%	**-7.35⁺⁺**	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.15%	91.71%	94.17%	+2.46⁺	★★★
Ages 18 to 64 Years	75.27%	78.27%	82.61%	+4.34⁺	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	75.65%	88.33%	86.42%	-1.91	★★★★
Total	86.80%	87.84%	89.89%	+2.05+	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	83.70%	78.59%	72.99%	-5.60	★★
Counseling for Nutrition—Total	72.99%	69.83%	65.45%	-4.38	★★
Counseling for Physical Activity—Total	69.59%	68.13%	64.72%	-3.41	★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	79.81%	79.08%	74.70%	-4.38	★
Postpartum Care	69.59%	67.88%	73.97%	+6.09	★★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	88.08%	85.89%	83.45%	-2.44	★★★
*HbA1c Poor Control (>9.0%)**	40.88%	44.04%	52.07%	**+8.03++**	★
HbA1c Control (<8.0%)	49.15%	47.45%	40.63%	**-6.82++**	★★
Eye Exam (Retinal) Performed	67.61%	50.17%	51.34%	+1.17	★★
BP Control (<140/90 mm Hg)	—	56.45%	55.72%	-0.73	★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	31.06%	30.15%	**-0.91++**	★★★
Ages 65 to 74 Years	—	36.07%	23.50%	**-12.57++**	★
Ages 75 to 85 Years	—	35.43%	23.60%	**-11.83++**	★
Total	—	31.21%	29.61%	**-1.60++**	★★
Asthma Medication Ratio					
Total	63.10%	60.15%	58.80%	-1.35	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	51.82%	48.91%	-2.91	★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	78.06%	75.72%	74.10%	-1.62	★★
Discussing Cessation Medications	55.05%	56.12%	54.94%	-1.18	★★★
Discussing Cessation Strategies	46.86%	46.81%	45.96%	-0.85	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	52.58%	50.48%	61.75%	+11.27+	★★★
Effective Continuation Phase Treatment	35.43%	33.33%	46.38%	+13.05+	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.14%	81.52%	81.01%	-0.51	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	73.60%	61.17%	66.28%	+5.11	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	79.55%	61.90%	62.50%	+0.60	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	69.10%	68.04%	70.36%	+2.32	★★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	59.99%	59.95%	65.87%	+5.92	NC
Total—Black or African American	21.94%	22.36%	23.86%	+1.50	NC
Total—American–Indian and Alaska Native	0.47%	0.48%	0.88%	+0.40	NC
Total—Asian	3.04%	2.43%	0.83%	-1.60	NC
Total—Native Hawaiian and Other Pacific Islander	0.07%	0.08%	0.10%	+0.02	NC
Total—Some Other Race	0.02%	0.00%	0.00%	0.00	NC
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Total—Unknown	6.70%	14.70%	8.46%	-6.24	NC
Total—Declined	7.76%	0.00%	0.00%	0.00	NC
Total—Hispanic or Latino	6.40%	0.00%	0.00%	0.00	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.53%	98.48%	98.39%	-0.09	NC
Spoken Language Preferred for Health Care—Non-English	1.44%	0.67%	0.68%	+0.01	NC
Spoken Language Preferred for Health Care—Unknown	0.04%	0.84%	0.93%	+0.09	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	98.53%	98.48%	98.39%	-0.09	NC
Language Preferred for Written Materials—Non-English	1.44%	0.67%	0.68%	+0.01	NC
Language Preferred for Written Materials—Unknown	0.04%	0.84%	0.93%	+0.09	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.53%	98.48%	96.75%	-1.73	NC
Other Language Needs—Non-English	1.44%	0.67%	0.65%	-0.02	NC
Other Language Needs—Unknown	0.04%	0.84%	2.60%	+1.76	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	64.84	45.54	47.97	+2.43	★
Outpatient Visits Including Telehealth—Total	389.60	397.73	427.01	+29.28	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	7.44	6.67	6.14	-0.53	NC
Total Inpatient—Average Length of Stay—Total All Ages	4.05	4.30	4.78	+0.48	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	2.88	2.63	2.14	-0.49	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	2.53	2.67	2.76	+0.09	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	1.76	1.52	1.40	-0.12	NC
Surgery—Average Length of Stay—Total All Ages	6.56	7.18	8.15	+0.97	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	3.62	3.25	3.17	-0.08	NC
Medicine—Average Length of Stay—Total All Ages	3.70	3.91	4.30	+0.39	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	15.44%	14.84%	14.26%	-0.58	★★★★
Multiple Pharmacies	3.73%	3.78%	1.94%	-1.84+	★★★
Multiple Prescribers and Multiple Pharmacies	2.08%	2.59%	1.16%	-1.43+	★★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	3.31%	2.65%	1.98%	-0.67+	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	13.21%	9.38%	8.04%	-1.34+	★★
At Least 31 Days Covered—Total	6.70%	5.91%	5.51%	-0.40+	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	8.21%	8.60%	8.43%	-0.17	★★★★
*Expected Readmissions—Total**	10.28%	9.60%	9.53%	-0.07	★★★
*O/E Ratio—Total**	0.80	0.90	0.8844	-0.02	★★★★

[1]HEDIS MY 2020 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–MY 2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Table B-6—MOL Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	71.29%	67.15%	54.83%	-12.32++	★
Combination 7	61.07%	58.64%	46.38%	-12.26++	★
Combination 10	33.82%	33.82%	26.33%	-7.49++	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	59.93%	55.95%	-3.98++	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	67.01%	60.53%	-6.48++	★
Lead Screening in Children					
Lead Screening in Children	78.83%	72.14%	59.61%	-12.53++	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	51.03%	59.60%	+8.57+	★★★
Ages 12 to 17 Years	—	45.06%	52.34%	+7.28+	★★★
Ages 18 to 21 Years	—	29.85%	31.90%	+2.05+	★★★
Total	—	45.75%	52.26%	+6.51+	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	87.59%	83.70%	77.32%	-6.38++	★★
Combination 2 (Meningococcal, Tdap, HPV)	42.09%	42.34%	32.54%	-9.80++	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	43.00%	51.67%	46.10%	-5.57++	★★★
Continuation and Maintenance Phase	47.17%	65.49%	57.07%	-8.42++	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	65.32%	59.09%	62.05%	+2.96+	★★★★
Ages 21 to 24 Years	71.11%	65.40%	65.63%	+0.23	★★★★
Total	67.64%	61.79%	63.67%	+1.88+	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	67.40%	63.99%	57.21%	-6.78++	★★
Breast Cancer Screening					
Breast Cancer Screening	59.27%	55.52%	51.37%	-4.15++	★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	78.91%	75.54%	76.83%	+1.29+	★★★
Ages 45 to 64 Years	87.19%	85.30%	85.37%	+0.07	★★★
Ages 65 Years and Older	93.18%	90.28%	91.58%	+1.30+	★★★★
Total	82.61%	79.57%	80.21%	+0.64+	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	56.03%	58.59%	64.02%	+5.43+	★★
Ages 18 to 64 Years	37.43%	38.65%	46.11%	+7.46+	★★★★
Ages 65 Years And Older	38.14%	22.73%	34.09%	+11.36	★★
Total	47.10%	48.76%	52.23%	+3.47+	★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	72.02%	70.08%	61.07%	-9.01++	★
Ages 18 to 64 Years	54.73%	52.12%	48.19%	-3.93++	★
Ages 65 Years And Older	41.67%	24.00%	26.32%	+2.32	★★★
Total	66.65%	63.70%	54.42%	-9.28++	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	88.42%	89.18%	92.82%	+3.64+	★★★
Ages 18 to 64 Years	73.82%	76.95%	79.99%	+3.04+	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	65.93%	61.31%	73.11%	+11.80+	★★
Total	84.57%	85.63%	88.38%	+2.75+	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	85.67%	76.89%	75.67%	-1.22	★★
Counseling for Nutrition—Total	74.63%	70.80%	71.29%	+0.49	★★★
Counseling for Physical Activity—Total	74.33%	67.64%	68.13%	+0.49	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	97.81%	81.27%	78.35%	-2.92	★
Postpartum Care	77.86%	70.32%	70.07%	-0.25	★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	89.29%	82.73%	87.10%	+4.37	★★★★
*HbA1c Poor Control (>9.0%)**	37.23%	44.77%	39.90%	-4.87	★★★
HbA1c Control (<8.0%)	52.07%	43.31%	51.82%	+8.51+	★★★★
Eye Exam (Retinal) Performed	58.88%	53.28%	57.18%	+3.90	★★★
BP Control (<140/90 mm Hg)	—	56.93%	62.77%	+5.84	★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	30.64%	27.62%	-3.02++	★★
Ages 65 to 74 Years	—	33.74%	30.61%	-3.13	★★
Ages 75 to 85 Years	—	34.29%	31.92%	-2.37	★★
Total	—	30.94%	27.91%	-3.03++	★★
Asthma Medication Ratio					
Total	55.87%	52.96%	54.32%	+1.36	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	50.85%	55.96%	+5.11	★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	77.25%	73.80%	79.05%	+5.25	★★★
Discussing Cessation Medications	58.59%	58.38%	61.84%	+3.46	★★★★★
Discussing Cessation Strategies	49.61%	51.35%	54.81%	+3.46	★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	43.73%	61.61%	64.51%	+2.90+	★★★★
Effective Continuation Phase Treatment	26.47%	43.83%	47.25%	+3.42+	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.56%	78.55%	80.71%	+2.16+	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	69.18%	62.18%	64.42%	+2.24	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	71.67%	67.27%	64.36%	-2.91	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	41.22%	71.35%	65.79%	-5.56++	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	45.25%	45.74%	46.75%	+1.01	NC
Total—Black or African American	34.24%	34.04%	34.09%	+0.05	NC
Total—American–Indian and Alaska Native	0.27%	0.27%	0.36%	+0.09	NC
Total—Asian	0.29%	0.30%	0.24%	-0.06	NC
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.00%	0.00%	0.00	NC
Total—Some Other Race	0.00%	0.00%	0.00%	0.00	NC
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Total—Unknown	19.95%	19.64%	18.56%	-1.08	NC
Total—Declined	0.00%	0.00%	0.00%	0.00	NC
Total—Hispanic or Latino	6.90%	6.92%	5.99%	-0.93	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.52%	98.51%	98.47%	-0.04	NC
Spoken Language Preferred for Health Care—Non-English	1.43%	1.47%	1.51%	+0.04	NC
Spoken Language Preferred for Health Care—Unknown	0.05%	0.02%	0.02%	0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	98.52%	98.51%	98.47%	-0.04	NC
Language Preferred for Written Materials—Non-English	1.43%	1.47%	1.51%	+0.04	NC
Language Preferred for Written Materials—Unknown	0.05%	0.02%	0.02%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.52%	98.51%	98.47%	-0.04	NC
Other Language Needs—Non-English	1.43%	1.47%	1.51%	+0.04	NC
Other Language Needs—Unknown	0.05%	0.02%	0.02%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	66.87	47.07	49.45	+2.38	★
Outpatient Visits Including Telehealth—Total	429.45	340.07	379.92	+39.85	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	7.20	5.99	6.70	+0.71	NC
Total Inpatient—Average Length of Stay—Total All Ages	4.80	5.13	5.08	-0.05	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	2.69	2.44	2.29	-0.15	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	2.85	2.83	2.83	0.00	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	1.70	1.35	1.45	+0.10	NC
Surgery—Average Length of Stay—Total All Ages	8.16	9.18	9.16	-0.02	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	3.56	2.86	3.55	+0.69	NC
Medicine—Average Length of Stay—Total All Ages	4.25	4.65	4.49	-0.16	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	14.07%	13.36%	13.12%	-0.24	★★★★
Multiple Pharmacies	3.84%	2.75%	2.11%	-0.64+	★★★
Multiple Prescribers and Multiple Pharmacies	2.06%	1.70%	1.43%	-0.27	★★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.29%	2.15%	6.68%	**+4.53++**	★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	12.76%	9.82%	19.58%	**+9.76++**	★
At Least 31 Days Covered—Total	6.62%	6.95%	12.07%	**+5.12++**	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	8.87%	9.43%	8.98%	-0.45	★★★
*Expected Readmissions—Total**	9.56%	9.90%	9.76%	-0.14	★★★
*O/E Ratio—Total**	0.93	0.95	0.9205	-0.03+	★★★

[1]HEDIS MY 2020 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–MY 2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Table B-7—PRI Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	76.89%	74.70%	61.26%	-13.44++	★
Combination 7	68.86%	65.94%	52.72%	-13.22++	★
Combination 10	47.93%	47.93%	35.68%	-12.25++	★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	65.77%	59.18%	-6.59++	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	75.71%	65.58%	-10.13++	★
Lead Screening in Children					
Lead Screening in Children	82.00%	78.35%	56.02%	-22.33++	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	55.86%	60.53%	+4.67+	★★★★
Ages 12 to 17 Years	—	46.32%	51.89%	+5.57+	★★★
Ages 18 to 21 Years	—	28.87%	30.06%	+1.19	★★★
Total	—	49.14%	52.67%	+3.53+	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	87.35%	87.59%	81.51%	-6.08++	★★
Combination 2 (Meningococcal, Tdap, HPV)	50.85%	45.99%	36.74%	-9.25++	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	36.56%	37.07%	31.21%	-5.86++	★
Continuation and Maintenance Phase	40.30%	42.59%	38.21%	-4.38	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	67.87%	58.78%	60.52%	+1.74	★★★★
Ages 21 to 24 Years	68.88%	63.95%	66.59%	+2.64+	★★★★
Total	68.30%	61.05%	63.39%	+2.34+	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	73.24%	67.88%	63.99%	-3.89	★★★★
Breast Cancer Screening					
Breast Cancer Screening	66.04%	64.51%	56.52%	-7.99++	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	81.45%	76.55%	73.78%	-2.77++	★★
Ages 45 to 64 Years	89.15%	85.47%	83.17%	-2.30++	★★
Ages 65 Years and Older	94.82%	91.77%	90.26%	-1.51	★★★★
Total	84.72%	80.06%	77.22%	-2.84++	★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	69.89%	71.56%	72.04%	+0.48	★★★
Ages 18 to 64 Years	45.63%	48.74%	52.75%	+4.01	★★★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	55.95%	59.51%	58.50%	-1.01	★★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	82.40%	81.08%	71.38%	-9.70++	★
Ages 18 to 64 Years	72.26%	68.19%	59.77%	-8.42++	★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	78.75%	76.32%	64.77%	-11.55++	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	94.65%	95.18%	96.10%	+0.92+	★★★★
Ages 18 to 64 Years	86.80%	87.57%	88.79%	+1.22	★★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	83.33%	89.74%	87.50%	-2.24	★★★★
Total	92.45%	93.04%	93.48%	+0.44	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	93.43%	90.02%	91.97%	+1.95	★★★★★
Counseling for Nutrition—Total	85.16%	81.75%	83.70%	+1.95	★★★★★
Counseling for Physical Activity—Total	84.43%	80.29%	82.73%	+2.44	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	92.21%	86.37%	79.56%	**-6.81⁺⁺**	★★
Postpartum Care	80.05%	79.56%	75.91%	-3.65	★★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	92.70%	90.51%	86.37%	-4.14	★★★★
*HbA1c Poor Control (>9.0%)**	26.28%	28.47%	34.31%	+5.84	★★★★
HbA1c Control (<8.0%)	65.94%	60.58%	55.72%	-4.86	★★★★★
Eye Exam (Retinal) Performed	72.75%	63.02%	61.31%	-1.71	★★★★
BP Control (<140/90 mm Hg)	—	75.91%	69.59%	**-6.32⁺⁺**	★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	38.84%	34.91%	**-3.93⁺⁺**	★★★
Ages 65 to 74 Years	—	31.63%	34.09%	+2.46	★★★
Ages 75 to 85 Years	—	36.36%	29.77%	-6.59	★★
Total	—	38.23%	34.79%	**-3.44⁺⁺**	★★★
Asthma Medication Ratio					
Total	71.70%	73.36%	62.79%	**-10.57⁺⁺**	★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	74.94%	66.42%	**-8.52⁺⁺**	★★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	81.78%	79.39%	76.92%	-2.47	★★★
Discussing Cessation Medications	58.88%	56.29%	49.42%	-6.87	★★
Discussing Cessation Strategies	55.14%	51.22%	44.71%	-6.51	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	74.59%	62.76%	68.78%	+6.02⁺	★★★★★
Effective Continuation Phase Treatment	55.74%	45.30%	51.45%	+6.15⁺	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.17%	80.64%	83.40%	+2.76	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	57.69%	61.00%	72.60%	+11.60⁺	★★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.11%	72.27%	66.79%	-5.48	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	58.71%	59.62%	59.24%	-0.38	NC
Total—Black or African American	14.63%	15.20%	26.40%	+11.20	NC
Total—American–Indian and Alaska Native	0.55%	0.55%	0.78%	+0.23	NC
Total—Asian	1.81%	0.97%	0.92%	-0.05	NC
Total—Native Hawaiian and Other Pacific Islander	0.07%	0.08%	0.11%	+0.03	NC
Total—Some Other Race	0.00%	0.00%	0.01%	+0.01	NC
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Total—Unknown	24.23%	23.58%	12.09%	-11.49	NC
Total—Declined	0.00%	0.00%	0.46%	+0.46	NC
Total—Hispanic or Latino	10.98%	11.27%	0.62%	-10.65	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	0.00%	0.00%	1.09%	+1.09	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	100.00%	98.91%	-1.09	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	0.00%	0.00%	1.09%	+1.09	NC
Language Preferred for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—Unknown	100.00%	100.00%	98.91%	-1.09	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.00%	0.00%	1.09%	+1.09	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	100.00%	100.00%	98.91%	-1.09	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	65.08	49.54	52.19	+2.65	★
Outpatient Visits Including Telehealth—Total	379.56	294.42	318.56	+24.14	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	6.33	5.35	5.78	+0.43	NC
Total Inpatient—Average Length of Stay—Total All Ages	3.85	4.27	4.72	+0.45	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	3.07	2.72	2.15	-0.57	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	2.94	3.01	2.88	-0.13	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	1.64	1.30	1.36	+0.06	NC
Surgery—Average Length of Stay—Total All Ages	5.41	6.23	7.59	+1.36	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	2.56	2.13	2.83	+0.70	NC
Medicine—Average Length of Stay—Total All Ages	3.61	4.21	4.38	+0.17	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	19.47%	18.70%	17.20%	-1.50^{+}	★★★
Multiple Pharmacies	2.39%	2.23%	2.38%	+0.15	★★★
Multiple Prescribers and Multiple Pharmacies	1.43%	1.21%	1.34%	+0.13	★★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	3.20%	3.04%	11.32%	**+8.28^{++}**	★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	9.87%	10.85%	14.30%	**+3.45^{++}**	★
At Least 31 Days Covered—Total	4.62%	5.88%	8.23%	**+2.35^{++}**	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	6.34%	7.75%	8.51%	+0.76	★★★★
*Expected Readmissions—Total**	9.97%	9.61%	9.75%	+0.14	★★★
*O/E Ratio—Total**	0.64	0.81	0.8721	**+0.06^{++}**	★★★★

[1]HEDIS MY 2020 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–MY 2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Table B-8—UNI Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	68.13%	61.80%	52.40%	-9.40++	★
Combination 7	57.18%	54.74%	43.81%	-10.93++	★
Combination 10	32.36%	29.68%	24.91%	-4.77++	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	61.25%	57.52%	-3.73++	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	65.10%	58.08%	-7.02++	★
Lead Screening in Children					
Lead Screening in Children	78.35%	74.70%	58.88%	-15.82++	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	50.09%	57.53%	+7.44+	★★★
Ages 12 to 17 Years	—	42.31%	50.23%	+7.92+	★★★
Ages 18 to 21 Years	—	29.19%	32.09%	+2.90+	★★★
Total	—	44.24%	50.60%	+6.36+	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	85.16%	80.78%	78.83%	-1.95	★★
Combination 2 (Meningococcal, Tdap, HPV)	42.34%	38.20%	34.31%	-3.89	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	BR	41.20%	38.96%	-2.24	★★
Continuation and Maintenance Phase	BR	54.09%	56.71%	+2.62	★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	64.73%	59.85%	60.01%	+0.16	★★★★
Ages 21 to 24 Years	69.61%	64.95%	65.18%	+0.23	★★★
Total	66.70%	62.06%	62.36%	+0.30	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	68.37%	57.66%	58.88%	+1.22	★★
Breast Cancer Screening					
Breast Cancer Screening	59.73%	54.30%	51.15%	-3.15++	★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	77.80%	73.73%	75.44%	+1.71+	★★★
Ages 45 to 64 Years	87.89%	84.72%	85.50%	+0.78+	★★★
Ages 65 Years and Older	92.43%	88.25%	91.11%	+2.86+	★★★★
Total	81.79%	77.79%	79.02%	+1.23+	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	59.47%	60.54%	62.35%	+1.81	★★
Ages 18 to 64 Years	36.88%	38.84%	43.88%	+5.04+	★★★
Ages 65 Years And Older	NA	31.25%	NA	NC	NC
Total	48.09%	49.38%	50.25%	+0.87	★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	76.94%	73.31%	62.16%	-11.15++	★
Ages 18 to 64 Years	52.83%	51.63%	41.68%	-9.95++	★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	68.81%	65.10%	50.73%	-14.37++	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	90.70%	91.43%	94.24%	+2.81+	★★★
Ages 18 to 64 Years	72.60%	75.01%	77.10%	+2.09+	★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	NA	67.80%	65.85%	-1.95	★
Total	86.03%	86.75%	88.40%	+1.65+	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	89.29%	82.48%	79.56%	-2.92	★★★
Counseling for Nutrition—Total	81.27%	73.72%	74.94%	+1.22	★★★
Counseling for Physical Activity—Total	79.81%	71.29%	74.94%	+3.65	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	86.86%	78.83%	82.48%	+3.65	★★
Postpartum Care	75.18%	71.78%	74.70%	+2.92	★★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	91.51%	83.21%	89.78%	+6.57+	★★★★★
*HbA1c Poor Control (>9.0%)**	29.63%	34.79%	33.09%	-1.70	★★★★★
HbA1c Control (<8.0%)	60.80%	54.26%	56.93%	+2.67	★★★★★
Eye Exam (Retinal) Performed	61.27%	55.23%	55.47%	+0.24	★★★
BP Control (<140/90 mm Hg)	—	63.75%	67.15%	+3.40	★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	35.65%	37.55%	+1.90+	★★★★
Ages 65 to 74 Years	—	35.70%	43.35%	+7.65+	★★★★
Ages 75 to 85 Years	—	40.96%	47.69%	+6.73	★★★★
Total	—	35.69%	37.87%	+2.18+	★★★★
Asthma Medication Ratio					
Total	62.58%	61.08%	59.94%	-1.14	★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	62.53%	64.72%	+2.19	★★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	85.02%	80.79%	79.19%	-1.60	★★★
Discussing Cessation Medications	63.05%	60.12%	56.76%	-3.36	★★★
Discussing Cessation Strategies	57.14%	52.02%	47.62%	-4.40	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	56.04%	54.48%	61.65%	+7.17+	★★★
Effective Continuation Phase Treatment	39.44%	38.21%	45.20%	+6.99+	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.12%	80.12%	84.31%	+4.19+	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	69.46%	61.61%	65.26%	+3.65	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	73.21%	67.86%	66.04%	-1.82	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	57.61%	65.78%	61.53%	-4.25++	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	50.75%	50.57%	55.96%	+5.39	NC
Total—Black or African American	30.35%	29.76%	30.84%	+1.08	NC
Total—American–Indian and Alaska Native	0.31%	0.30%	0.60%	+0.30	NC
Total—Asian	2.23%	3.38%	1.79%	-1.59	NC
Total—Native Hawaiian and Other Pacific Islander	0.08%	0.08%	0.10%	+0.02	NC
Total—Some Other Race	0.00%	0.00%	0.00%	0.00	NC
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Total—Unknown	16.28%	15.90%	10.70%	-5.20	NC
Total—Declined	0.00%	0.00%	0.00%	0.00	NC
Total—Hispanic or Latino	6.14%	6.34%	1.23%	-5.11	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	96.02%	96.13%	96.20%	+0.07	NC
Spoken Language Preferred for Health Care—Non-English	3.94%	3.86%	3.80%	-0.06	NC
Spoken Language Preferred for Health Care—Unknown	0.04%	0.01%	0.00%	-0.01	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	96.02%	96.13%	96.20%	+0.07	NC
Language Preferred for Written Materials—Non-English	3.94%	3.86%	3.80%	-0.06	NC
Language Preferred for Written Materials—Unknown	0.04%	0.01%	0.00%	-0.01	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	96.02%	96.13%	96.20%	+0.07	NC
Other Language Needs—Non-English	3.94%	3.86%	3.80%	-0.06	NC
Other Language Needs—Unknown	0.04%	0.01%	0.00%	-0.01	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	65.10	46.01	49.35	+3.34	★
Outpatient Visits Including Telehealth—Total	374.36	315.19	355.48	+40.29	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	5.68	5.29	4.90	-0.39	NC
Total Inpatient—Average Length of Stay—Total All Ages	4.63	4.70	5.11	+0.41	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	2.53	2.27	1.84	-0.43	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	2.60	2.46	2.46	0.00	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	1.40	1.19	1.19	0.00	NC
Surgery—Average Length of Stay—Total All Ages	7.61	8.02	8.56	+0.54	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	2.44	2.41	2.32	-0.09	NC
Medicine—Average Length of Stay—Total All Ages	4.45	4.61	4.94	+0.33	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	15.67%	14.38%	15.22%	+0.84	★★★
Multiple Pharmacies	3.21%	2.00%	1.70%	-0.30	★★★★
Multiple Prescribers and Multiple Pharmacies	1.64%	1.17%	1.15%	-0.02	★★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	3.60%	2.90%	2.76%	-0.14	★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	15.82%	9.87%	9.06%	-0.81+	★
At Least 31 Days Covered—Total	7.14%	6.80%	6.51%	-0.29	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	11.39%	12.05%	10.76%	-1.29+	★★
*Expected Readmissions—Total**	10.69%	10.77%	10.75%	-0.02	★
*O/E Ratio—Total**	1.06	1.12	1.0007	-0.12+	★★

[1]HEDIS MY 2020 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Table B-9—UPP Trend Table

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	70.07%	66.08%	60.69%	-5.39++	★
Combination 7	57.91%	53.94%	50.58%	-3.36	★
Combination 10	40.63%	39.21%	36.32%	-2.89	★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	70.27%	67.53%	-2.74	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	73.13%	67.43%	-5.70++	★★
Lead Screening in Children					
Lead Screening in Children	79.23%	74.48%	39.75%	-34.73++	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	50.87%	57.85%	+6.98+	★★★
Ages 12 to 17 Years	—	43.87%	51.87%	+8.00+	★★★
Ages 18 to 21 Years	—	22.41%	23.44%	+1.03	★★
Total	—	44.29%	49.99%	+5.70+	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	77.32%	80.72%	79.30%	-1.42	★★
Combination 2 (Meningococcal, Tdap, HPV)	35.07%	34.93%	34.53%	-0.40	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	47.77%	50.42%	38.40%	-12.02++	★★
Continuation and Maintenance Phase	58.76%	62.20%	43.30%	-18.90++	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	46.00%	41.01%	41.06%	+0.05	★
Ages 21 to 24 Years	55.87%	49.82%	51.13%	+1.31	★
Total	50.29%	44.89%	45.73%	+0.84	★
Cervical Cancer Screening					
Cervical Cancer Screening	64.96%	58.15%	61.31%	+3.16	★★★
Breast Cancer Screening					
Breast Cancer Screening	64.85%	61.87%	59.29%	-2.58++	★★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	81.08%	78.29%	76.69%	-1.60++	★★★
Ages 45 to 64 Years	87.99%	85.12%	84.68%	-0.44	★★★
Ages 65 Years and Older	94.93%	92.68%	95.29%	+2.61+	★★★★★
Total	84.69%	81.72%	80.61%	-1.11++	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	58.03%	64.64%	64.47%	-0.17	★★
Ages 18 to 64 Years	31.94%	36.47%	45.14%	+8.67+	★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	42.62%	47.53%	50.77%	+3.24	★★
Appropriate Testing for Pharyngitis					
Ages 3 to 17 Years	78.22%	79.18%	85.35%	+6.17+	★★★
Ages 18 to 64 Years	68.24%	71.84%	76.03%	+4.19	★★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	74.41%	76.40%	80.23%	+3.83+	★★★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	89.64%	91.43%	94.19%	+2.76+	★★★
Ages 18 to 64 Years	83.16%	83.13%	88.85%	+5.72+	★★★★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Ages 65 Years And Older	80.00%	NA	NA	NC	NC
Total	87.63%	88.72%	92.24%	+3.52+	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	89.29%	88.08%	89.54%	+1.46	★★★★★
Counseling for Nutrition—Total	69.59%	72.99%	75.18%	+2.19	★★★
Counseling for Physical Activity—Total	69.10%	69.59%	72.02%	+2.43	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	92.46%	91.24%	92.21%	+0.97	★★★★★
Postpartum Care	90.27%	87.59%	88.08%	+0.49	★★★★★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	92.70%	87.59%	90.51%	+2.92	★★★★★
*HbA1c Poor Control (>9.0%)**	24.57%	29.93%	33.33%	+3.40	★★★★★
HbA1c Control (<8.0%)	61.07%	57.42%	55.47%	-1.95	★★★★★
Eye Exam (Retinal) Performed	70.56%	61.07%	59.61%	-1.46	★★★★
BP Control (<140/90 mm Hg)	—	78.35%	82.48%	+4.13	★★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	34.80%	34.50%	-0.30	★★★
Ages 65 to 74 Years	—	38.66%	39.38%	+0.72	★★★
Ages 75 to 85 Years	—	27.78%	35.06%	+7.28	★★★
Total	—	34.97%	34.98%	+0.01	★★★
Asthma Medication Ratio					
Total	62.33%	58.42%	57.59%	-0.83	★

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	73.24%	79.08%	+5.84+	★★★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	79.96%	76.50%	76.40%	-3.10	★★★
Discussing Cessation Medications	59.96%	63.00%	58.87%	-4.13	★★★★
Discussing Cessation Strategies	54.65%	56.03%	52.69%	-3.34	★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	55.85%	62.13%	64.14%	+2.01	★★★★
Effective Continuation Phase Treatment	40.30%	44.50%	46.68%	+2.18	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.08%	85.06%	86.36%	+1.30	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	81.25%	82.35%	85.71%	+3.36	★★★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	81.84%	84.72%	85.09%	+0.37	★★★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
Total—White	86.34%	87.12%	87.82%	+0.70	NC
Total—Black or African American	1.46%	1.66%	1.77%	+0.11	NC
Total—American–Indian and Alaska Native	2.34%	2.67%	3.70%	+1.03	NC
Total—Asian	2.07%	0.44%	0.28%	-0.16	NC
Total—Native Hawaiian and Other Pacific Islander	0.11%	0.13%	0.13%	0.00	NC
Total—Some Other Race	1.92%	2.08%	0.19%	-1.89	NC
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Total—Unknown	0.00%	0.00%	0.00%	0.00	NC
Total—Declined	5.76%	5.90%	6.11%	+0.21	NC
Total—Hispanic or Latino	1.92%	2.08%	0.19%	-1.89	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.90%	99.90%	99.88%	-0.02	NC
Spoken Language Preferred for Health Care—Non-English	0.07%	0.07%	0.10%	+0.03	NC
Spoken Language Preferred for Health Care—Unknown	0.02%	0.03%	0.02%	-0.01	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	99.90%	99.90%	99.88%	-0.02	NC
Language Preferred for Written Materials—Non-English	0.07%	0.07%	0.10%	+0.03	NC
Language Preferred for Written Materials—Unknown	0.02%	0.03%	0.02%	-0.01	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	54.01	42.87	48.47	+5.60	★
Outpatient Visits Including Telehealth—Total	351.79	317.54	343.99	+26.45	NC
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total All Ages	7.06	6.20	6.06	-0.14	NC
Total Inpatient—Average Length of Stay—Total All Ages	4.08	4.41	4.65	+0.24	NC
Maternity—Discharges per 1,000 Member Months—Total All Ages	2.13	2.01	1.83	-0.18	NC

Measure	HEDIS MY 2019	HEDIS MY 2020	HEDIS MY 2021	MY 2020–MY 2021 Comparison[1]	MY 2021 Performance Level[2]
Maternity—Average Length of Stay—Total All Ages	2.80	2.75	2.61	-0.14	NC
Surgery—Discharges per 1,000 Member Months—Total All Ages	2.25	1.83	1.81	-0.02	NC
Surgery—Average Length of Stay—Total All Ages	5.71	6.46	6.80	+0.34	NC
Medicine—Discharges per 1,000 Member Months—Total All Ages	3.26	2.88	2.88	0.00	NC
Medicine—Average Length of Stay—Total All Ages	3.56	3.96	4.27	+0.31	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	15.76%	16.04%	17.73%	+1.69	★★★
Multiple Pharmacies	6.33%	6.41%	6.83%	+0.42	★
Multiple Prescribers and Multiple Pharmacies	4.24%	4.77%	5.17%	+0.40	★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	3.51%	3.33%	2.38%	-0.95	★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	7.95%	9.27%	7.87%	-1.40+	★★
At Least 31 Days Covered—Total	4.38%	5.43%	5.30%	-0.13	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	8.40%	9.38%	9.06%	-0.32	★★★
*Expected Readmissions—Total**	9.82%	9.97%	9.99%	+0.02	★★
*O/E Ratio—Total**	0.86	0.94	0.9076	-0.03	★★★★

[1]HEDIS MY 2021 to HEDIS MY 2020 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2021 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–MY 2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2021 Performance Levels were based on comparisons of the HEDIS MY 2021 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2020 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2020 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates and any Performance Levels for MY 2021 or MY 2020–MY 2021 Comparisons provided for these measures are for information purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2021 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Appendix C. Performance Summary Stars

Introduction

This section presents the MHPs' performance summary stars for each measure within the following measure domains:

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Obesity
- Living With Illness
- Utilization

Performance ratings were assigned by comparing the MHPs' HEDIS MY 2021 rates to the HEDIS MY 2020 MWA Quality Compass national Medicaid benchmarks (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*). Please note, HSAG assigned performance ratings to all but one measure in the Utilization measure domain, *Plan All-Cause Readmissions*. Please refer to Appendix B for comparisons to national percentiles for *Plan All-Cause Readmissions*. Measures in the Health Plan Diversity domain and the remaining utilization-based measure rates were not evaluated based on comparisons to national benchmarks; however, rates for these measure indicators are presented in Appendix B. Due to changes in the technical specifications for Well-Child Visits in the First 30 Months of Life—Six or More Well-Child Visits, Child and Adolescent Well-Care Visits, Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), Controlling High Blood Pressure in HEDIS MY 2021, NCQA does not recommend comparing these measures' rates to national Medicaid benchmarks; therefore, these measures are not displayed in this appendix. Additional details about the performance comparisons and star ratings are found in Section 2.

Child & Adolescent Care Performance Summary Stars

Table C-1—Child & Adolescent Care Performance Summary Stars (Table 1 of 3)

MHP	*Childhood Immunization Status—Combination 3*	*Childhood Immunization Status—Combination 7*	*Childhood Immunization Status—Combination 10*	*Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*	*Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*	*Lead Screening in Children*
AET	★	★	★	★	★	★
BCC	★	★	★	★★★★	★	★
HAP	★	★	★	★	★	★
MCL	★	★	★	★★★	★	★
MER	★	★	★	★★★	★	★
MOL	★	★	★	★★★	★	★
PRI	★	★	★★	★★★	★	★
UNI	★	★	★	★★★	★	★
UPP	★	★	★★	★★★★	★★	★

Table C-2—Child & Adolescent Care Performance Summary Stars (Table 2 of 3)

MHP	*Child and Adolescent Well-Care Visits—Ages 3 to 11 Years*	*Child and Adolescent Well-Care Visits—Ages 12 to 17 Years*	*Child and Adolescent Well-Care Visits—Ages 18 to 21 Years*	*Child and Adolescent Well-Care Visits—Total*	*Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*	*Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
AET	★★★	★★	★★	★★	★	★
BCC	★★★	★★★	★★★	★★★	★	★★
HAP	★★	★	★★	★	★	★
MCL	★★★	★★	★★	★★★	★★	★
MER	★★★	★★★	★★★	★★★	★	★★
MOL	★★★	★★★	★★★	★★★	★★	★★
PRI	★★★★	★★★	★★★	★★★	★★	★★★
UNI	★★★	★★★	★★★	★★★	★★	★★
UPP	★★★	★★★	★★	★★★	★★	★★

Table C-3—Child & Adolescent Care Performance Summary Stars (Table 3 of 3)

MHP	*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*	*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
AET	★	NA
BCC	★★	★★★
HAP	★	NA
MCL	★★	★★
MER	★★	★★
MOL	★★★	★★★
PRI	★	★
UNI	★★	★★★
UPP	★★	★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Women—Adult Care Performance Summary Stars

Table C-4—Women—Adult Care Performance Summary Stars

MHP	*Chlamydia Screening in Women—Ages 16 to 20 Years*	*Chlamydia Screening in Women—Ages 21 to 24 Years*	*Chlamydia Screening in Women—Total*	*Cervical Cancer Screening*	*Breast Cancer Screening*
AET	★★★★	★★★★	★★★★	★	★
BCC	★★★	★★★	★★★	★★★	★★
HAP	★★★	★★	★★★	★	★★★
MCL	★★★	★★★	★★★	★★	★★
MER	★★★	★★★	★★★	★★	★★
MOL	★★★★	★★★★	★★★★	★★	★★
PRI	★★★★	★★★★	★★★★	★★★★	★★★
UNI	★★★★	★★★	★★★★	★★	★★
UPP	★	★	★	★★★	★★★★

Access to Care Performance Summary Stars

Table C-5—Access to Care Performance Summary Stars (Table 1 of 3)

MHP	*Adults' Access to Preventive/ Ambulatory Health Services—Ages 20 to 44 Years*	*Adults' Access to Preventive/ Ambulatory Health Services—Ages 45 to 64 Years*	*Adults' Access to Preventive/ Ambulatory Health Services—Ages 65 Years and Older*	*Adults' Access to Preventive/ Ambulatory Health Services—Total*	*Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis—Ages 3 Months to 17 Years*	*Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis—Ages 18 to 64 Years*
AET	★	★★	★★★★	★	★★★	★★★★★
BCC	★★★	★★★	★	★★★	★★★	★★★
HAP	★	★	★★★★	★	★★★	★★★
MCL	★★	★★	★	★★	★★	★★★
MER	★★★	★★★	★★★	★★★	★★★	★★★★
MOL	★★★	★★★	★★★★	★★★	★★	★★★★
PRI	★★	★★	★★★★	★★	★★★	★★★★★
UNI	★★★	★★★	★★★★	★★★	★★	★★★
UPP	★★★	★★★	★★★★★	★★★	★★	★★★

Table C-6—Access to Care Performance Summary Stars (Table 2 of 3)

MHP	*Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis—Ages 65 Years And Older*	*Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis—Total*	*Appropriate Testing for Pharyngitis—Ages 3 to 17 Years*	*Appropriate Testing for Pharyngitis—Ages 18 to 64 Years*	*Appropriate Testing for Pharyngitis—Ages 65 Years And Older*	*Appropriate Testing for Pharyngitis—Total*
AET	NA	★★★	★	★	NA	★
BCC	NA	★★	★	★	NA	★
HAP	NA	★★	★	★	NA	★
MCL	NA	★★	★★	★★★	NA	★★
MER	★★★	★★	★	★★	NA	★
MOL	★★	★★	★	★	★★★	★
PRI	NA	★★★	★	★★	NA	★
UNI	NA	★★	★	★	NA	★
UPP	NA	★★	★★★	★★★★	NA	★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table C-7—Access to Care Performance Summary Stars (Table 3 of 3)

MHP	*Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*	*Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years*	*Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years And Older*	*Appropriate Treatment for Upper Respiratory Infection—Total*
AET	★★★	★★★	★★	★★★
BCC	★★★	★★★	NA	★★
HAP	★★★★	★★★	★	★★
MCL	★★★	★★★	NA	★★★
MER	★★★	★★★	★★★★	★★★
MOL	★★★	★★★	★★	★★
PRI	★★★★	★★★★	★★★★	★★★★
UNI	★★★	★★	★	★★
UPP	★★★	★★★★	NA	★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Obesity Performance Summary Stars

Table C-8—Obesity Performance Summary Stars

MHP	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
AET	★★★★	★★★	★★★
BCC	★★★★	★★★	★★★★
HAP	★★★	★★★	★★★★
MCL	★	★	★
MER	★★	★★	★★
MOL	★★	★★★	★★★
PRI	★★★★★	★★★★★	★★★★★
UNI	★★★	★★★	★★★★
UPP	★★★★★	★★★	★★★

Pregnancy Care Performance Summary Stars

Table C-9—Pregnancy Care Performance Summary Stars

MHP	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*	*Prenatal and Postpartum Care—Postpartum Care*
AET	★	★
BCC	★★★	★★★
HAP	★	★
MCL	★	★
MER	★	★★
MOL	★	★
PRI	★★	★★
UNI	★★	★★
UPP	★★★★★	★★★★★

Living With Illness Performance Summary Stars

Table C-10—Living With Illness Performance Summary Stars (Table 1 of 4)

MHP	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*	*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*	*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*	*Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years*
AET	★★	★★★	★★★	★★★	★	★
BCC	★★★	★★★★	★★★	★★★	★★★	★★
HAP	★★★	★★	★★	★★	★★	★★★
MCL	★★★★	★	★	★★	★	★★
MER	★★★	★	★★	★★	★★	★★★
MOL	★★★★	★★★	★★★★	★★★	★★★	★★
PRI	★★★★	★★★★	★★★★★	★★★★	★★★★	★★★
UNI	★★★★★	★★★★★	★★★★★	★★★	★★★★	★★★★
UPP	★★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★

Table C-11—Living With Illness Performance Summary Stars (Table 2 of 4)

MHP	*Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years*	*Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years*	*Kidney Health Evaluation for Patients With Diabetes—Total*	*Asthma Medication Ratio—Total*	*Controlling High Blood Pressure*	*Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*
AET	★	★	★	★	★★★	★★
BCC	★★	★★	★★	★	★★★	★★
HAP	★★★	★★★	★★★	★	★★★	★
MCL	★★★	NA	★★	★	★	★
MER	★	★	★★	★	★	★★
MOL	★★	★★	★★	★	★★★	★★★
PRI	★★★	★★	★★★	★★	★★★★	★★★
UNI	★★★★	★★★★	★★★★	★★	★★★★	★★★
UPP	★★★	★★★	★★★	★	★★★★★	★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table C-12—Living With Illness Performance Summary Stars (Table 3 of 4)

MHP	*Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications*	*Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*	*Antidepressant Medication Management—Effective Acute Phase Treatment*	*Antidepressant Medication Management—Effective Continuation Phase Treatment*	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*Diabetes Monitoring for People With Diabetes and Schizophrenia*
AET	★★★★	★★★	★★★★	★★★★	★★★	★
BCC	★★	★★	★★★★★	★★★★	★★★★	★
HAP	★★	★★	★★★★★	★★★★★	★★	★★★
MCL	★★	★★	★★★★★	★★★★	★★★	★★★
MER	★★★	★★	★★★	★★★★	★★★★	★★★
MOL	★★★★★	★★★★	★★★★	★★★★	★★★★	★★★
PRI	★★	★★	★★★★★	★★★★	★★★★★	★★★★
UNI	★★★	★★★	★★★	★★★	★★★★★	★★★
UPP	★★★★	★★★★	★★★★	★★★★	★★★★★	★★★★★

Table C-13—Living With Illness Performance Summary Stars (Table 4 of 4)

MHP	*Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
AET	NA	★★
BCC	NA	★★
HAP	NA	★★
MCL	★	★★★
MER	★	★★★★
MOL	★	★★★
PRI	NA	★★★
UNI	★	★★
UPP	NA	★★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Utilization Performance Summary Stars

Table C-14—Utilization Performance Summary Stars (Table 1 of 2)[1]

MHP	*Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total**	*Use of Opioids From Multiple Providers—Multiple Prescribers*	*Use of Opioids From Multiple Providers—Multiple Pharmacies*	*Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies*	*Use of Opioids at High Dosage*	*Risk of Continued Opioid Use—At Least 15 Days Covered—Total*
AET	★	★★★	★★★	★★	★★★	★
BCC	★★	★★★	★★★	★★	★★★★	★★
HAP	★	★★★	★★★	★★	★★★★	★
MCL	★	★★★★	★★★	★★★	★★★	★★
MER	★	★★★★	★★★	★★★	★★★★	★★
MOL	★	★★★★	★★★	★★★	★★	★
PRI	★	★★★	★★★	★★★	★	★
UNI	★	★★★	★★★★	★★★	★★★	★
UPP	★	★★★	★	★	★★★	★★

[1]*A lower rate may indicate more favorable performance for this measure indicator (i.e., low rates of ED services may indicate better utilization of services). Therefore, percentiles were reversed to align with performance (e.g., the 10th percentile [a lower rate] was inverted to become the 90th percentile, indicating better performance).*

Table C-15—Utilization Performance Summary Stars (Table 2 of 2)[1]

MHP	*Risk of Continued Opioid Use—At Least 31 Days Covered—Total*	*Plan All-Cause Readmissions—Observed Readmissions—Total*	*Plan All-Cause Readmissions—Expected Readmissions—Total*	*Plan All-Cause Readmissions—O/E Ratio—Total*
AET	★	★	★	★
BCC	★	★★	★★	★★
HAP	★	★★★	★★★	★★
MCL	★	★★★	★★★	★★★
MER	★	★★★★	★★★	★★★★
MOL	★	★★★	★★★	★★★
PRI	★	★★★★	★★★	★★★★
UNI	★	★★	★	★★
UPP	★	★★★	★★	★★★★

[1]*A lower rate may indicate more favorable performance for this measure indicator (i.e., low rates of ED services may indicate better utilization of services). Therefore, percentiles were reversed to align with performance (e.g., the 10th percentile [a lower rate] was inverted to become the 90th percentile, indicating better performance).*