



State Fiscal Year 2023 External Quality Review Technical Report

for Integrated Care Organizations

April 2024



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1. Executive Summary

Purpose and Overview of Report

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

The Behavioral and Physical Health and Aging Services Administration (BPHASA) within MDHHS administers and oversees the Michigan Medicaid managed care program, including the MI Health Link program, which contracts with six MCEs, referred to as integrated care organizations (ICOs), to provide Medicare and Medicaid benefits to dual-eligible members in Michigan. The ICOs contracted with MDHHS during state fiscal year (SFY) 2023 are displayed in Table 1-1.

Table 1-1—ICOs in Michigan

| ICO Name | ICO Short Name |
|---|----------------|
| Aetna Better Health Premier Plan (Aetna) | AET |
| AmeriHealth Caritas VIP Care Plus (AmeriHealth) | AMI |
| HAP Empowered (HAP) ¹⁻¹ | HAP |
| MeridianComplete (Meridian) | MER |
| Molina Dual Options MI Health Link (Molina) | MOL |
| Upper Peninsula Health Plan MI Health Link (UPHP) | UPHP |

¹⁻¹ HAP Empowered (HAP) transitioned to HAP CareSource (HCS) effective January 1, 2024. As HAP was the existing name of the ICO during implementation of the external quality review (EQR) activities for this annual EQR technical report, HAP Empowered or HAP is referenced throughout.

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the CMS EQR Protocols).^{1-2,1-3} The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to the quality, timeliness, and accessibility of care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher performing healthcare delivery systems for their dual-eligible Medicare-Medicaid members. For the SFY 2023 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each ICO. Detailed information about each activity's methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

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

¹⁻² Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: <https://www.medicare.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>. Accessed on: Mar 1, 2024.

¹⁻³ HSAG updated the EQR methodologies to align with the 2023 CMS EQR Protocols published in February 2023. However, for the SFY 2023 activities initiated with the ICOs prior to the release of the 2023 CMS EQR Protocols, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols (<https://www.medicare.gov/sites/default/files/2023-03/2019-eqr-protocols-updated.pdf>) and initiated discussions with MDHHS, as appropriate, to align the methodologies to the 2023 CMS EQR Protocols.

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

| Activity | Description | CMS EQR Protocol |
|--|---|--|
| Network Adequacy Validation (NAV) | This activity assesses components of network adequacy in alignment with the priorities of the State. | Protocol 4. Validation of Network Adequacy ¹⁻⁵ (CMS EQR Protocol 4) |
| Encounter Data Validation (EDV) | This activity validates the accuracy and completeness of encounter data submitted by an ICO. | Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (CMS EQR Protocol 5) |
| Consumer Assessment of Healthcare Providers and Systems (CAHPS®) ¹⁻⁶ Analysis | This activity assesses member experience with an ICO and its providers, and the quality of care they receive. | Protocol 6. Administration or Validation of Quality of Care Surveys (CMS EQR Protocol 6) |

MI Health Link Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2023 activities to comprehensively assess the ICOs' performance in providing quality, timely, and accessible healthcare services to dual-eligible members. For each ICO reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the ICO's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all ICOs were also compared and analyzed to develop overarching conclusions and recommendations for MDHHS and the MI Health Link program. Table 1-3 highlights substantive conclusions and actionable, state-specific recommendations, when applicable, for MDHHS to drive progress toward achieving the goals of Michigan's Comprehensive Quality Strategy (CQS)¹⁻⁷ and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members.

¹⁻⁵ This activity was mandatory effective February 2024 with the creation of CMS EQR Protocol 4. HSAG's approach to conducting NAV activities in SFY 2023 were tailored to address the specific needs of MDHHS by focusing on areas selected by MDHHS to assess network adequacy. Future NAV activities will be conducted in full alignment with CMS EQR Protocol 4 and will be included in the EQR technical report in SFY 2025 as required by CMS.

¹⁻⁶ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

¹⁻⁷ The 2020–2023 MDHHS CQS was submitted to CMS and published on the MDHHS website in January 2021. Due to the timing of the EQR activities, and at the direction of MDHHS, HSAG used the 2020–2023 MDHHS CQS for the SFY 2023 EQR assessment. However, the 2023–2026 MDHHS CQS was submitted to CMS in October 2023 and has replaced the 2020–2023 version on MDHHS' website. The 2023–2026 MDHHS CQS is now available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=c062404614184b219a8e4b1d6ddd520a.

Table 1-3—MI Health Link Program Substantive Findings

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|---|---|---|
| Goal #1 —Ensure high quality and high levels of access to care | <p>Conclusions: The results of the SFY 2023 NAV and secret shopper activities identified mixed results related to the assessment of adequate access to providers. As demonstrated through the NAV activity, the ICOs met minimum network requirements for each region, or were granted an exception(s), for most provider types. Overall, MI Health Link members had access to an adequate network of providers. However, one ICO did not meet the minimum standard for Adult Day Program in Region 4, and a second ICO did not meet the minimum standard for Assistive Technology—Van Lifts and Tie Downs in regions 7 and 9, indicating some MI Health Link members residing in these regions may not have adequate access to these services. Additionally, while the median appointment wait time for scheduling an initial dental appointment was 14 calendar days and met MDHHS’ appointment standard of eight weeks, the secret shopper survey findings also demonstrated that 64.7 percent of overall cases (i.e., sampled providers) were unable to be reached, did not accept the ICO (i.e., the insurance plan), did not accept and/or recognize the MI Health Link program, were not accepting new patients, or were unable to offer an appointment date. Further, the maximum wait time for an initial dental appointment exceeded the eight-week standard in all regions except Region 4. These findings suggest that MI Health Link members may have challenges contacting dental providers and scheduling appointments for routine dental services, and may experience long wait times for dental appointments. Further, as indicated through the statewide HEDIS averages within the Respiratory Conditions, Cardiovascular Conditions, Musculoskeletal Conditions, and Overuse/Appropriateness domains, 10 out of 13 performance measure rates declined from the prior year. Within the Behavioral Health domain, while three of the six performance measure rates also declined, the remaining three demonstrated improvement from the prior year.</p> <p>However, the MI Health Link program made progress toward achieving Goal #1 as demonstrated through improvement in all six Prevention and Screening domain performance measure rates, four out of six Diabetes domain performance measure rates, and all four performance measure rates under the Access/Availability of Care domain.</p> <p>Recommendations: MDHHS has a robust corrective action plan (CAP) process that the ICOs must complete for all identified network adequacy deficiencies and, through this CAP process, must provide</p> | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|--|--|---|
| | <p>evidence to MDHHS demonstrating that evidence of education and training was provided to applicable dental provider offices. Additionally, MDHHS required the ICOs to extend all training and oversight activities implemented through the CAP process to dental providers not included in the NAV study (i.e., not included in the sample of providers selected). HSAG recommends that MDHHS continue to keep the ICOs accountable for correcting deficiencies identified through EQR activities. Additionally, MDHHS has added several quantitative Quality Measures for Goal #1 to monitor high quality and high levels of access to care. HSAG recommends MDHHS evaluate the MI Health Link program's performance against the established Statewide Performance Target and determine whether the defined Quality Measures and/or performance targets need to be updated based on performance. For example, the baseline rate for <i>PM13 Number and percent of enrollees whose IICSP [Integrated Individualized Care and Supports Plan] addressed their assessed health and safety risks (HCBS C-waiver population)</i> is high at 98.40 percent; however, the established goal is less than the baseline rate (i.e., ≥ 86 percent). Therefore, MDHHS could determine whether this Quality Measure will promote performance improvement and progress toward achieving Goal #1.</p> | |
| Goal #2 —Strengthen person and family-centered approaches | <p>Conclusions: MDHHS requested that the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS) Survey be conducted in SFY 2023. This survey gathers direct feedback from members receiving HCBS about their experiences and the quality of long-term services and supports (LTSS) they receive. For 10 of the 17 reportable measures, the 2023 top-box scores were statistically significantly higher than the 2021 AHRQ Top-Box Aggregate, indicating many MI Health Link members reported having positive experiences.</p> <p>However, the lowest performing CAHPS measure was <i>Planning Your Time and Activities</i>, with a 2023 top-box score of 63.7 percent, indicating opportunities for the MI Health Link program to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.</p> <p>Additionally, the SFY 2023 compliance review activity included a review of each ICO's grievance and appeal systems. These systems are important managed care rights that allow members to advocate for themselves and the care they receive by being able to file complaints with the ICO, including expressions of dissatisfaction</p> | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|-----------------------|--|--------------------|
| | <p>with any aspect of the operations, activities, or behavior of the ICO or its delegated entity in the provision of healthcare items, services, or prescription drugs; and requesting a review of initial adverse benefit determinations (ABDs) made by an ICO on requests for healthcare services or items. The MI Health Link program's score for the Grievance and Appeal Systems program area was only 76 percent, indicating multiple opportunities to ensure members receive adequate resolution of complaints and access to all appeal and State fair hearing (SFH) rights.</p> <p>Recommendations: As <i>Planning Your Time and Activities</i> was the lowest scoring CAHPS measure, MDHHS could consider requiring the ICOs to develop a nonclinical QIP or initiatives that focus on improving the rate for this measure.</p> <p>Additionally, many of the deficiencies related to the Grievance and Appeal Systems standard were related to the ICOs and/or the ICOs' delegates not using current model notices and/or the ICOs not disseminating updated model notices to all applicable internal departments and/or delegates. As such, HSAG recommends that MDHHS require each ICO to provide an email confirmation when model notices have been disseminated to all appropriate individuals, including applicable delegates, when MDHHS distributes updated model notices. MDHHS should also request that the ICOs provide confirmation when the updated model notices have been fully integrated within their systems and processes, both internally and by applicable delegates. Further, in most instances, the ICOs were following Medicare regulations for services that were Medicare primary and not adhering to all applicable Three-Way Contract provisions as required. HSAG recommends that MDHHS add specific language in the Three-Way Contract requiring the ICOs to follow the Three-Way Contract provisions for processing all grievances and appeals. If the Three-Way Contract conflicts with Medicare or Medicaid regulations, MDHHS should mandate that the ICOs follow the most stringent provision and notify MDHHS when a conflict has been identified. As the MI Health Link program is transitioning to Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) effective January 1, 2026, HSAG also recommends that MDHHS consider ways to integrate Medicare and Medicaid grievance and appeal processes for this new program.</p> <p>Lastly, MDHHS has added <i>SNS-E Social Needs Screening & Intervention</i> as a 2023–2026 CQS Quality Measure for the MI Health Link program; however, a Statewide Baseline Performance rate and a Statewide Performance Target rate have yet to be determined. As such,</p> | |

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|---|---|--|
| | HSAG recommends that MDHHS proceed with establishing a baseline rate and target rate for this measure. | |
| Goal #3 —Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external) | <p>Conclusions: One of MDHHS’ objectives to support Goal #3 is to promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes. This objective aligns with CMS’ goal to advance interoperability with the mission of promoting the secure exchange, access, and use of electronic health information to support better informed decision making and a more efficient healthcare system. The SFY 2023 compliance review included a review of the Health Information Systems standard, which included an assessment of each ICO’s implementation of CMS’ interoperability final rules. The MI Health Link program received a score of 98 percent for this standard, and all ICOs implemented the Patient Access Application Programming Interface (API) and Provider Directory API, indicating the MI Health Link program is making progress toward achieving Goal #3.</p> <p>Additionally, based on the results of the PMV activity, while the ICOs had opportunities for improvement, all rates were considered <i>Reportable</i>, indicating MDHHS can rely on the validity of the results to monitor care coordination processes employed by the MI Health Link program’s ICOs. Further, all HEDIS performance measure rates under the Medication Management and Care Coordination domain demonstrated improvement from the prior year.</p> <p>Recommendations: CMS has enhanced current interoperability and API requirements as described in the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F). However, the due date for implementation of these new provisions is effective after the transition of the MI Health Link program to HIDE SNPs. As such, HSAG recommends that MDHHS consider the provisions of CMS-0057-F when initiating contracts with the new HIDE SNPs. Additionally, as CMS-0057-F will require future reporting of Patient Access API usage and prior authorization metrics, HSAG recommends that MDHHS consider if these metrics align with MDHHS’ current CQS goals and objectives and identify whether a new Quality Measure should be developed to address the new API requirements to further support Goal #3.</p> | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|--|--|---|
| Goal #4 —Reduce racial and ethnic disparities in healthcare and health outcomes | <p>Conclusions: MDHHS required the ICOs to continue their QIPs focused on reducing healthcare disparities within their populations. For the SFY 2023 QIP activity, the ICOs reported Remeasurement 1 rates. While only one ICO eliminated the existing disparity during Remeasurement 1, four ICOs increased the rates for their disparate populations. Two ICOs also demonstrated programmatically significant improvement. According to the Centers for Disease Control and Prevention (CDC), racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions (e.g., diabetes, hypertension, obesity, asthma, and heart disease) when compared to their White counterparts.¹⁻⁸ Continuing these QIPs in SFY 2024, including placing an emphasis on identifying barriers and implementing targeted interventions that focus specifically on the disparate populations, should have a positive impact for African-American and American Indian/Alaskan Native MI Health Link members relating to diabetes management, transitions of care, management of hypertension, statin therapy, or dental care.</p> <p>Additionally, MDHHS contractually requires each ICO's quality assessment and performance improvement (QAPI) program to incorporate activities that reduce disparities in health and healthcare broadly irrespective of race, ethnicity, national origin, religion, sex, or gender. The SFY 2023 compliance review activity demonstrated that the MI Health Link program received a score of 90 percent in this related program area. All ICOs demonstrated the implementation of various initiatives related to social determinants of health and health disparity reduction.</p> <p>The MI Health Link program has placed a strong emphasis on addressing health disparities as demonstrated through the EQR activities (i.e., through mandating a health equity QIP and contractually requiring the ICOs' QAPIs to include activities addressing healthcare disparities), in addition to other initiatives implemented by MDHHS outside of the EQR activities such as the Health Equity Project and facilitating health equity training for the ICOs in support of Goal #4.</p> <p>Recommendations: While all ICOs demonstrated the implementation of various initiatives related to social determinants of health and health disparity reduction, HSAG identified that these</p> | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

¹⁻⁸ Centers for Disease Control and Prevention. Minority Health, September 18, 2023. Available at: <https://www.cdc.gov/minorityhealth/racism-disparities/index.html>. Accessed on: Mar 18, 2024.

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|---|---|---|
| | activities were not clearly outlined in the QAPI work plan consistently across the ICOs. HSAG recommends that MDHHS place a strong focus on each ICO's initiatives addressing health disparities during each annual QAPI submission to MDHHS. MDHHS could also consider enhancing templates the ICOs are required to submit as part of the annual QAPI submission to require more specific information on these activities. | |
| Goal #5 —Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | <p>Conclusions: Although the findings of the EQR activities do not allow for a comprehensive evaluation of the MI Health Link program's progress towards achieving Goal #5, MDHHS has implemented a quality withhold policy in which CMS and MDHHS withhold a percentage of their respective components of the capitations payment. The withheld amounts are then repaid subject to each ICO's performance consistent with the established quality thresholds. MDHHS' contract with the ICOs identifies the quality withhold measures for each year of the demonstration and includes a combination of CMS/state-defined measures, Healthcare Effectiveness Data and Information Set (HEDIS®),¹⁻⁹ CAHPS, and CMS data. In SFY 2023, which relied on measurement year (MY) 2022 data, all ICOs received a portion of their withheld funds.</p> <p>Additionally, according to <i>Effectiveness Evaluation Appendix C Results of 2020–2023 CQS Goals & Objectives Program Evaluation Assessments</i> included as part of the 2023–2026 CQS, the MI Health Link program met both objectives under Goal #5. Specifically, the evaluation indicated that MDHHS contractually requires the ICOs to demonstrate use of alternative payment models (APMs) that will advance the delivery system innovations inherent in the MI Health Link model, incentivize quality care, and improve health outcomes for members.</p> <p>Recommendations: While MDHHS has updated its 2023–2026 CQS to include Quality Measures under Goal #5, with Statewide Baseline Performance rates and Statewide Performance Target rates, no quantitative Quality Measures specific to the MI Health Link program were included. As the MI Health Link program is transitioning to a HIDE SNP effective January 1, 2026, HSAG recommends that MDHHS consider future Quality Measures to include under Goal #5 for the new HIDE SNP program.</p> | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

¹⁻⁹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2. Overview of the Integrated Care Organizations

Managed Care in Michigan

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

Table 2-1—Medicaid Managed Care Programs in Michigan

| Medicaid Managed Care Program | MCE Type | Managed Care Authority | Date Initiated | Populations Served |
|---|---------------------------------|--|----------------|--|
| Comprehensive Health Care Program (CHCP) | | | | |
| Medicaid Health Plans (MHPs) | Managed Care Organization (MCO) | 1915(b) | July 1997 | MHPs provide comprehensive healthcare services to low-income adults and children. |
| <ul style="list-style-type: none"> MICHild (CHIP) | | 1915(b) | January 2016 | MICHild is a Medicaid program for low-income uninsured children under the age of 19. |
| <ul style="list-style-type: none"> Children's Special Health Care Services (CSHCS) | | Michigan Medicaid State Plan | October 2012 | CSHCS is a program within MDHHS for children and some adults with special health care needs and their families. |
| Healthy Michigan Plan (HMP) (Medicaid Expansion) | MCO | 1115 Demonstration | April 2014 | HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment. |
| Flint Medicaid Expansion (FME) Waiver | MCO | 1115 Demonstration | March 2016 | The waiver provides Medicaid coverage and benefits to individuals affected by the Flint Water Crisis. |
| MI Health Link Demonstration (ICOs) | ICO | 1915(b) & 1915(c) | March 2015 | Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age of 21 and reside in one of the four regions where the program is available. |
| MI Choice Waiver Program (Prepaid Ambulatory Health Plans [PAHPs]) | PAHP | 1915(c) since 1992 1915(b) since 2012 | 1992 | The elderly or disabled adults (aged 18+) who meet the nursing facility level of care. |

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

MI Health Link Program

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

Overview of Integrated Care Organizations

During the SFY 2023 review period, MDHHS contracted with six ICOs. These ICOs were responsible for the provision of services to MI Health Link members. Table 2-2 provides a profile for each ICO. Figure 2-1 shows a visual representation of the counties included in each region served.

Table 2-2—ICO Profiles and Enrollment Data

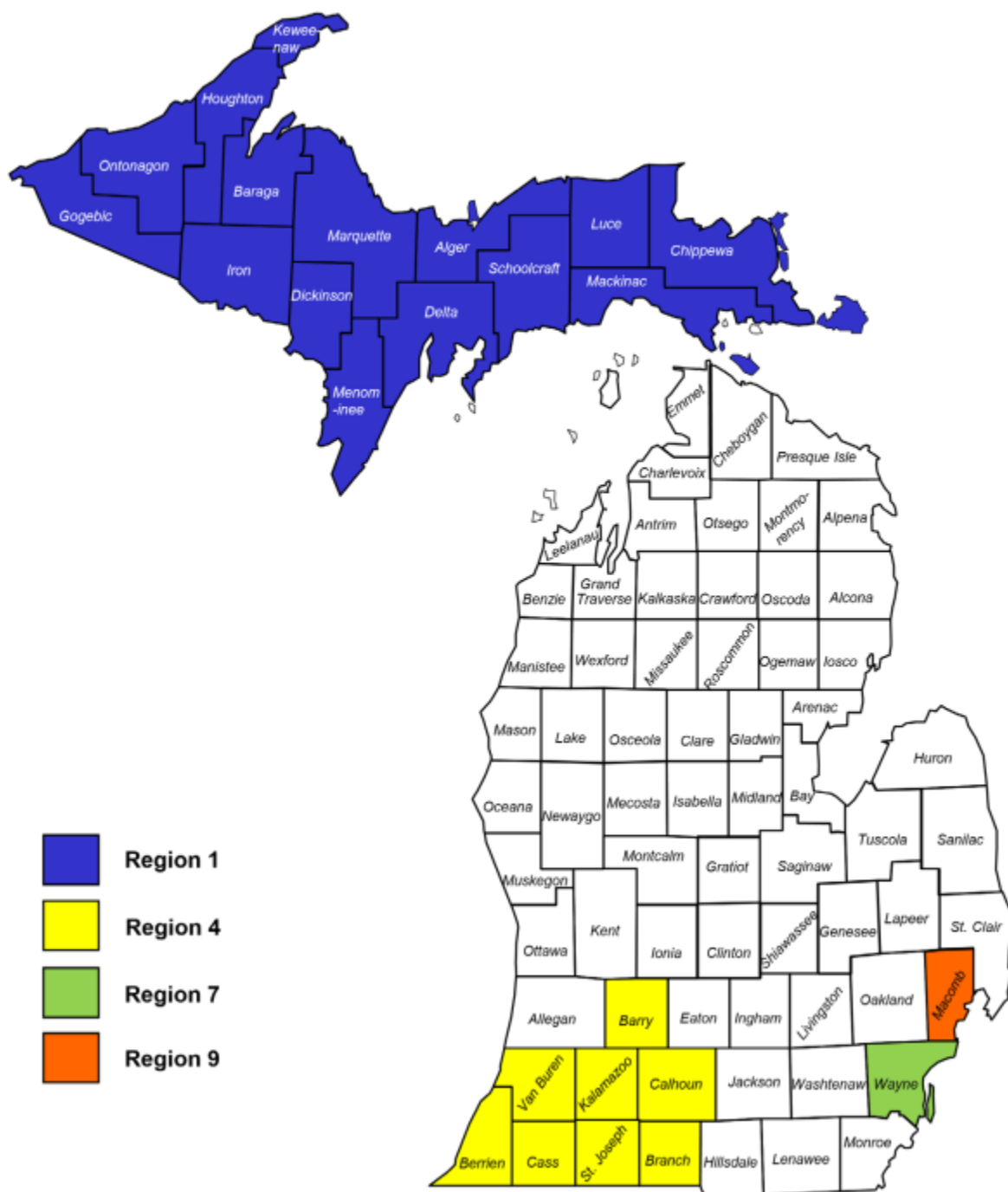
| ICO | Covered Services ²⁻¹ | Service Area/Regions Served ²⁻² | Member Enrollment ²⁻³ |
|------|--|--|----------------------------------|
| AET | MI Health Link benefits include: <ul style="list-style-type: none"> • No co-pays for in-network services, including medications • No deductibles for in-network services • Medications • Care coordination • Behavioral healthcare • Dental care • Hearing care • Medicare care • Vision care • HCBS • Transportation for covered medical services • Medical equipment and supplies • Nursing facility care | Regions 4, 7, and 9 | 8,542 |
| AMI | | Regions 7 and 9 | 2,775 |
| HAP | | Regions 7 and 9 | 4,019 |
| MER | | Regions 4, 7, and 9 | 5,894 |
| MOL | | Regions 7 and 9 | 10,044 |
| UPHP | | Region 1 | 4,300 |

²⁻¹ Michigan Department of Health and Human Services. *MI Health Link*. Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---,00.html. Accessed on: Mar 1, 2024.

²⁻² Michigan Department of Health and Human Services. Integrated Care Division. *Integrated Care Organization (ICOs) Health Plan Telephone Numbers, Websites, and County Service Areas*. Available at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077-354084--,00.html. Accessed on: Mar 1, 2024.

²⁻³ Michigan Department of Health and Human Services. Integrated Care Division. *MI Health Link Enrollment Dashboard*. Available at: <https://www.michigan.gov/mdhhs/doing-business/providers/integrated/q-and-e/enrollment>. Accessed on: Mar 1, 2024.

Figure 2-1—ICO Regions²⁻⁴



²⁻⁴ Michigan Department of Community Health. *MI Health Link Regions*. Available at: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder93/Folder1/Folder193/MI_Health_Link_Counties.pdf?rev=e625ee0535d44526aa94b885636b3e47&hash=3305162FEE2BB48400F71D25B885FB68. Accessed on: Mar 1, 2024.

Quality Strategy

The 2020–2023 MDHHS CQS²⁻⁵ provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including CHCP, LTSS, dental programs, and behavioral health managed care. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 CQS, MDHHS strives to incorporate each managed care program’s individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The CQS also aligns with CMS’ Quality Strategy and the United States (U.S.) Department of Health and Human Services’ (HHS’) National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. The MDHHS CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3 and align with MDHHS’ vision to *deliver health and opportunity to all Michiganders*, *reducing intergenerational poverty and health inequity*, and specifically were designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

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

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

²⁻⁵ The 2020–2023 MDHHS CQS was submitted to CMS and published on the MDHHS website in January 2021. Due to the timing of the EQR activities, and at the direction of MDHHS, HSAG used the 2020–2023 MDHHS CQS for the SFY 2023 EQR assessment. However, the 2023–2026 MDHHS CQS was submitted to CMS in October 2023 and has replaced the 2020–2023 version on MDHHS’ website. The 2023–2026 MDHHS CQS is now available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=c062404614184b219a8e4b1d6ddd520a.

| MDHHS CQS Managed Care Program Goals | MDHHS Strategic Priorities | Objectives |
|---|--|---|
| | | Objective 1.5: Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care. |
| Goal #2: Strengthen person and family-centered approaches | | |
| NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person | Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services | Objective 2.1: Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible. |
| | | Objective 2.2: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals. |
| | | Objective 2.3: Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches. |
| | | Objective 2.4: Encourage community engagement and systematic referrals among healthcare providers and to other needed services. |
| | | Objective 2.5: Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a networkwide, effective approach to healthcare within the community. |
| Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external) | | |
| NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person | Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services | Objective 3.1: Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems. |
| | | Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations. |
| | | Objective 3.3: Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes. |

| MDHHS CQS Managed Care Program Goals | MDHHS Strategic Priorities | Objectives |
|---|--|--|
| Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes | | |
| NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start MDHHS Pillar #3: Serve the whole person | Improve maternal-infant health and reduce outcome disparities | 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. |
| | Address food and nutrition, housing, and other social determinants of health | 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. |
| | Integrate services, including physical and behavioral health, and medical care with long-term support services | Objective 4.3: Promote and ensure access to and participation in health equity training. |
| | | Objective 4.4: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations. |
| | | Objective 4.5: Expand and share promising practices for reducing racial disparities. |
| | | Objective 4.6: Collaborate and expand partnerships with community-based organizations and public health entities across the state to address racial inequities. |
| Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | | |
| NQS Aim #3: Affordable Care MDHHS Pillar #4: Use data to drive outcomes | Drive value in Medicaid | Objective 5.1: Promote the use of value-based payment models to improve quality of care. |
| | Ensure we are managing to outcomes and investing in evidence-based solutions | 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. Examples of these initiatives and interventions include:

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

system that maximizes the health status of members, improves member experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology/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 social determinants of health, creating health equity and supporting efforts to build more resilient communities. MDHHS supports payment reform initiatives that pay providers for value rather than volume, with “value” defined as health outcome per dollar of cost expended over the full cycle of care. In this regard, performance metrics are linked to outcomes. The Medicaid managed care programs are at varying degrees of payment reform; however, all programs use a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize quality improvement and improved outcomes.

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

3. Assessment of Integrated Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2023 review period to evaluate the performance of ICOs on providing quality, timely, and accessible healthcare services to MI Health Link members. Quality, as it pertains to EQR, means the degree to which the ICO increased the likelihood of desired outcomes of its members through its structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. 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 outcomes, as evidenced by how effective the ICOs were at successfully demonstrating and reporting on outcome information for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2023 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 related time period, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Quality Improvement Projects

For the SFY 2023 QIP validation activity, the ICOs continued the QIP topics that focus on disparities within their populations and reported Remeasurement 1 data for each specified performance indicator. HSAG conducted validation on the QIP Design (Steps 1 through 6), Implementation (Steps 7 and 8), and Outcomes (Step 9) stages of the selected QIP topic for each ICO in accordance with CMS EQR Protocol

1. Table 3-1 outlines the selected QIP topics and performance indicators as defined by each ICO. Although all steps may not be included in the validation activities for SFY 2023 for every ICO, the validation rating for each ICO incorporates all steps in the validation process.

Table 3-1—QIP Topics and Performance Indicators

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

Performance Measure Validation

The purpose of PMV was to assess the accuracy of performance measures reported by ICOs and to determine the extent to which performance measures reported by the ICOs followed the *Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements* (Medicare-Medicaid Plan [MMP] Core Reporting Requirements)³⁻¹ and *Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements* (Michigan-Specific Reporting Requirements).³⁻² For the SFY 2023 PMV, the ICOs were required to submit a completed Information Systems Capabilities Assessment Tool (ISCAT) that provided information on their information systems (IS); processes used for collecting, storing, and processing data; and processes used for performance measure reporting. HSAG subsequently validated the ICOs' data collection and reporting processes used to calculate and report performance measure results for performance measures MDHHS selected for validation.

Table 3-2 lists the performance measures calculated and reported by the ICOs for calendar year (CY) 2022 (i.e., January 1, 2022, through December 31, 2022), along with the performance measure number. The performance measures are numbered as they appear in the MMP Core Reporting Requirements and the Michigan-Specific Reporting Requirements technical specification manuals.

Table 3-2—Performance Measures for Validation

| Performance Measure | Description |
|---------------------|--|
| Core Measure 9.3 | <i>Minimizing Institutional Length of Stay</i> |
| MI2.6 | <i>Timely Transmission of Care Transition Record to Health Care Professional</i> |
| MI5.6 | <i>Care for Adults—Medication Review</i> |
| MI7.3 | <i>Annual Dental Visit</i> |

³⁻¹ The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements*, November 1, 2021. Available at: <https://www.cms.gov/files/document/mmpcorereportingreqscy2022.pdf>. Accessed on: Mar 1, 2024.

³⁻² The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements*, February 28, 2023. Available at: <https://www.cms.gov/files/document/mireportingrequirements02282023.pdf>. Accessed on: Mar 1, 2024.

Performance Measure Rates

MDHHS and CMS also required each ICO to contract with an NCQA-certified HEDIS vendor and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS MY 2022 performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and risk-adjusted utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR. The HEDIS measures and performance areas reviewed by HSAG are included in Table 3-3.

Table 3-3—HEDIS Measures

| HEDIS Measure |
|--|
| Prevention and Screening |
| <i>BCS—Breast Cancer Screening</i> |
| <i>COL—Colorectal Cancer Screening</i> |
| <i>COA—Care for Older Adults—Medication Review</i> |
| <i>COA—Care for Older Adults—Functional Status Assessment</i> |
| <i>COA—Care for Older Adults—Pain Assessment</i> |
| Respiratory Conditions |
| <i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD [Chronic Obstructive Pulmonary Disease]</i> |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i> |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i> |
| Cardiovascular Conditions |
| <i>CBP—Controlling High Blood Pressure</i> |
| <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i> |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i> |
| Diabetes |
| <i>HBD—Hemoglobin A1c Control in Patients With Diabetes—HbA1c Poor Control (>9.0%)*</i> |
| <i>HBD—Hemoglobin A1c in Patients With Diabetes—HbA1c Control (<8.0%)</i> |
| <i>EED—Eye Exam for Patients With Diabetes</i> |
| <i>BPD—Blood Pressure Control for Patients With Diabetes</i> |
| <i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i> |
| <i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i> |
| Musculoskeletal Conditions |
| <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> |

| HEDIS Measure |
|--|
| Behavioral Health |
| <i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment</i> |
| <i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment</i> |
| <i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i> |
| <i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i> |
| <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i> |
| <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i> |
| Medication Management and Care Coordination |
| <i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i> |
| <i>TRC—Transitions of Care—Notification of Inpatient Admission</i> |
| <i>TRC—Transitions of Care—Receipt of Discharge Information</i> |
| <i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i> |
| Overuse/Appropriateness |
| <i>PSA—Non-Recommended PSA [Prostate-Specific Antigen]-Based Screening in Older Men*</i> |
| <i>DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*</i> |
| <i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*</i> |
| <i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*</i> |
| <i>DAE—Use of High-Risk Medications in Older Adults—Total*</i> |
| Access/Availability of Care |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years</i> |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years</i> |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 and Older</i> |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i> |
| Risk-Adjusted Utilization |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i> |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i> |

* Measures for which lower rates indicate better performance.

Compliance Review

MDHHS requires its ICOs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The SFY 2023 compliance review is the second year of the three-year cycle of compliance reviews. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific requirements. The compliance reviews for the MI Health Link program consist of 14 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first seven standards in Year One (SFY 2022) and a review of the remaining standards in Year Two (SFY 2023). Table 3-4 outlines the standards reviewed over the three-year compliance review cycle. The compliance review activity was conducted in accordance with CMS EQR Protocol 3.

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

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

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

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

Network Adequacy Validation

HSAG collaborated with MDHHS to design annual NAV tasks pertinent to Medicaid services and LTSS covered by the MI Health Link program and that complemented the annual CMS NAV without duplication. As such, HSAG conducted two SFY 2023 activities assessing different aspects of the ICOs' network adequacy:

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

Time/Distance and Provider Capacity Analysis

To initiate the NAV activity, each ICO submitted member and network provider data files and exception requests to HSAG in September 2023, followed by an initial data file review. Following the initial data file review, HSAG requested that applicable ICOs submit updated data files and/or exception³⁻³ requests during October 2023 to address potential data quality and validity concerns prior to completing the NAV analyses. The provider types included in the validation are displayed in Table 3-5.

Table 3-5—MI Health Link Provider Types

| Provider Type |
|--|
| Provider Types With Travel Time and Distance Network Requirements |
| Adult Day Program |
| Dental (preventive and restorative) |
| Eye Examinations (provided by optometrists) |
| Eye Wear (providers dispensing eyeglasses and contact lenses) |
| Hearing Examinations |
| Hearing Aids |
| Provider Types With Capacity-Based Network Requirements |
| Adaptive Medical Equipment and Supplies |
| Assistive Technology—Devices |
| Assistive Technology—Van Lifts and Tie Downs |
| Chore Services |
| Community Transition Services |

³⁻³ MDHHS allowed ICOs to request exceptions to the minimum network requirements for any provider types for which there are known network access gaps. Exception requests were allowed when the ICO had contracted to the fullest extent of the available providers but was unable to meet the minimum network requirements.

| Provider Type |
|--|
| Environmental Modifications |
| Expanded Community Living Supports (ECLS) |
| Fiscal Intermediary |
| Home Delivered Meals |
| Medical Supplies |
| Maternal Infant Health Program (MIHP) Agency |
| Non-Emergency Medical Transportation (NEMT) |
| Non-Medical Transportation (waiver service only) |
| Personal Care Services |
| Personal Emergency Response System |
| Preventive Nursing Services |
| Private Duty Nursing |
| Respite |
| Skilled Nursing Home |

Secret Shopper Survey

During March and April 2023, HSAG completed a secret shopper telephone survey of dental offices contracted with one or more ICOs under the MI Health Link program to collect appointment availability information for preventive dental care visits for the ICOs' new MI Health Link members.

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

1. Determine whether dental service locations accept patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligns with the ICOs' provider data.
2. Determine whether dental service locations accepting MI Health Link for the requested ICO accept new patients and the degree to which new patient acceptance aligns with the ICOs' provider data.
3. Determine appointment availability with the sampled dental service locations for preventive dental care.

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

Encounter Data Validation

In SFY 2023, HSAG conducted and completed EDV activities for all six ICOs. The EDV activities included:

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

Consumer Assessment of Healthcare Providers and Systems Analysis

For SFY 2023, HSAG administered the HCBS CAHPS Survey for MI Health Link members enrolled in the HCBS C-waiver program and receiving at least one qualifying personal care service, respite care at home, chore services, or expanded community living supports. The primary objective of the HCBS CAHPS Survey is to effectively and efficiently obtain information on members’ experiences with the LTSS they receive. A sample of 2,056 adult members was selected across the ICOs.³⁻⁴ Sampled adult members completed the survey from May to July 2023 over the telephone in either English or Spanish.

Results presented in this report include three global ratings, seven composite measures, three recommendation measures, five unmet need measures, and one physical safety measure. For purposes of reporting members’ experience with care results, CMS requires a minimum of 11 respondents per measure (i.e., a minimum cell size of 11). Due to the low number of respondents for each ICO and CMS suppression rules, HSAG could not present individual ICO-level results for the HCBS CAHPS Survey measures; therefore, results are only presented for the MI Health Link program in Section 5—Integrated Care Organization Comparative Information. HSAG presented the results in top-box scores³⁻⁵ for each measure in accordance with CMS’ *Technical Assistance Guide for Analyzing Data from the HCBS CAHPS Survey*.³⁻⁶ Top-box scores represent the percentage of eligible respondents who answered with

³⁻⁴ The sample was drawn from the four regions where the demonstration is present (i.e., all counties in Upper Peninsula; Macomb County; Wayne County; and Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties in Southwest Michigan).

³⁻⁵ HSAG updated its analysis of 2023 results from mean scores to top-box scores and recalculated the 2022 and 2021 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability. Therefore, the 2022 and 2021 results in this report will not match previous reports.

³⁻⁶ Centers for Medicare & Medicaid Services. CAHPS Home and Community-Based Services Survey. *Technical Assistance Guide for Analyzing Data from the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS®) Survey*, July 2021. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/hcbshcahps-appk-data-analysis-guide.pdf>. Accessed on: Mar 4, 2024.

the most positive response. For more detailed information regarding top-box scores, please refer to Appendix A.

External Quality Review Activity Results

Aetna Better Health Premier Plan

Validation of Quality Improvement Project

Performance Results

HSAG’s validation evaluated the technical methods of Aetna’s QIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., the QIP Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-6 displays the overall validation rating, the baseline and Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-6—Overall Validation Rating for AET

| QIP Topic | Validation Rating ¹ | Performance Indicator | Performance Indicator Results | | | |
|--|--------------------------------|---|-------------------------------|---------|----|-----------|
| | | | Baseline ² | R1 | R2 | Disparity |
| <i>Comprehensive Diabetes Care—HbA1c Test: Decreasing the Disparity Between White and African American Members</i> | <i>Met</i> | Comprehensive Diabetes Care—HbA1c Test: Black or African American (Non-Hispanic or Latino). | 73.6% | 76.6% ⇌ | | Yes |
| | | Comprehensive Diabetes Care—HbA1c Test: White (Non-Hispanic or Latino). | 87.8% | 89.6% ⇌ | | |

R1 = Remeasurement 1

R2 = Remeasurement 2

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)

⇌ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)

↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

¹ The QIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its QIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the QIP adhered to an acceptable methodology for all phases of design and data collection, and the ICO conducted accurate data analysis and interpretation of QIP results; overall confidence that the QIP produced significant evidence of improvement.)

² In the 2023 annual submission, the ICO revised the baseline data that were reported in the prior year. The data reported in the table above reflect the revised data.

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

Table 3-7—Remeasurement 1 Barriers and Interventions for AET

| Barriers | Interventions |
|--|---|
| Members are not routinely being treated/seen by their primary care providers (PCPs). | Directed a member outreach call campaign targeting members with no PCP visit in the last year and a diagnosis of diabetes. |
| Members are not aware that they are due for an HbA1c test during a provider visit. | Conducted outreach to PCPs who have treated members who do not have a completed HbA1c test for the year. Also reminded providers of those with a gap in care for an HbA1c test. |
| Black/African American Non-Hispanic members, despite accessing ambulatory care at the same rate as White Non-Hispanic members (including Region 7) do not complete HbA1c testing at the same rate as White Non-Hispanic members. | Scheduled time with providers/groups to discuss the impact of race/ethnicity-based inequities on their patients, shared the QIP, and laid the foundation that the evaluation of race/ethnicity disparities will be a part of all future conversations pertaining to quality improvement. |
| It is uncomfortable to have discussions of race/ethnicity-based disparities when it feels personal to internal member-facing team members or to providers. | Educated care managers on the disparities within their caseloads and targeted Black/African American Non-Hispanic members for direct intervention and assistance with completing an HbA1c test. |
| Unable to reach members. Invalid contact information to engage and coordinate care/screenings. | Care management associate attempted to contact unable-to-reach members following multiple outreach attempts. Outreach includes alternative methods such as mailed letters, text messaging, and phone calls. Research for additional contact information was done through provider and downstream entity outreach. Upon contact, members are connected to the care manager for coordination of closing any gaps in care. |
| The ICO does not ask members how race/ethnicity impacts how they access, use, or experience healthcare. | Bring the topic of this QIP to the Quarter 4 Member Advisory Committee [meeting] and keep it as a standing agenda item moving forward to update membership on the progress of the work. |

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: **Aetna** met 100 percent of the requirements for data analysis and implementation of improvement strategies. The ICO conducted accurate statistical testing between the two subgroups for the first remeasurement period and provided a narrative interpretation of the results. **Aetna** used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

Weaknesses and Recommendations

Weakness #1: **Aetna** did not demonstrate significant improvement over the baseline performance for the disparate subgroup (Black or African-American members). The ICO did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period. [Quality and Access]

Why the weakness exists: While it is unclear why the goals were not achieved with the first remeasurement period, **Aetna** has made progress in improving performance for the disparate subgroup, demonstrating a non-statistically significant increase in performance as compared to the baseline.

Recommendation: HSAG recommends **Aetna** revisit its causal/barrier analysis to determine if any new barriers exist for the disparate subgroup that require the development of targeted strategies to improve performance. In accordance with direction from MDHHS, **Aetna** is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the Black or African-American population, within the next annual submission.

Performance Measure Validation

Performance Results

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

Aetna received a measure designation of *Reportable (R)* for all measures, signifying that **Aetna** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-8 includes the validation designation for each performance measure as well as the validated SFY 2023 performance measure rates.

Table 3-8—Measure-Specific Validation Designation and Rates for AET

| Performance Measure | Validation Designation | SFY 2023 Rate |
|--|---|---------------|
| Core Measure 9.3: <i>Minimizing Institutional Length of Stay</i> | REPORTABLE (R) The ICO reported this measure in alignment with the MMP Core Reporting Requirements. | 1.07 |
| MI2.6: <i>Timely Transmission of Care Transition Record to Health Care Professional</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 20.70% |
| MI5.6: <i>Care for Adults—Medication Review</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 87.80% |
| MI7.3: <i>Annual Dental Visit</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 25.10% |

Performance Measure Rates

Table 3-9 shows each of **Aetna**'s audited HEDIS measures, rates for HEDIS MY 2021 and HEDIS MY 2022 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2022 with HEDIS MY 2021, and the HEDIS MY 2021 and HEDIS MY 2022 MI Health Link statewide average performance rates. HEDIS MY 2021 and HEDIS MY 2022 measure rates performing better than the MY 2021 and MY 2022 statewide averages are notated by green font.

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

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------------|-------------------------|------------------------------------|--|--|
| Prevention and Screening | | | | | |
| BCS—Breast Cancer Screening | 47.16 | 50.40 | +3.24 | 52.74 | 56.70 |
| COL—Colorectal Cancer Screening | 50.12 | 50.26 | +0.14 | 56.03 | 57.59 |
| COA—Care for Older Adults—Medication Review | 58.64 | 93.67 | +35.03 | 74.85 | 80.41 |
| COA—Care for Older Adults—Functional Status Assessment | 78.10 | 71.53 | −6.57 | 58.42 | 62.71 |
| COA—Care for Older Adults—Pain Assessment | 81.75 | 79.32 | −2.43 | 75.25 | 78.04 |
| Respiratory Conditions | | | | | |
| SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 21.37 | 19.88 | −1.49 | 22.93 | 22.01 |
| PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid | 78.43 | 82.02 | +3.59 | 68.65 | 74.10 |
| PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator | 88.73 | 93.26 | +4.53 | 89.67 | 88.82 |
| Cardiovascular Conditions | | | | | |
| CBP—Controlling High Blood Pressure | 54.99 | 61.56 | +6.57 | 60.52 | 66.14 |
| PBH—Persistence of Beta-Blocker Treatment After a Heart Attack | 100 | 86.67 | −13.33 | 95.25 | 90.85 |
| SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy | 78.85 | 76.71 | −2.14 | 82.00 | 80.90 |
| SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80% | 76.02 | 78.13 | +2.11 | 84.22 | 79.55 |
| Diabetes | | | | | |
| HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* | 44.77 | 32.36 | −12.41 | 43.53 | 34.07 |
| HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) | 48.42 | 58.64 | +10.22 | 49.06 | 58.51 |
| EED—Eye Exam for Patients With Diabetes | 52.80 | 59.37 | +6.57 | 57.33 | 62.89 |
| BPD—Blood Pressure Control for Patients With Diabetes | 52.80 | 64.96 | +12.16 | 60.82 | 68.13 |
| SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy | 74.37 | 73.88 | −0.49 | 76.83 | 76.44 |
| SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80% | 75.89 | 74.48 | −1.41 | 82.46 | 78.95 |
| Musculoskeletal Conditions | | | | | |
| OMW—Osteoporosis Management in Women Who Had a Fracture | 5.88 | 12.50 | +6.62 | 16.12 | 11.18 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------------|-------------------------|------------------------------------|--|--|
| Behavioral Health | | | | | |
| AMM—Antidepressant Medication Management—Effective Acute Phase Treatment | 69.19 | 71.18 | +1.99 | 75.06 | 73.66 |
| AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment | 52.53 | 54.15 | +1.62 | 60.75 | 57.94 |
| FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up | 20.95 | 29.61 | +8.66 | 26.13 | 32.79 |
| FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up | 47.97 | 53.95 | +5.98 | 50.22 | 58.91 |
| FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up | 43.93 | 48.60 | +4.67 | 33.87 | 32.06 |
| FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up | 58.88 | 68.16 | +9.28 | 51.71 | 54.39 |
| Medication Management and Care Coordination | | | | | |
| TRC—Transitions of Care—Medication Reconciliation Post-Discharge | 38.69 | 67.88 | +29.19 | 43.96 | 47.59 |
| TRC—Transitions of Care—Notification of Inpatient Admission | 0.49 | 1.22 | +0.73 | 13.11 | 16.53 |
| TRC—Transitions of Care—Receipt of Discharge Information | 2.19 | 2.19 | +/-0.00 | 12.77 | 15.38 |
| TRC—Transitions of Care—Patient Engagement After Inpatient Discharge | 74.70 | 71.53 | -3.17 | 74.60 | 77.74 |
| Overuse/Appropriateness | | | | | |
| PSA—Non-Recommended PSA-Based Screening in Older Men* | 18.27 | 22.95 | +4.68 | 24.68 | 26.71 |
| DDE—Potentially Harmful Drug-Disease Interactions in Older Adults* | 34.83 | 36.83 | +2.00 | 31.94 | 33.45 |
| DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid* | 17.05 | 17.64 | +0.59 | 17.81 | 18.16 |
| DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis* | 5.93 | 5.36 | -0.57 | 5.50 | 5.23 |
| DAE—Use of High-Risk Medications in Older Adults—Total* | 21.39 | 21.53 | +0.14 | 21.56 | 21.78 |
| Access/Availability of Care | | | | | |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years | 81.40 | 81.31 | -0.09 | 84.27 | 84.90 |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years | 92.50 | 92.66 | +0.16 | 93.49 | 93.83 |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 and Older | 90.19 | 90.16 | -0.03 | 91.45 | 91.69 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------|-------------------|---------------------------|-------------------------------|-------------------------------|
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 89.13 | 89.08 | −0.05 | 90.77 | 91.08 |
| Risk-Adjusted Utilization | | | | | |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i> | 1.24 | 1.40 | +0.16 | 1.17 | 1.07 |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i> | 1.40 | 1.51 | +0.11 | 1.20 | 1.21 |

* Measures for which lower rates indicate better performance.

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: For MI5.6, **Aetna** incorporated supplemental data from clinical pharmacist medication reviews that were maintained in the Dynamo Case Trakker system. This significantly improved the reported rate from the prior year. [**Quality, Timeliness, and Access**]

Strength #2: In the Prevention and Screening domain, **Aetna**’s rate for the *COA—Care for Older Adults—Medication Review* measure indicator increased by more than 35 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in adult members ages 66 years and older having medication reviews conducted during the measurement year. Older adults may have more complex medication regimens. This measure ensures that older adults receive the care they need to optimize quality of life.³⁻⁷ [**Quality**]

Strength #3: In the Diabetes domain, **Aetna**’s rates for the *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicators decreased by more than 12 percentage points and increased by more than 10 percentage points, respectively, from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting

³⁻⁷ National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/hedis/measures/care-for-older-adults/>. Accessed on: Mar 28, 2024.

strength and improvement in adult members ages 18 to 75 years with diabetes having controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.³⁻⁸ [Quality]

Strength #4: In the Musculoskeletal Conditions domain, **Aetna**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by more than 6 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in timely screening and treatment of women who suffered a fracture with either a bone mineral density test or a prescription for a drug to treat osteoporosis. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.³⁻⁹ [Quality, Timeliness, and Access]

Strength #5: In the Medication Management and Care Coordination domain, **Aetna**'s rate for the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge* measure indicator increased by more than 29 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in timely medication reconciliation being performed for adult members following discharge from an inpatient facility. Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs.³⁻¹⁰ [Quality and Timeliness]

Weaknesses and Recommendations

Weakness #1: Although **Aetna** improved the MI2.6 rate from the prior year's reported rate, it continued to have a low MI2.6 rate in comparison to the other Michigan ICOs' reported rates. [Quality and Access]

Why the weakness exists: **Aetna**'s reported MI2.6 rate was lower in comparison to other Michigan ICOs' reported rates.

Recommendation: HSAG recommends that **Aetna** consider implementing targeted interventions to improve its MI2.6 rate.

³⁻⁸ National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: <https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/>. Accessed on: Mar 28, 2024.

³⁻⁹ National Committee for Quality Assurance. Osteoporosis Management in Women Who Had a Fracture (OMW). Available at: <https://www.ncqa.org/hedis/measures/osteoporosis-management-in-women-who-had-a-fracture/>. Accessed on: Mar 28, 2024.

³⁻¹⁰ National Committee for Quality Assurance. Transitions of Care (TRC). Available at: <https://www.ncqa.org/hedis/measures/transitions-of-care/>. Accessed on: Mar 28, 2024.

Weakness #2: Similar to the prior year, **Aetna** could not use data from one of its delegated PIHPs in the MI2.6 sample. [Quality, Timeliness, and Access]

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

Recommendation: HSAG recommends that **Aetna** issue a formal CAP to Detroit Wayne Integrated Health Network to ensure it provides accurate data reflecting member hospital discharges so that **Aetna** can include these members in future MI2.6 reporting. Although this data gap had a marginal impact on the eligible population, the denominator sample, and the numerator, the MI2.6 data were still underreported as a result of this issue.

Weakness #3: For MI7.3, **Aetna** did not incorporate any race and ethnicity data other than the data submitted by the State in the 834 enrollment file. [Quality]

Why the weakness exists: **Aetna** only used the race and ethnicity data submitted by the State in the 834 enrollment file.

Recommendation: HSAG recommends that **Aetna** explore additional sources for race and ethnicity data including care management, member survey, and electronic health record (EHR) data.

Weakness #4: For 26 of the 40 reported HEDIS measures (65 percent), **Aetna**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization. [Quality]

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

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

Weakness #5: In the Cardiovascular Conditions domain, **Aetna**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adult members were not using a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart

and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.³⁻¹¹ [Quality, Access, and Timeliness]

Why the weakness exists: The rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreasing by more than 13 percentage points from MY 2021 to MY 2022 suggests that barriers exist for some adult members to use a beta-blocker as treatment after a heart attack.

Recommendation: HSAG recommends that **Aetna** conduct a root cause analysis or focused study to determine why some adults were not using a beta-blocker after a heart attack. Upon identification of a root cause, **Aetna** should implement appropriate interventions to improve the performance related to the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator. **Aetna** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).

³⁻¹¹ National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: <https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/>. Accessed on: Mar 28, 2024.

Compliance Review

Performance Results

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

Table 3-10—SFY 2022 and SFY 2023 Standard Compliance Scores for AET

| Compliance Review Standard | Compliance Score |
|---|------------------|
| Year One (SFY 2022) | |
| Standard I—Disenrollment: Requirements and Limitations ¹ | 100% |
| Standard II—Member Rights and Member Information | 65% |
| Standard III—Emergency and Poststabilization Services ¹ | 100% |
| Standard IV—Availability of Services | 92% |
| Standard V—Assurances of Adequate Capacity and Services | 100% |
| Standard VI—Coordination and Continuity of Care | 73% |
| Standard VII—Coverage and Authorization of Services | 89% |
| Year Two (SFY 2023) | |
| Standard VIII—Provider Selection | 91% |
| Standard IX—Confidentiality | 100% |
| Standard X—Grievance and Appeal Systems | 78% |
| Standard XI—Subcontractual Relationships and Delegation | 80% |
| Standard XII—Practice Guidelines | 100% |
| Standard XIII—Health Information Systems ² | 89% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 90% |
| Year Three (SFY 2024) | |
| Review of ICO's implementation of Year One and Year Two CAPs | |

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

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

Table 3-11 presents **Aetna**'s scores for each standard evaluated during the SFY 2023 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Aetna**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2023 compliance review activity demonstrated how successful **Aetna** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-11—SFY 2023 Standard Compliance Scores for AET

| Standard | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|----------------|---------------------------|--------------------|-----------|-----------|------------------------|
| | | | <i>M</i> | <i>NM</i> | <i>NA</i> | |
| Standard VIII—Provider Selection | 23 | 23 | 21 | 2 | 0 | 91% |
| Standard IX—Confidentiality | 11 | 11 | 11 | 0 | 0 | 100% |
| Standard X—Grievance and Appeal Systems | 45 | 45 | 35 | 10 | 0 | 78% |
| Standard XI—Subcontractual Relationships and Delegation | 6 | 5 | 4 | 1 | 1 | 80% |
| Standard XII—Practice Guidelines | 6 | 6 | 6 | 0 | 0 | 100% |
| Standard XIII—Health Information Systems ¹ | 9 | 9 | 8 | 1 | 0 | 89% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 21 | 21 | 19 | 2 | 0 | 90% |
| Total | 121 | 120 | 104 | 16 | 1 | 87% |

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

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

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

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

¹This standard includes a comprehensive assessment of the ICO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: **Aetna** achieved full compliance in the Confidentiality program area, demonstrating that the ICO established and implemented adequate procedures for the use and disclosure of individually identifiable health information in accordance with privacy requirements in 45 CFR parts 160 and 164. **[Quality]**

Strength #2: Aetna achieved full compliance in the Practice Guidelines program area, demonstrating that the ICO maintained adequate processes for the adoption, dissemination, and application of clinical practice guidelines (CPGs). [Quality]

Weaknesses and Recommendations

Weakness #1: Aetna received a *Not Met* score for 10 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. [Quality, Timeliness, and Access]

Why the weakness exists: Several gaps in Aetna's grievance and appeal processes were identified; specifically, those related to acknowledgement of grievances, written grievance resolutions, grievance resolution extensions, member written consent for filing appeals, acknowledgement of appeals, timely written resolution of expedited appeals, content and accuracy of written appeal resolution notices, timely reinstatement of services, and information provided to providers and subcontractors related to the member grievance and appeal systems.

Recommendation: While Aetna was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that Aetna continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member grievances and appeals. HSAG further recommends that Aetna implement procedures to ensure model notices used are the most current version required by MDHHS, and that Aetna follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG’s NAV results indicated that **Aetna** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. For Region 4, Aetna did not meet the minimum network requirements for Adult Day Program. Table 3-12 presents **Aetna**’s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS’ exception determinations.

Table 3-12—SFY 2023 NAV Results for AET, by Region and Provider Type

| Provider Type | Region 4 Validation Result | Region 7 Validation Result | Region 9 Validation Result |
|--|-------------------------------|-------------------------------|-------------------------------|
| Provider Types With Travel Time and Distance Requirements | | | |
| Adult Day Program | <i>Not Met</i> | <i>Met</i> | <i>Met</i> |
| Dental | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Eye Examinations | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Eye Wear | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Hearing Aids | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Hearing Examinations | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Provider Types Rendering Home-Based Services | | | |
| Adaptive Medical Equipment and Supplies | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Devices | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Van Lifts and Tie Downs | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Chore Services | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Community Transition Services | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| ECLS | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Environmental Modifications | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Fiscal Intermediary | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Home-Delivered Meals | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| MIHP Agency | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Medical Supplies | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| NEMT | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Non-Medical Transportation | <i>Met</i> | <i>Met</i> | <i>Met</i> |

| Provider Type | Region 4 Validation Result | Region 7 Validation Result | Region 9 Validation Result |
|--------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Personal Care Services | Met | Met | Met |
| Personal Emergency Response System | Met | Met | Met |
| Preventive Nursing | Met | Met | Met |
| Private Duty Nursing | Met | Met | Met |
| Respite | Met | Met | Met |
| Skilled Nursing Home | Met | Met | Met |
| Percentage of Total Requirements Met | 96% | 100% | 100% |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

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

Weaknesses and Recommendations

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

Why the weakness exists: Aetna did not meet the minimum network requirements for Adult Day Program in Region 4. MDHHS did not approve Aetna's exception request for the Adult Day Program provider type in Region 4.

Recommendation: Aetna should continue to maintain an internal data verification process to identify and contract with Adult Day Program providers as they become available in Region 4 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 4 will be evaluated during the SFY 2024 NAV.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 110 sampled provider locations (i.e., “cases”) for **Aetna**, with an overall response rate of 88.2 percent (97 cases) among **Aetna**’s three MI Health Link regions. Table 3-13 summarizes the SFY 2023 secret shopper survey response rates for **Aetna**, and for each of **Aetna**’s contracted MI Health Link regions.

Table 3-13—Summary of AET Secret Shopper Survey Results for Routine Dental Visits, by Region³⁻¹²

| | | Response Rate | | Accepting ICO | | Accepting MI Health Link | | Accepting New Patients | |
|--------------------|--------------------|---------------|-----------------------|---------------|-----------------------|--------------------------|-----------------------|------------------------|-----------------------|
| Region | Total Survey Cases | Cases Reached | Rate (%) ¹ | Accepting ICO | Rate (%) ² | Accepting MI Health Link | Rate (%) ² | Accepting New Patients | Rate (%) ² |
| Region 4 | 15 | 11 | 73.3% | 11 | 100% | 6 | 54.5% | 5 | 45.5% |
| Region 7 | 51 | 45 | 88.2% | 41 | 91.1% | 34 | 75.6% | 32 | 71.1% |
| Region 9 | 44 | 41 | 93.2% | 34 | 82.9% | 22 | 53.7% | 21 | 51.2% |
| Aetna Total | 110 | 97 | 88.2% | 86 | 88.7% | 62 | 63.9% | 58 | 59.8% |

¹ The denominator includes total survey cases.

² The denominator includes cases reached.

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

³⁻¹² Denominators used for the 2023 accepting MI Health Link and accepting new patients rates include cases reached. In 2022 and 2021, denominators for these rates were different. The accepting MI Health Link rate’s denominator included cases responding to the survey and indicating that at least one practitioner at the location accepted the requested ICO. The accepting new patients rate’s denominator included cases responding to the survey that accepted the ICO and MI Health Link. Caution should be exercised when comparing the 2023 results to the 2022 and 2021 results.

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

| Region | Total Survey Cases | Cases Contacted and Accepting New Patients | Cases Offered an Appointment | | | Appointment Wait Time (Days) ³ | | | |
|--------------------|--------------------|--|------------------------------|--|--|---|-----------|-----------|-----------|
| | | | Number | Rate Among All Surveyed Cases ¹ (%) | Rate Among Cases Accepting New Patients ² (%) | Min | Max | Average | Median |
| Region 4 | 15 | 5 | 3 | 20.0% | 60.0% | 1 | 56 | 35 | 49 |
| Region 7 | 51 | 32 | 28 | 54.9% | 87.5% | 0 | 79 | 18 | 13 |
| Region 9 | 44 | 21 | 19 | 43.2% | 90.5% | 1 | 35 | 15 | 14 |
| Aetna Total | 110 | 58 | 50 | 45.5% | 86.2% | 0 | 79 | 18 | 14 |

¹ The denominator includes total survey cases.

² The denominator includes cases reached that accept the ICO, MI Health Link, and new patients.

³ MDHHS' wait time standard for initial dental appointments is eight weeks.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Of the 110 total survey cases, 88.2 percent (n=97) of the provider locations could be contacted. [**Quality** and **Access**]

Strength #2: Of the cases reached, 88.7 percent of provider locations accepted **Aetna**. [**Access**]

Weaknesses and Recommendations

Weakness #1: Of the cases reached, 63.9 percent of provider locations accepted the MI Health Link program, and 59.8 percent accepted new patients. [**Access**]

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

Recommendation: HSAG recommends that **Aetna** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance and new patient acceptance) to address the provider data deficiencies and educate

provider offices on the MI Health Link program. Additionally, as MDHHS required **Aetna** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Weakness #2: Among all surveyed cases, the overall appointment rate was 45.5 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 being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid identification (ID) number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

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

Encounter Data Validation

Performance Results

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

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

Table 3-15 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-15—EDV Results for Aetna

| Analysis | Key Findings |
|------------------------------------|--|
| IS Review | |
| Encounter Data Sources and Systems | <ul style="list-style-type: none"> Aetna used QNXT, Edifecs, and Ramp Manager as its primary software for claim adjudication and encounter preparation. Aetna had processes in place to detect and identify duplicate claims. Aetna exclusively submitted complete claims. Additionally, it indicated that denied claims are not transmitted by its vendors. In cases requiring adjustments, such as errors, voided claims, or new paid claims, Aetna had implemented systems to track and manage these adjustments. Aetna and its subcontractors were responsible for collecting and maintaining provider information. Additionally, Aetna handled enrollment data received from MDHHS via 834 files, while subcontractors processed these files to manage transactions such as processing, updating, and terminating enrollments. |
| Payment Structures | <ul style="list-style-type: none"> Aetna used the Diagnosis-Related Group (DRG) method for its claim payment strategies for inpatient encounters. For outpatient and pharmacy encounters, it utilized line-by-line and ingredient cost methods, respectively. In general, Aetna processed claims with third-party liability (TPL) based on the collected insurance coverage information. |

| Analysis | Key Findings |
|---------------------------------------|--|
| | When a claim suggests the existence of additional primary insurance for a member, Aetna 's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details. |
| Encounter Data Quality Monitoring | <ul style="list-style-type: none"> Aetna and/or its subcontractors performed several data quality checks on the encounter data collected. These checks included but were not limited to assessing field-level completeness and validity (for all subcontractor encounters), evaluating timeliness (for all subcontractor encounters except pharmacy and fiscal intermediary), and ensuring alignment between payment fields in claims and financial reports (specifically for pharmacy). For encounters collected by Aetna, it only conducted data quality checks by evaluating whether the payment fields in the claims align with the financial reports. |
| Administrative Profile | |
| Encounter Data Completeness | <ul style="list-style-type: none"> Aetna displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. Aetna had a low volume of duplicate encounters, with 0.3 percent of professional encounters, less than 0.1 percent of institutional encounters, 0.2 percent of dental encounters, and less than 0 percent of pharmacy encounters identified as duplicative. |
| Encounter Data Timeliness | <ul style="list-style-type: none"> Aetna demonstrated timely submission of professional, institutional, dental, and pharmacy encounters. Within 60 days, Aetna submitted 95.2 percent of professional encounters and 98.9 percent of institutional encounters to MDHHS after the payment date. Within 30 days, Aetna submitted 100 percent of dental encounters and 99.8 percent of pharmacy encounters to MDHHS after the payment date. |
| Field-Level Completeness and Accuracy | <ul style="list-style-type: none"> In Aetna's submitted professional encounters, the billing provider National Provider Identifier (NPI) was populated 21.4 percent of the time, and the rendering provider NPI was populated 11.3 percent of the time. All other data elements in Aetna's submitted data had high rates of population and validity. |
| Encounter Referential Integrity | <ul style="list-style-type: none"> Of all identified member IDs in Aetna's submitted professional, institutional, and dental encounter data, 99.7 percent were identified in the enrollment data. |

| Analysis | Key Findings |
|----------------------|--|
| | <ul style="list-style-type: none"> Of all identified member IDs in Aetna's submitted pharmacy data, 99.3 percent were identified in the enrollment data. Of all identified provider NPIs in Aetna's submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. Of all identified provider NPIs in Aetna's submitted pharmacy encounter data, 95.2 percent were identified in the provider data. |
| Encounter Data Logic | <ul style="list-style-type: none"> No major concerns were noted for Aetna. |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Strength #2: **Aetna** submitted professional, institutional, dental, and pharmacy encounters in a timely manner from the payment date, with greater than 95 percent of all encounters submitted within 60 days of the payment date. [Quality and Timeliness]

Strength #3: Across all categories of service, all key data elements for **Aetna** were populated at high rates, and all but one was greater than 98 percent valid. [Quality]

Weaknesses and Recommendations

Weakness #1: **Aetna** did not indicate timeliness quality checks were performed for claims/encounters originating from its pharmacy and fiscal intermediary subcontractors. [Quality]

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: **Aetna** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Weakness #2: Aetna reported only conducting one quality check for claims/encounters stored in its data warehouses. [Quality]

Why the weakness exists: Only the reconciliation with the financial report was listed as being conducted, and no other checks for accuracy, completeness, or timeliness were mentioned.

Recommendation: Aetna should build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness for encounters collected and stored by Aetna.

Weakness #3: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95.2 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [Quality]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: Aetna should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #4: Although not required to be populated, 21.4 percent of professional encounters contained a billing provider NPI, and 11.3 percent contained a rendering provider NPI. [Quality]

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

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

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: While no **Aetna**-specific results could be presented, the statewide analysis identified that the 2023 top-box score for the *Recommend Personal Assistance/Behavioral Health Staff* measure was statistically significantly lower than the 2021 top-box score. This demonstrates a statistically significant decline from 2023, indicating opportunities for improvement for the MI Health Link program. Additionally, the lowest performing measure was *Planning Your Time and Activities* with a 2023 top-box score of 63.70 percent, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. Therefore, HSAG recommends that **Aetna** develop and implement interventions to improve member experience related to the *Recommend Personal Assistance/Behavioral Health Staff* and *Planning Your Time and Activities* measures. HSAG further recommends that **Aetna** develop innovative approaches to increase the number of members participating in future survey administrations.

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

HSAG performed a comprehensive assessment of **Aetna**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Aetna** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Aetna**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-16 displays each MDHHS CQS goal and EQR activity results that indicate whether the ICO positively (✓) or negatively (✗) impacted the MI Health Link program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Aetna**'s Medicaid members.

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

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| Goal #1 —Ensure high quality and high levels of access to care | <ul style="list-style-type: none"> ✓ The ICO met all minimum network requirements for all provider types with capacity-based requirements and most network requirements for provider types with travel time and distance requirements. ✓ Nearly 90 percent of dental provider locations could be contacted through secret shopper calls. ✓ Nearly 90 percent of dental providers reported accepting the ICO during secret shopper calls. ✓ The median wait time for a dental appointment was 14 calendar days, which is within MDHHS' initial dental appointment standard of eight weeks (i.e., 56 calendar days). ✓ For MI5.6 <i>Care for Adults—Medication Review</i>, the ICO incorporated supplemental data from clinical pharmacist medication reviews that were maintained in the Dynamo Case Trakker system, which significantly improved the reported rate from the prior year. ✓ The ICO's rate for the <i>COA—Care for Older Adults—Medication Review</i> measure indicator increased by more than 35 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✓ The ICO's rates for the <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)</i> and <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)</i> measure indicators decreased by more than 12 percentage points and increased by more than 10 percentage points, respectively, from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✓ The ICO's rate for the <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> measure indicator increased by more than 6 percentage points from MY 2021 to MY 2022 and | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|--|---|
| | <p>exceeded the HEDIS MY 2022 MI Health Link statewide average.</p> <ul style="list-style-type: none"> ✗ The ICO failed to meet the minimum network requirements for Adult Day Programs in Region 4. ✗ Only 63.9 percent of dental providers reported accepting the MI Health Link program, and only 59.8 percent of dental providers reported accepting new patients during secret shopper calls. ✗ The overall dental appointment rate among all surveyed providers was only 45.5 percent. ✗ The maximum wait time for a dental appointment was 79 calendar days, which exceeded MDHHS' initial dental appointment of eight weeks (i.e., 56 calendar days). ✗ The ICO's rate for the <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> measure indicator decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ For 26 of the 40 reported HEDIS measures (65 percent), the ICO's rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple HEDIS domains impacting quality and high levels of access to care. | |
| Goal #2 —Strengthen person and family-centered approaches | The ICO's findings for the EQR activities did not substantially impact Goal #2. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |
| Goal #3 —Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external) | <ul style="list-style-type: none"> ✓ The ICO implemented the Patient Access API and the Provider Directory API. ✓ The ICO's <i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i> measure indicator increased by more than 29 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✗ Although the ICO improved the MI2.6 <i>Timely Transmission of Care Transition Record to Health Care Professional</i> performance measure rate from the prior year's reported rate, it continued to have a low MI2.6 rate in comparison to the other Michigan ICOs' reported rates. ✗ The ICO was unable to use data from one of its delegated PIHPs to calculate MI2.6 <i>Timely Transmission of Care Transition Record to Health Care Professional</i> due to an | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|--|---|
| | incorrectly reported discharge code; therefore, data for this measure were underreported. | |
| Goal #4 —Reduce racial and ethnic disparities in healthcare and health outcomes | <ul style="list-style-type: none"> ✓ The ICO’s QAPI program addressed social determinants of health to reduce health disparities experienced by different subpopulations of members. ✓ While not statistically significant, the rates of members diagnosed with diabetes who receive an HbA1c test for both Black or African-American and White members increased from the baseline rate. ✗ The ICO did not meet the QIP goal of eliminating the existing disparity between Black or African-American and White members diagnosed with diabetes who receive an HbA1c test. ✗ The ICO did not incorporate any race and ethnicity data other than the data submitted by MDHHS in the enrollment file for the MI7.3 <i>Annual Dental Visit</i> performance measure. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |
| Goal #5 —Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | The ICO’s findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact value-based initiatives and payment reform had on improving quality outcomes for the ICO’s members. However, Table 5-5—CMS Core Measure Quality Withhold Results within Section 5 provides information on the results of MDHHS’ quality withhold program for the ICO. The information for the quality withhold program was provided by MDHHS and not assessed through the EQR activities. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

AmeriHealth Caritas VIP Care Plus

Validation of Quality Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **AmeriHealth**’s QIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., the QIP Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-17 displays the overall validation rating, the baseline and Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-17—Overall Validation Rating for AMI

| QIP Topic | Validation Rating ¹ | Performance Indicator | Performance Indicator Results | | | |
|--|--------------------------------|---|-------------------------------|---------|----|-----------|
| | | | Baseline | R1 | R2 | Disparity |
| <i>Transitions of Care, Medication Reconciliation Post-Discharge</i> | <i>Met</i> | Medication Reconciliation Post-Discharge for Disparate Group: Members Identified as Black/African American. | 66.2% | 61.4% ⇔ | | Yes |
| | | Medication Reconciliation Post-Discharge for Comparison Group: Members Identified as White. | 80.0% | 59.1% ↓ | | |

R1 = Remeasurement 1

R2 = Remeasurement 2

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)

⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)

↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

¹The QIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its QIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the QIP adhered to an acceptable methodology for all phases of design and data collection, and the ICO conducted accurate data analysis and interpretation of QIP results; overall confidence that the QIP produced significant evidence of improvement.)

The goals for **AmeriHealth**’s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black/African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-18 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

Table 3-18—Remeasurement 1 Barriers and Interventions for AMI

| Barriers | Interventions |
|--|---|
| Not leveraging ability of nurse care coordinators to complete medication reconciliation post-discharge (MRP) on every member who experiences a transition of care (TOC). | Revised internal processes to include MRP as a required step. Nurse care coordinators to complete the process with every TOC, utilizing functionality within the ICO's medical record system, forwarding MRP to PCPs, and including it in HEDIS data abstraction. |
| Providers may not submit applicable Current Procedural Terminology (CPT) II codes after completing MRP. | Notified providers that they will receive a \$25 payment for submission of CPT II codes after reconfiguration of the claims system to support it. |
| Providers may not be aware that TOC has occurred and MRP is needed. | Developed and implemented automated fax notifications to providers of admission and discharge dates based on a daily report. |
| Members may not complete timely follow-up care with providers after TOC has occurred. | Requested new text campaign to remind members who have experienced TOC to follow up with the provider within 30 days. |
| Verify that all race, ethnicity, and language (REL) data available to the ICO are included in HEDIS reporting. | Requested evaluation of systems where REL data are stored and development of a process to ensure all REL data are being included in HEDIS reporting. |

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: **AmeriHealth** used appropriate quality improvement tools to conduct a causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

Weaknesses and Recommendations

Weakness #1: Both performance indicators reported by **AmeriHealth** demonstrated a decline in performance as compared to the baseline rate. The ICO did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period without a decline in performance for the comparison subgroup. [Quality and Access]

Why the weakness exists: While it is unclear what led to the decline in performance for both subgroups, the ICO had opportunities for improvement related to identifying barriers specific to the disparate subgroup and the development of interventions to address those barriers.

Recommendation: HSAG recommends that **AmeriHealth** consider evidence-based intervention efforts and risk factors in quality of care for the Black/African-American population for the selected performance indicator and put interventions in place that would support improvement in the White population. In accordance with direction from MDHHS, **AmeriHealth** is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the Black/African-American population, within the next annual submission.

Performance Measure Validation

Performance Results

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

AmeriHealth received a measure designation of *Reportable (R)* for all measures, signifying that **AmeriHealth** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-19 includes the validation designation for each performance measure as well as the validated SFY 2023 performance measure rates.

Table 3-19—Measure-Specific Validation Designation for AMI

| Performance Measure | Validation Designation | SFY 2023 Rate |
|--|---|---------------|
| Core Measure 9.3: <i>Minimizing Institutional Length of Stay</i> | REPORTABLE (R) The ICO reported this measure in alignment with the MMP Core Reporting Requirements. | 0.62 |
| MI2.6: <i>Timely Transmission of Care Transition Record to Health Care Professional</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 22.60% |
| MI5.6: <i>Care for Adults—Medication Review</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 96.80% |
| MI7.3: <i>Annual Dental Visit</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 16.10% |

Performance Measure Rates

Table 3-20 shows each of **AmeriHealth**'s audited HEDIS measures, rates for HEDIS MY 2021 and HEDIS MY 2022 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2022 with HEDIS MY 2021, and the HEDIS MY 2021 and HEDIS MY 2022 MI Health Link statewide average performance rates. HEDIS MY 2021 and HEDIS MY 2022 measure rates performing better than the MY 2021 and MY 2022 statewide averages are notated by **green** font.

Table 3-20—Measure-Specific Percentage Rates for AMI

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------|-------------------|---------------------------|-------------------------------|-------------------------------|
| Prevention and Screening | | | | | |
| <i>BCS—Breast Cancer Screening</i> | 46.82 | 50.11 | +3.29 | 52.74 | 56.70 |
| <i>COL—Colorectal Cancer Screening</i> | 49.15 | 45.45 | –3.70 | 56.03 | 57.59 |
| <i>COA—Care for Older Adults—Medication Review</i> | 85.89 | 95.13 | +9.24 | 74.85 | 80.41 |
| <i>COA—Care for Older Adults—Functional Status Assessment</i> | 60.83 | 64.48 | +3.65 | 58.42 | 62.71 |
| <i>COA—Care for Older Adults—Pain Assessment</i> | 74.45 | 72.51 | –1.94 | 75.25 | 78.04 |
| Respiratory Conditions | | | | | |
| <i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i> | 17.24 | 20.31 | +3.07 | 22.93 | 22.01 |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i> | 55.10 | 60.00 | +4.90 | 68.65 | 74.10 |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i> | 91.84 | 86.67 | –5.17 | 89.67 | 88.82 |
| Cardiovascular Conditions | | | | | |
| <i>CBP—Controlling High Blood Pressure</i> | 60.83 | 62.03 | +1.20 | 60.52 | 66.14 |
| <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> | 100 | 90.00 | –10.00 | 95.25 | 90.85 |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i> | 84.92 | 84.87 | –0.05 | 82.00 | 80.90 |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i> | 85.05 | 81.19 | –3.86 | 84.22 | 79.55 |
| Diabetes | | | | | |
| <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*</i> | 38.44 | 37.32 | –1.12 | 43.53 | 34.07 |
| <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)</i> | 54.26 | 53.66 | –0.60 | 49.06 | 58.51 |
| <i>EED—Eye Exam for Patients With Diabetes</i> | 52.55 | 56.83 | +4.28 | 57.33 | 62.89 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|--|-------------------------|-------------------------|------------------------------------|--|--|
| <i>BPD—Blood Pressure Control for Patients With Diabetes</i> | 54.50 | 59.51 | +5.01 | 60.82 | 68.13 |
| <i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i> | 78.52 | 77.82 | −0.70 | 76.83 | 76.44 |
| <i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i> | 72.17 | 77.50 | +5.33 | 82.46 | 78.95 |
| Musculoskeletal Conditions | | | | | |
| <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> | 40.00 | 0.00 | −40.00 | 16.12 | 11.18 |
| Behavioral Health | | | | | |
| <i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment</i> | 79.17 | 78.13 | −1.04 | 75.06 | 73.66 |
| <i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment</i> | 59.72 | 59.38 | −0.34 | 60.75 | 57.94 |
| <i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i> | 17.07 | 24.56 | +7.49 | 26.13 | 32.79 |
| <i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i> | 31.71 | 49.12 | +17.41 | 50.22 | 58.91 |
| <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i> | 22.22 | 11.43 | −10.79 | 33.87 | 32.06 |
| <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i> | 40.74 | 34.29 | −6.45 | 51.71 | 54.39 |
| Medication Management and Care Coordination | | | | | |
| <i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i> | 64.48 | 58.15 | −6.33 | 43.96 | 47.59 |
| <i>TRC—Transitions of Care—Notification of Inpatient Admission</i> | 2.19 | 25.30 | +23.11 | 13.11 | 16.53 |
| <i>TRC—Transitions of Care—Receipt of Discharge Information</i> | 2.68 | 16.79 | +14.11 | 12.77 | 15.38 |
| <i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i> | 74.70 | 71.68 | −3.02 | 74.60 | 77.74 |
| Overuse/Appropriateness | | | | | |
| <i>PSA—Non-Recommended PSA-Based Screening in Older Men*</i> | 18.82 | 22.18 | +3.36 | 24.68 | 26.71 |
| <i>DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*</i> | 27.68 | 26.23 | −1.45 | 31.94 | 33.45 |
| <i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*</i> | 11.54 | 10.69 | −0.85 | 17.81 | 18.16 |
| <i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*</i> | 4.05 | 4.21 | +0.16 | 5.50 | 5.23 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------------|-------------------------|------------------------------------|--|--|
| <i>DAE—Use of High-Risk Medications in Older Adults—Total*</i> | 14.55 | 14.18 | −0.37 | 21.56 | 21.78 |
| Access/Availability of Care | | | | | |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years</i> | 78.63 | 82.30 | +3.67 | 84.27 | 84.90 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years</i> | 90.58 | 90.13 | −0.45 | 93.49 | 93.83 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 and Older</i> | 87.28 | 86.31 | −0.97 | 91.45 | 91.69 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 86.75 | 86.71 | −0.04 | 90.77 | 91.08 |
| Risk-Adjusted Utilization | | | | | |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i> | 1.80 | 0.95 | −0.85 | 1.17 | 1.07 |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i> | 1.44 | 1.66 | +0.22 | 1.20 | 1.21 |

* Measures for which lower rates indicate better performance.

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: AmeriHealth successfully demonstrated the identification of institutional admissions and discharges to the community. This was noted as a strong improvement over the prior year’s reporting, which identified several concerns impacting data element B. **AmeriHealth** demonstrated the integration of the prior year’s feedback and Core Measure 9.3 Frequently Asked Questions (FAQs) guidance to ensure that its programming logic was consistent with the measure specifications. [Quality, Access, and Timeliness]

Strength #2: AmeriHealth demonstrated significant improvement in its MI2.6 performance measure rate over the prior year related to the timely transmission of the care transmission records to healthcare professionals after discharge. The timely transmission of this information may help improve the TOC for members between care settings, improve access to follow-up care, and potentially reduce readmissions. **AmeriHealth** increased resources to improve in this area and made

improvements in its process for receiving and communicating care transmission records. [Quality, Access, and Timeliness]

Strength #3: AmeriHealth was able to report valid data for MI7.3, which was a new measure for reporting. The audit found that **AmeriHealth** used multiple sources for the capture of race and ethnicity data including MI Level 1 Assessments, stand-alone REL assessments, State 834 enrollment files, and CMS daily transaction reply report (DTRR) files. The use of multiple sources promotes the accuracy and completeness of data, which makes the stratification results more meaningful in informing future targeted quality improvement efforts. [Quality, Access, and Timeliness]

Strength #4: In the Medication Management and Care Coordination domain, **AmeriHealth**'s rates for the *TRC—Transitions of Care—Notification of Inpatient Admission and Receipt of Discharge Information* measure indicators increased by more than 14 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in timely notification of inpatient admissions and documentation of discharge information. Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs. Inadequate care coordination and poor care transitions can result in unnecessary spending.³⁻¹³ [Quality and Timeliness]

Weaknesses and Recommendations

Weakness #1: Primary source verification (PSV) results for MI7.3 found that **AmeriHealth** did not appropriately integrate enrollment data for the continuous enrollment calculation, which resulted in some members not meeting enrollment criteria included in the measure denominator. [Quality and Timeliness]

Why the weakness exists: **AmeriHealth** had a data timing issue.

Recommendation: HSAG recommends that **AmeriHealth** consider revising its performance measure production timeline to allow adequate time for review and data quality checks before data are submitted to the FAI Data Collection System (DCS).

Weakness #2: **AmeriHealth** was required to resubmit its Core Measure 9.3 data to Health Plan Management System (HPMS), as the data submitted to HSAG differed from the data originally sent to HPMS. [Quality, Timeliness, and Access]

Why the weakness exists: **AmeriHealth** likely did not allow enough time to produce performance measure rate data and perform its quality checks on the data, which resulted in **AmeriHealth** identifying errors after its submission to HPMS.

³⁻¹³ National Committee for Quality Assurance. Transitions of Care (TRC). Available at: <https://www.ncqa.org/hedis/measures/transitions-of-care/>. Accessed on: Mar 28, 2024.

Recommendation: HSAG recommends that **AmeriHealth** consider revising its performance measure production timeline to allow adequate time for review and data quality checks before data are submitted to HPMS.

Weakness #3: While **AmeriHealth** had a strong process for collecting race and ethnicity data, MI7.3 data counts for race and ethnicity stratifications had errors. [Quality and Access]

Why the weakness exists: MI7.3 was reported for the first time, and the stratifications for race and ethnicity were also new; therefore, **AmeriHealth** did not have experience reporting these data.

Recommendation: HSAG recommends that **AmeriHealth** ensure that it adds some quality checks for measures that require race and ethnicity stratifications to ensure that the data align with the measure denominator. In addition, HSAG recommends that **AmeriHealth** perform some internal PSV to help identify potential errors prior to the submission of data.

Weakness #4: For 24 of the 40 reported HEDIS measures (60 percent), **AmeriHealth**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization. [Quality]

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

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

Weakness #5: In the Respiratory Conditions domain, **AmeriHealth**'s rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measure indicator decreased by more than 5 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. COPD exacerbations make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD.³⁻¹⁴ [Quality and Access]

Why the weakness exists: The rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measure indicator decreasing by more than 5 percentage points from

³⁻¹⁴ National Committee for Quality Assurance. Pharmacotherapy Management of COPD Exacerbation (PCE). Available at: <https://www.ncqa.org/hedis/measures/pharmacotherapy-management-of-copd-exacerbation/>. Accessed on: Apr 1, 2024.

MY 2021 to MY 2022 suggests that barriers exist for receiving medication therapy to manage exacerbation for some adult members with COPD.

Recommendation: HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measure indicator. **AmeriHealth** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).

Weakness #6: In the Cardiovascular Conditions domain, **AmeriHealth**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased by 10 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adult members were not using a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.³⁻¹⁵ [Quality, Access, and Timeliness]

Why the weakness exists: The rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreasing by 10 percentage points from MY 2021 to MY 2022 suggests that barriers exist for some adult members to use a beta-blocker as treatment after a heart attack.

Recommendation: HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some adults were not using a beta-blocker after a heart attack. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator. **AmeriHealth** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).

Weakness #7: In the Musculoskeletal Conditions domain, **AmeriHealth**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator was 0 percent, and the measure indicator decreased by 40 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, suggesting that some women who suffered a fracture did not receive a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality.

³⁻¹⁵ National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: <https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/>. Accessed on: Mar 28, 2024.

With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.³⁻¹⁶ [Quality, Timeliness, and Access]

Why the weakness exists: The rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator was 0 percent and decreased by 40 percentage points from MY 2021 to MY 2022, suggesting barriers exist for women to receive timely bone mineral density tests or prescriptions to treat osteoporosis within six months of a fracture.

Recommendation: HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some women were not always receiving timely bone mineral density tests or a prescription to treat osteoporosis within six months of a fracture. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator.

AmeriHealth should consider the nature and scope of the issue (e.g., whether the issues related to patient and provider education or barriers to accessing care).

³⁻¹⁶ National Committee for Quality Assurance. Osteoporosis Management In Women Who Had a Fracture (OMW). Available at: <https://www.ncqa.org/hedis/measures/osteoporosis-management-in-women-who-had-a-fracture/>. Accessed on: Mar 28, 2024.

Compliance Review

Performance Results

Table 3-21 presents **AmeriHealth**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **AmeriHealth** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **AmeriHealth**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-21—SFY 2022 and SFY 2023 Standard Compliance Scores for AMI

| Compliance Review Standard | Compliance Score |
|---|------------------|
| Year One (SFY 2022) | |
| Standard I—Disenrollment: Requirements and Limitations ¹ | 100% |
| Standard II—Member Rights and Member Information | 59% |
| Standard III—Emergency and Poststabilization Services ¹ | 100% |
| Standard IV—Availability of Services | 85% |
| Standard V—Assurances of Adequate Capacity and Services | 100% |
| Standard VI—Coordination and Continuity of Care | 77% |
| Standard VII—Coverage and Authorization of Services | 89% |
| Year Two (SFY 2023) | |
| Standard VIII—Provider Selection | 91% |
| Standard IX—Confidentiality | 73% |
| Standard X—Grievance and Appeal Systems | 71% |
| Standard XI—Subcontractual Relationships and Delegation | 80% |
| Standard XII—Practice Guidelines | 100% |
| Standard XIII—Health Information Systems ² | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 90% |
| Year Three (SFY 2024) | |
| Review of ICO's implementation of Year One and Year Two CAPs | |

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

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

Table 3-22 presents **AmeriHealth**'s scores for each standard evaluated during the SFY 2023 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **AmeriHealth**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2023 compliance review activity demonstrated how successful **AmeriHealth** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-22—SFY 2023 Standard Compliance Scores for AMI

| Standard | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|----------------|---------------------------|--------------------|-----------|-----------|------------------------|
| | | | <i>M</i> | <i>NM</i> | <i>NA</i> | |
| Standard VIII—Provider Selection | 23 | 23 | 21 | 2 | 0 | 91% |
| Standard IX—Confidentiality | 11 | 11 | 8 | 3 | 0 | 73% |
| Standard X—Grievance and Appeal Systems | 45 | 45 | 32 | 13 | 0 | 71% |
| Standard XI—Subcontractual Relationships and Delegation | 6 | 5 | 4 | 1 | 1 | 80% |
| Standard XII—Practice Guidelines | 6 | 6 | 6 | 0 | 0 | 100% |
| Standard XIII—Health Information Systems ¹ | 9 | 9 | 9 | 0 | 0 | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 21 | 21 | 19 | 2 | 0 | 90% |
| Total | 121 | 120 | 99 | 21 | 1 | 83% |

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

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

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

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

¹This standard includes a comprehensive assessment of the ICO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: **AmeriHealth** achieved full compliance in the Practice Guidelines program area, demonstrating that the ICO maintained adequate processes for the adoption, dissemination, and application of CPGs. [Quality]

Strength #2: AmeriHealth achieved full compliance in the Health Information Systems program area, demonstrating that the ICO maintained adequate IS that collects, analyzes, integrates, and reports data to achieve the ICO's contractual obligations with MDHHS. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: AmeriHealth received a *Not Met* score for three elements within the Confidentiality program area, indicating inadequate processes related to the use and disclosure of individually identifiable health information in accordance with privacy requirements in 45 CFR parts 160 and 164. [Quality and Access]

Why the weakness exists: AmeriHealth's confidentiality procedures did not adequately address member requests for privacy protection of their protected health information (PHI), member requests for access to their PHI, and member requests for an amendment of PHI or member's record.

Recommendation: While AmeriHealth was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that AmeriHealth continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal requirements specific to member requests for privacy protection, access of PHI, and member requests for an amendment of PHI or member's record.

Weakness #2: AmeriHealth received a *Not Met* score for 13 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. [Quality, Timeliness, and Access]

Why the weakness exists: Several gaps in AmeriHealth's grievance and appeal processes were identified; specifically, those related to member written consent for filing grievances and appeals, written acknowledgement of grievances and appeals, written grievance and appeal resolution notices, written notice of grievance resolution time frame extensions, an appeal committee, the member's right to request a copy of the case file, untimely appeal resolution time frames, notice of appeal dismissals, timely reinstatement of services, and information provided to subcontractors related to the member grievance and appeal systems.

Recommendation: While AmeriHealth was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that AmeriHealth continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member grievances and appeals. HSAG further recommends that AmeriHealth implement procedures to ensure model notice language used is the most current version required by MDHHS, and that AmeriHealth follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG’s NAV results indicated that **AmeriHealth** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. Table 3-23 presents **AmeriHealth**’s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS’ exception determinations.

Table 3-23—SFY 2023 NAV Results for AMI, by Region and Provider Type

| Provider Type | Region 7 Validation Result | Region 9 Validation Result |
|--|-------------------------------|-------------------------------|
| Provider Types With Travel Time and Distance Requirements | | |
| Adult Day Program | <i>Met</i> | <i>Met</i> |
| Dental | <i>Met</i> | <i>Met</i> |
| Eye Examinations | <i>Met</i> | <i>Met</i> |
| Eye Wear | <i>Met</i> | <i>Met</i> |
| Hearing Aids | <i>Met</i> | <i>Met</i> |
| Hearing Examinations | <i>Met</i> | <i>Met</i> |
| Provider Types Rendering Home-Based Services | | |
| Adaptive Medical Equipment and Supplies | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Devices | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Van Lifts and Tie Downs | <i>Met</i> | <i>Met</i> |
| Chore Services | <i>Met</i> | <i>Met</i> |
| Community Transition Services | <i>Met</i> | <i>Met</i> |
| ECLS | <i>Met</i> | <i>Met</i> |
| Environmental Modifications | <i>Met</i> | <i>Met</i> |
| Fiscal Intermediary | <i>Met</i> | <i>Met</i> |
| Home-Delivered Meals | <i>Met</i> | <i>Met</i> |
| MIHP Agency | <i>Met</i> | <i>Met</i> |
| Medical Supplies | <i>Met</i> | <i>Met</i> |
| NEMT | <i>Met</i> | <i>Met</i> |
| Non-Medical Transportation | <i>Met</i> | <i>Met</i> |

| Provider Type | Region 7 Validation Result | Region 9 Validation Result |
|--------------------------------------|-------------------------------|-------------------------------|
| Personal Care Services | <i>Met</i> | <i>Met</i> |
| Personal Emergency Response System | <i>Met</i> | <i>Met</i> |
| Preventive Nursing Services | <i>Met</i> | <i>Met</i> |
| Private Duty Nursing | <i>Met</i> | <i>Met</i> |
| Respite | <i>Met</i> | <i>Met</i> |
| Skilled Nursing Home | <i>Met</i> | <i>Met</i> |
| Percentage of Total Requirements Met | 100% | 100% |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

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

Weaknesses and Recommendations

Weakness #1: HSAG identified no substantial weaknesses for **AmeriHealth** based on the SFY 2023 NAV results.

Why the weakness exists: NA

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

Secret Shopper Survey

Performance Results

HSAG attempted to contact 34 sampled provider locations (i.e., “cases”) for **AmeriHealth**, with an overall response rate of 76.5 percent (26 cases) among **AmeriHealth**’s two MI Health Link regions. Table 3-24 summarizes the SFY 2023 secret shopper survey response rates for **AmeriHealth**, and for each of **AmeriHealth**’s contracted MI Health Link regions.

Table 3-24—Summary of AMI Secret Shopper Survey Results for Routine Dental Visits, by Region³⁻¹⁷

| | | Response Rate | | Accepting ICO | | Accepting MI Health Link | | Accepting New Patients | |
|--------------------------|--------------------|---------------|-----------------------|---------------|-----------------------|--------------------------|-----------------------|------------------------|-----------------------|
| Region | Total Survey Cases | Cases Reached | Rate (%) ¹ | Accepting ICO | Rate (%) ² | Accepting MI Health Link | Rate (%) ² | Accepting New Patients | Rate (%) ² |
| Region 7 | 17 | 13 | 76.5% | 11 | 84.6% | 5 | 38.5% | 5 | 38.5% |
| Region 9 | 17 | 13 | 76.5% | 9 | 69.2% | 5 | 38.5% | 5 | 38.5% |
| AmeriHealth Total | 34 | 26 | 76.5% | 20 | 76.9% | 10 | 38.5% | 10 | 38.5% |

¹ The denominator includes total survey cases.

² The denominator includes cases reached.

Table 3-25 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **AmeriHealth**, and for each of **AmeriHealth**’s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

³⁻¹⁷ Denominators used for the 2023 accepting MI Health Link and accepting new patient rates include cases reached. In 2022 and 2021, denominators for these rates were different. The accepting MI Health Link rate’s denominator included cases responding to the survey and indicating that at least one practitioner at the location accepted the requested ICO. The accepting new patient rate’s denominator included cases responding to the survey that accepted the ICO and MI Health Link. Caution should be exercised when comparing the 2023 results to the 2022 and 2021 results.

Table 3-25—Summary of AMI Secret Shopper Survey Appointment Availability Results, by Region

| Region | Total Survey Cases | Cases Contacted and Accepting New Patients | Cases Offered an Appointment | | | Appointment Wait Time (Days) ³ | | | |
|--------------------------|--------------------|--|------------------------------|--|--|---|------------|-----------|-----------|
| | | | Number | Rate Among All Surveyed Cases ¹ (%) | Rate Among Cases Accepting New Patients ² (%) | Min | Max | Average | Median |
| Region 7 | 17 | 5 | 2 | 11.8% | 40.0% | 24 | 35 | 30 | 30 |
| Region 9 | 17 | 5 | 4 | 23.5% | 80.0% | 28 | 124 | 62 | 49 |
| AmeriHealth Total | 34 | 10 | 6 | 17.6% | 60.0% | 24 | 124 | 51 | 34 |

¹ The denominator includes total survey cases.

² The denominator includes cases reached that accept the ICO, MI Health Link, and new patients.

³ MDHHS' wait time standard for initial dental appointments is eight weeks.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: No substantial strengths were identified for **AmeriHealth** through the secret shopper survey.

Weaknesses and Recommendations

Weakness #1: Of the 34 total survey cases, 76.5 percent (n=26) of the provider locations could be contacted. Of the cases reached, 76.9 percent of provider locations accepted **AmeriHealth**, and 38.5 percent accepted the MI Health Link program and new patients. **[Quality and Access]**

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

Recommendation: HSAG recommends that **AmeriHealth** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect phone number, MI Health Link acceptance, and new patient acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS

required **AmeriHealth** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

Weakness #2: Among all surveyed cases, the overall appointment rate was 17.6 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 being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

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

Encounter Data Validation

Performance Results

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

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

Table 3-26 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-26—EDV Results for AmeriHealth

| Analysis | Key Findings |
|------------------------------------|---|
| IS Review | |
| Encounter Data Sources and Systems | <ul style="list-style-type: none"> AmeriHealth used International Business Machines’ (IBM’s) Sterling File Gateway, IBM’s Standards Processing Engine, and TriZetto’s Encounter Data Manager (EDM) as its primary software for claim adjudication and encounter preparation. AmeriHealth had processes in place to detect and identify duplicate claims. AmeriHealth indicated that it sends all encounters including paid claims, voided claims, interest and penalties (both paid and recovered), incentive payments (both paid and recovered), “zero paid” claims, cost settlements, sub-capitated services, TPL denials, claim line adjustments, and other financial activities related to payments and recoveries. If there were any adjustments needed, AmeriHealth updated MDHHS with the changes and checked for any errors in the encounters it receives from MDHHS. AmeriHealth’s system kept track of these errors, and it had a process in place to handle and resolve these errors efficiently. AmeriHealth and its subcontractors were responsible for collecting and maintaining provider information. Additionally, AmeriHealth handled enrollment data received from MDHHS via 834 files, while subcontractors used these for claims processing. |
| Payment Structures | <ul style="list-style-type: none"> AmeriHealth used the percent of allowed method for its claim payment strategies for inpatient, outpatient, and pharmacy encounters. TPL data were gathered from various sources and integrated into AmeriHealth’s claims payment system for coordination of benefits (COB). AmeriHealth covered the difference between its allowed amount and the payment from other insurers. Vendors assisted in updating TPL information, which was stored in the core claim administration system. COB and TPL details were included in X12 HIPAA compliant 837 encounter files. |
| Encounter Data Quality Monitoring | <ul style="list-style-type: none"> AmeriHealth and/or its subcontractors performed several data quality checks on the encounter data collected. These checks included but were not limited to analyzing claim volume by submission month (for all subcontractor encounters except for pharmacy and LTSS), assessing field-level completeness and validity (for all subcontractor encounters), evaluating timeliness (for all subcontractor encounters except for LTSS), and ensuring alignment between payment fields in claims and financial reports (all subcontractor encounters except for pharmacy). |

| Analysis | Key Findings |
|---------------------------------------|--|
| | <ul style="list-style-type: none"> For encounters collected by AmeriHealth, it conducted data quality checks including electronic data interchange (EDI) compliance edits, assessed field-level completeness and accuracy, and evaluated whether the payment fields in the claims align with the financial reports. |
| Administrative Profile | |
| Encounter Data Completeness | <ul style="list-style-type: none"> AmeriHealth displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. AmeriHealth had a low volume of duplicate encounters, with 0.2 percent of professional encounters and 0 percent of institutional, dental, and pharmacy encounters identified as duplicative. |
| Encounter Data Timeliness | <ul style="list-style-type: none"> AmeriHealth demonstrated timely submission of professional, dental, and pharmacy encounters. Within 60 days, AmeriHealth submitted 98.4 percent of professional encounters, 99.7 percent of dental encounters, and 100 percent of pharmacy encounters to MDHHS after the payment date. Although AmeriHealth demonstrated timely submission of institutional encounters overall, it demonstrated a slower submission rate compared to professional, dental, and pharmacy encounters. Within 60 days, AmeriHealth submitted 66.8 percent of institutional encounters. However, within 90 days from the payment date, AmeriHealth submitted 100 percent of institutional encounters to MDHHS. |
| Field-Level Completeness and Accuracy | <ul style="list-style-type: none"> The CPT/Healthcare Common Procedure Coding System (HCPCS) Codes with Procedure-to-Procedure (PTP) Edits field had lower than expected validity rates for institutional encounters in AmeriHealth's submitted data, with an 88.1 percent validity rate. All other data elements in AmeriHealth's submitted data had high rates of population and validity. |
| Encounter Referential Integrity | <ul style="list-style-type: none"> Of all identified member IDs in AmeriHealth's submitted professional, institutional, and dental encounter data, 99.7 percent were identified in the enrollment data. Of all identified member IDs in AmeriHealth's submitted pharmacy data, 97.2 percent were identified in the enrollment data. Of all identified provider NPIs in AmeriHealth's submitted professional, institutional, and dental encounter data, 100 percent were identified in the provider data. |

| Analysis | Key Findings |
|----------------------|---|
| | <ul style="list-style-type: none"> Of all identified provider NPIs in AmeriHealth's submitted pharmacy encounter data, 98.3 percent were identified in the provider data. |
| Encounter Data Logic | <ul style="list-style-type: none"> No major concerns were noted for AmeriHealth. |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Strength #2: AmeriHealth submitted professional, institutional, dental, and pharmacy encounters in a timely manner from the payment date, with greater than 98 percent of all encounters submitted within 90 days of the payment date. [Quality and Timeliness]

Strength #3: AmeriHealth had no duplicative records identified in institutional, dental, or pharmacy encounters. [Quality]

Strength #4: Across all categories of service, all key data elements for **AmeriHealth** were populated at high rates, and all but one was greater than 97 percent valid. [Quality]

Weaknesses and Recommendations

Weakness #1: AmeriHealth did not indicate timeliness quality checks were performed for claims/encounters originating from its LTSS subcontractors. [Quality]

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: AmeriHealth should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Weakness #2: Although nearly all key data elements had high validity rates across all categories of service, CPT/HCPCS codes with PTP edits was valid 88.1 percent of the time in institutional data.

[Quality]

Why the weakness exists: Incorrectly reported pairs of CPT/HCPCS codes may cause improper payments.

Recommendation: AmeriHealth should continue to evaluate its data for accuracy and evaluate CPT/HCPCS codes with PTP edit checks to ensure proper payment.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: While no AmeriHealth-specific results could be presented, the statewide analysis identified that the 2023 top-box score for the *Recommend Personal Assistance/Behavioral Health Staff* measure was statistically significantly lower than the 2021 top-box score. This demonstrates a statistically significant decline from 2023, indicating opportunities for improvement for the MI Health Link program. Additionally, the lowest performing measure was *Planning Your Time and Activities* with a 2023 top-box score of 63.70 percent, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. Therefore, HSAG recommends that AmeriHealth develop and implement

interventions to improve member experience related to the *Recommend Personal Assistance/Behavioral Health Staff* and *Planning Your Time and Activities* measures. HSAG further recommends that **AmeriHealth** develop innovative approaches to increase the number of members participating in future survey administrations.

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

HSAG performed a comprehensive assessment of **AmeriHealth**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **AmeriHealth** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **AmeriHealth**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-27 displays each MDHHS CQS goal and EQR activity results that indicate whether the ICO positively (✓) or negatively (✗) impacted the MI Health Link program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **AmeriHealth**'s Medicaid members.

Table 3-27—Overall Performance Impact to CQS and Quality, Timeliness, and Access

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| Goal #1 —Ensure high quality and high levels of access to care | <ul style="list-style-type: none"> ✓ The ICO met all minimum network requirements for all provider types with capacity-based requirements and for all provider types with travel time and distance requirements. ✓ The median wait time for a dental appointment was 34 calendar days, which is within MDHHS' initial dental appointment standard of eight weeks (i.e., 56 calendar days). ✗ Only 76.5 percent of dental provider locations could be contacted during secret shopper calls. ✗ Only 76.9 percent of dental providers reported accepting the ICO, and only 38.5 percent of dental providers reported accepting the MI Health Link program and new patients during secret shopper calls. ✗ The overall dental appointment rate among all surveyed providers was only 17.6 percent. ✗ The maximum wait time for a dental appointment was 124 calendar days, which exceeded MDHHS' initial dental appointment standard of eight weeks (i.e., 56 calendar days). ✗ The ICO did not appropriately integrate enrollment data for the continuous enrollment calculation, which resulted in some members not meeting enrollment criteria included in the measure denominator for the MI7.3 <i>Annual Dental Visit</i> performance measure. ✗ The ICO's rate for the <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i> measure indicator | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|--|---|
| | <p>decreased by more than 5 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average.</p> <ul style="list-style-type: none"> ✗ The ICO's rate for the <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> measure indicator decreased by 10 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ The ICO's rate for the <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> measure indicator was 0 percent and the measure indicator decreased by 40 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ For 24 of the 40 reported HEDIS measures (60 percent), the ICO's rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple HEDIS domains impacting quality and high levels of access to care. | |
| Goal #2 —Strengthen person and family-centered approaches | <ul style="list-style-type: none"> ✓ The ICO showed strong improvement over the prior year's reporting by demonstrating the integration of the prior year's feedback and Core Measure 9.3 FAQs guidance to ensure that its programming logic was consistent with the <i>Minimizing Institutional Length of Stay</i> measure specifications. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |
| Goal #3 —Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external) | <ul style="list-style-type: none"> ✓ The ICO implemented the Patient Access API and the Provider Directory API. ✓ The ICO demonstrated significant improvement in its MI2.6 performance measure rate over the prior year related to the timely transmission of the care transmission records to healthcare professionals after discharge. ✓ The ICO's rates for the <i>TRC—Transitions of Care—Notification of Inpatient Admission and Receipt of Discharge Information</i> measure indicators increased by more than 14 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |
| Goal #4 —Reduce racial and ethnic disparities in healthcare and health outcomes | <ul style="list-style-type: none"> ✓ The ICO's QAPI program addressed social determinants of health to reduce health disparities experienced by different subpopulations of members. ✓ The ICO used multiple sources for the capture of race and ethnicity data including MI Level 1 Assessments, stand-alone REL assessments, State 834 enrollment files, and CMS DTRR files as they related to the MI7.3 <i>Annual Dental Visit</i> performance measure. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| | <ul style="list-style-type: none"> ✗ While the ICO had a strong process for collecting race and ethnicity data, MI7.3 <i>Annual Dental Visit</i> data counts for race and ethnicity stratifications had errors. ✗ The rates of Black/African-American and White members who received medication reconciliation post-discharge declined from the baseline rate. ✗ The ICO did not meet the QIP goal of eliminating the existing disparity between Black/African-American and White members who received medication reconciliation post-discharge. | |
| Goal #5 —Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | The ICO’s findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact value-based initiatives and payment reform had on improving quality outcomes for the ICO’s members. However, Table 5-5—CMS Core Measure Quality Withhold Results within Section 5 provides information on the results of MDHHS’ quality withhold program for the ICO. The information for the quality withhold program was provided by MDHHS and not assessed through the EQR activities. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

HAP Empowered

Validation of Quality Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **HAP**’s QIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., the QIP Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-28 displays the overall validation rating, the baseline and Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-28—Overall Validation Rating for HAP

| QIP Topic | Validation Rating ¹ | Performance Indicator | Performance Indicator Results | | | |
|--|--------------------------------|---|-------------------------------|---------|----|-----------|
| | | | Baseline | R1 | R2 | Disparity |
| Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members | Met | The percentage of African American members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. | 51.1% | 63.8% ↑ | | No |
| | | The percentage of Caucasian members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. | 74.2% | 67.4% ⇔ | | |

R1 = Remeasurement 1

R2 = Remeasurement 2

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)

⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)

↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

¹ The QIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its QIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the QIP adhered to an acceptable methodology for all phases of design and data collection, and the ICO conducted accurate data analysis and interpretation of QIP results; overall confidence that the QIP produced significant evidence of improvement.)

The goals for **HAP**’s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Caucasian) or achieve clinically or programmatically significant improvement as a result of initiated

intervention(s). Table 3-29 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

Table 3-29—Remeasurement 1 Barriers and Interventions for HAP

| Barriers | Interventions |
|---|--|
| The coronavirus disease 2019 (COVID-19) pandemic exacerbated pre-existing health inequities, such as access to healthcare services. | The ICO pharmacy benefit manager (PBM), Express Scripts, Inc. (ESI) has a medication adherence program and targets members for outreach. |
| | A new report for providers that focused on gaps in care for their members was disseminated to providers starting in 2022. |
| Racial disparities between Caucasian and African-American populations in hypertension control are well-documented in the United States. | Created an adherence report to ensure providers are monitoring members who have uncontrolled blood pressure readings. Members were encouraged to have follow-up visits with the provider for regular monitoring. |
| | The ICO identified a new geo-mapping intervention to identify demographic and geographic trends of members who are nonadherent for blood pressure readings. This information will be utilized in conjunction with food insecurity maps to do targeted outreach as needed to select geographic areas. |
| Having multiple information technology (IT) systems makes pulling data difficult. | The ICO is modifying supplemental data HEDIS extracts to include at-home and telehealth visit blood pressure readings. |
| Contact information for members is incorrect. | Designed an incentive program to reward PCPs for high-quality, cost-effective primary care services. This will encourage providers, who may have more updated contact information for members, to contact members and make appointments for a blood pressure check. |
| | Updated its internal customer service resource tool which shows member-facing staff which HEDIS measures the members need. This enabled staff to discuss the member's gaps in care when the member calls HAP and update contact information as well. |
| Members do not attend provider appointments to document their blood pressure. | The ICO has focused on an access to care campaign, with outreach conducted to members who need to schedule a physician visit. |

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HAP met 100 percent of the requirements for data analysis and implementation of improvement strategies. The ICO conducted accurate statistical testing between the two subgroups for the first remeasurement period and provided a narrative interpretation of the results. **HAP** used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

Strength #2: The disparate subgroup demonstrated statistically significant improvement over the baseline performance for the first remeasurement period. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: HAP partially achieved the state-defined goals. While the existing disparity was eliminated between the two subgroups with the first remeasurement period, the comparison subgroup demonstrated a decline in performance as compared to the baseline. [Quality and Access]

Why the weakness exists: While it is unclear why the comparison subgroup demonstrated a decline in performance, **HAP** has made progress in improving performance among the disparate subgroup, demonstrating statistically significant improvement over the baseline.

Recommendation: HSAG recommends **HAP** continue efforts to maintain, or improve, its performance for the comparison subgroup. The ICO should also determine if any new barriers exist that are driving down performance for this subgroup. Also, in accordance with direction from MDHHS, **HAP** is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the African-American population, within the next annual submission.

Performance Measure Validation

Performance Results

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

HAP received a measure designation of *Reportable (R)* for all measures, signifying that **HAP** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-30 includes the validation designation for each performance measure as well as the validated SFY 2023 performance measure rates.

Table 3-30—Measure-Specific Validation Designation for HAP

| Performance Measure | Validation Designation | SFY 2023 Rate |
|--|---|---------------|
| Core Measure 9.3: <i>Minimizing Institutional Length of Stay</i> | REPORTABLE (R) The ICO reported this measure in alignment with the MMP Core Reporting Requirements. | 1.35 |
| MI2.6: <i>Timely Transmission of Care Transition Record to Health Care Professional</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 34.50% |
| MI5.6: <i>Care for Adults—Medication Review</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 68.60% |
| MI7.3: <i>Annual Dental Visit</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 29.10% |

Performance Measure Rates

Table 3-31 shows each of **HAP**'s audited HEDIS measures, rates for HEDIS MY 2021 and HEDIS MY 2022 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2022 with HEDIS MY 2021, and the HEDIS MY 2021 and HEDIS MY 2022 MI Health Link statewide average performance rates. HEDIS MY 2021 and HEDIS MY 2022 measure rates performing better than the MY 2021 and MY 2022 statewide averages are notated by green font.

Table 3-31—Measure-Specific Percentage Rates for HAP

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------|-------------------|---------------------------|-------------------------------|-------------------------------|
| Prevention and Screening | | | | | |
| <i>BCS—Breast Cancer Screening</i> | 56.87 | 59.61 | +2.74 | 52.74 | 56.70 |
| <i>COL—Colorectal Cancer Screening</i> | 63.04 | 57.63 | –5.41 | 56.03 | 57.59 |
| <i>COA—Care for Older Adults—Medication Review</i> | 59.21 | 61.67 | +2.46 | 74.85 | 80.41 |
| <i>COA—Care for Older Adults—Functional Status Assessment</i> | 63.88 | 68.55 | +4.67 | 58.42 | 62.71 |
| <i>COA—Care for Older Adults—Pain Assessment</i> | 75.18 | 78.62 | +3.44 | 75.25 | 78.04 |
| Respiratory Conditions | | | | | |
| <i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i> | 25.26 | 29.81 | +4.55 | 22.93 | 22.01 |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i> | 61.62 | 74.42 | +12.80 | 68.65 | 74.10 |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i> | 88.89 | 94.19 | +5.30 | 89.67 | 88.82 |
| Cardiovascular Conditions | | | | | |
| <i>CBP—Controlling High Blood Pressure</i> | 61.31 | 68.11 | +6.80 | 60.52 | 66.14 |
| <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> | 91.67 | 100 | +8.33 | 95.25 | 90.85 |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i> | 79.40 | 82.86 | +3.46 | 82.00 | 80.90 |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i> | 82.28 | 87.36 | +5.08 | 84.22 | 79.55 |
| Diabetes | | | | | |
| <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*</i> | 50.36 | 29.20 | –21.16 | 43.53 | 34.07 |
| <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)</i> | 44.28 | 64.23 | +19.95 | 49.06 | 58.51 |
| <i>EED—Eye Exam for Patients With Diabetes</i> | 60.34 | 66.67 | +6.33 | 57.33 | 62.89 |
| <i>BPD—Blood Pressure Control for Patients With Diabetes</i> | 60.58 | 66.91 | +6.33 | 60.82 | 68.13 |
| <i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i> | 79.48 | 78.56 | –0.92 | 76.83 | 76.44 |
| <i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i> | 81.86 | 80.00 | –1.86 | 82.46 | 78.95 |
| Musculoskeletal Conditions | | | | | |
| <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> | 14.29 | 20.00 | +5.71 | 16.12 | 11.18 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------------|-------------------------|------------------------------------|--|--|
| Behavioral Health | | | | | |
| AMM—Antidepressant Medication Management—Effective Acute Phase Treatment | 70.54 | 74.16 | +3.62 | 75.06 | 73.66 |
| AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment | 56.25 | 60.67 | +4.42 | 60.75 | 57.94 |
| FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up | 16.25 | 20.90 | +4.65 | 26.13 | 32.79 |
| FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up | 37.50 | 52.24 | +14.74 | 50.22 | 58.91 |
| FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up | 12.90 | 34.55 | +21.65 | 33.87 | 32.06 |
| FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up | 38.71 | 50.91 | +12.20 | 51.71 | 54.39 |
| Medication Management and Care Coordination | | | | | |
| TRC—Transitions of Care—Medication Reconciliation Post-Discharge | 39.17 | 42.09 | +2.92 | 43.96 | 47.59 |
| TRC—Transitions of Care—Notification of Inpatient Admission | 16.55 | 15.57 | −0.98 | 13.11 | 16.53 |
| TRC—Transitions of Care—Receipt of Discharge Information | 14.84 | 16.55 | +1.71 | 12.77 | 15.38 |
| TRC—Transitions of Care—Patient Engagement After Inpatient Discharge | 75.67 | 79.32 | +3.65 | 74.60 | 77.74 |
| Overuse/Appropriateness | | | | | |
| PSA—Non-Recommended PSA-Based Screening in Older Men* | 24.60 | 28.02 | +3.42 | 24.68 | 26.71 |
| DDE—Potentially Harmful Drug-Disease Interactions in Older Adults* | 31.53 | 35.26 | +3.73 | 31.94 | 33.45 |
| DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid* | 22.16 | 23.18 | +1.02 | 17.81 | 18.16 |
| DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis* | 5.03 | 4.62 | −0.41 | 5.50 | 5.23 |
| DAE—Use of High-Risk Medications in Older Adults—Total* | 25.41 | 25.78 | +0.37 | 21.56 | 21.78 |
| Access/Availability of Care | | | | | |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years | 84.65 | 84.08 | −0.57 | 84.27 | 84.90 |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years | 93.23 | 94.49 | +1.26 | 93.49 | 93.83 |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 and Older | 89.48 | 91.42 | +1.94 | 91.45 | 91.69 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------|-------------------|---------------------------|-------------------------------|-------------------------------|
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 89.80 | 91.13 | +1.33 | 90.77 | 91.08 |
| Risk-Adjusted Utilization | | | | | |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i> | 1.02 | 1.00 | –0.02 | 1.17 | 1.07 |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i> | 1.11 | 0.99 | –0.12 | 1.20 | 1.21 |

* Measures for which lower rates indicate better performance.

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HAP significantly improved the MI2.6 rate from the prior measurement year due to expanded access to the Henry Ford Health System EHR. [Quality, Timeliness, and Access]

Strength #2: In the Respiratory Conditions domain, HAP’s rates for the PCE—Pharmacotherapy Management of COPD Exacerbation—Systematic Corticosteroid and Bronchodilator measure indicators increased by more than 5 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in adult members 40 years of age and older receiving appropriate medication therapy to manage exacerbations. COPD exacerbations make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication.³⁻¹⁸ [Quality and Access]

Strength #3: In the Cardiovascular Conditions domain, HAP’s rate for the PBH—Persistence of Beta-Blocker Treatment After a Heart Attack measure indicator increased by more than 8 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in adult members using a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to

³⁻¹⁸ National Committee for Quality Assurance. Pharmacotherapy Management of COPD Exacerbation (PCE). Available at: <https://www.ncqa.org/hedis/measures/pharmacotherapy-management-of-copd-exacerbation/>. Accessed on: Apr 1, 2024.

prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.³⁻¹⁹ **[Quality, Access, and Timeliness]**

Strength #4: In the Cardiovascular Conditions domain, **HAP**'s rates for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* and *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* measure indicators increased by more than 3 percentage points and 5 percentage points, respectively, from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide averages, suggesting strength in cardiovascular treatment and prevention for members. Cardiovascular disease is the leading cause of death in the United States. American College of Cardiology and American Heart Association (ACC/AHA) guidelines state that statins of moderate or high intensity are recommended for adults with established clinical atherosclerotic cardiovascular disease (ASCVD).³⁻²⁰ **[Quality, Access, and Timeliness]**

Strength #5: In the Diabetes domain, **HAP**'s rates for the *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicators decreased by more than 21 percentage points and increased by more than 19 percentage points, respectively, from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in adult members ages 18 to 75 years with diabetes having controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.³⁻²¹ **[Quality]**

Strength #6: In the Musculoskeletal Conditions domain, **HAP**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator increased by more than 5 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in timely screening and treatment of women who suffered a fracture with either a bone mineral density test or a prescription for a drug to treat osteoporosis. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.³⁻²² **[Quality, Timeliness, and Access]**

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- ³⁻¹⁹ National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: <https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/>. Accessed on: Mar 28, 2024.
- ³⁻²⁰ National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: <https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/>. Accessed on: Mar 28, 2024.
- ³⁻²¹ National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: <https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/>. Accessed on: Mar 28, 2024.
- ³⁻²² National Committee for Quality Assurance. Osteoporosis Management in Women Who Had a Fracture (OMW). Available at: <https://www.ncqa.org/hedis/measures/osteoporosis-management-in-women-who-had-a-fracture/>. Accessed on: Mar 28, 2024.
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Strength #7: In the Behavioral Health domain, **HAP**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator increased by more than 21 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in timely follow-up care with a mental health provider for members with a diagnosis of mental illness following inpatient discharge. Research suggests that follow-up care for people with mental illness is linked to fewer repeat emergency department (ED) visits, improved physical and mental function, and increased compliance with follow-up instructions.³⁻²³ [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: Although **HAP** improved the MI5.6 rate from the prior measurement year's reported rate, it continued to have a low MI5.6 rate in comparison to the other Michigan ICOs' reported rates. [Quality, Timeliness, and Access]

Why the weakness exists: **HAP** used a vendor to complete medical record review (MRR) for MI5.6 and did not conduct any overreads of noncompliant cases.

Recommendation: HSAG recommends that **HAP** overread a portion of the vendor's noncompliant cases.

Weakness #2: The member-level data provided to HSAG for PMV included incorrect race and ethnicity data counts for MI7.3. [Quality]

Why the weakness exists: It was identified in **HAP**'s member-level detail file submission to HSAG for MI7.3 that the file included the incorrect race and ethnicity stratification data counts. The denominator count listed for each race/ethnicity category was the total count overall versus the number of members in each category that were in the denominator.

Recommendation: HSAG recommends that **HAP** incorporate more stringent quality assurance checks and validation checks prior to submission of member-level data to HSAG. The validation checks should include ensuring that the appropriate race and ethnicity data counts are reported and in alignment with the reported MI7.3 numerator and denominator counts.

Weakness #3: While only 13 of the 40 reported HEDIS measures rates (33 percent) indicated worse performance than the statewide average, opportunity exists for **HAP** to further improve performance across multiple domains including Prevention and Screening, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Access/Availability of Care. [Quality]

Why the weakness exists: Some measures included in the Prevention and Screening, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Access/Availability of Care domains demonstrated worse performance than the statewide average,

³⁻²³ National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: <https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/>. Accessed on: Apr 1, 2024.

indicating **HAP** was not performing as well as the other ICOs for some measures within these domains.

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

Compliance Review

Performance Results

Table 3-32 presents **HAP**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **HAP** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **HAP**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-32—SFY 2022 and SFY 2023 Standard Compliance Scores for HAP

| Compliance Review Standard | Compliance Score |
|---|------------------|
| Year One (SFY 2022) | |
| Standard I—Disenrollment: Requirements and Limitations ¹ | 100% |
| Standard II—Member Rights and Member Information | 61% |
| Standard III—Emergency and Poststabilization Services ¹ | 100% |
| Standard IV—Availability of Services | 100% |
| Standard V—Assurances of Adequate Capacity and Services | 75% |
| Standard VI—Coordination and Continuity of Care | 80% |
| Standard VII—Coverage and Authorization of Services | 86% |
| Year Two (SFY 2023) | |
| Standard VIII—Provider Selection | 87% |
| Standard IX—Confidentiality | 91% |
| Standard X—Grievance and Appeal Systems | 78% |
| Standard XI—Subcontractual Relationships and Delegation | 80% |
| Standard XII—Practice Guidelines | 100% |
| Standard XIII—Health Information Systems ² | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 90% |
| Year Three (SFY 2024) | |
| Review of ICO's implementation of Year One and Year Two CAPs | |

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

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

Table 3-33 presents **HAP**'s scores for each standard evaluated during the SFY 2023 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **HAP**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2023 compliance review activity demonstrated how successful **HAP** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-33—SFY 2023 Standard Compliance Scores for HAP

| Standard | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|----------------|---------------------------|--------------------|-----------|-----------|------------------------|
| | | | <i>M</i> | <i>NM</i> | <i>NA</i> | |
| Standard VIII—Provider Selection | 23 | 23 | 20 | 3 | 0 | 87% |
| Standard IX—Confidentiality | 11 | 11 | 10 | 1 | 0 | 91% |
| Standard X—Grievance and Appeal Systems | 45 | 45 | 35 | 10 | 0 | 78% |
| Standard XI—Subcontractual Relationships and Delegation | 6 | 5 | 4 | 1 | 1 | 80% |
| Standard XII—Practice Guidelines | 6 | 6 | 6 | 0 | 0 | 100% |
| Standard XIII—Health Information Systems ¹ | 9 | 9 | 9 | 0 | 0 | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 21 | 21 | 19 | 2 | 0 | 90% |
| Total | 121 | 120 | 103 | 17 | 1 | 86% |

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

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

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

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

¹This standard includes a comprehensive assessment of the ICO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HAP achieved full compliance in the Practice Guidelines program area, demonstrating that the ICO maintained adequate processes for the adoption, dissemination, and application of CPGs. [Quality]

Strength #2: HAP achieved full compliance in the Health Information Systems program area, demonstrating that the ICO maintained adequate IS that collects, analyzes, integrates, and reports data to achieve the ICO's contractual obligations with MDHHS. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: HAP received a *Not Met* score for three elements within the Provider Selection program area, indicating providers were not being credentialed in accordance with the ICO's contractual obligations with MDHHS. [Quality]

Why the weakness exists: One of **HAP**'s delegates did not have an account with the National Practitioner Databank (NPDB), nor did it have an alternative method to verify a provider's history of professional liability claims. Additionally, **HAP** and one of its delegates were not reviewing all required performance data at the time of recredentialing. Further, **HAP** and its delegates performing credentialing activities did not consistently obtain disclosures on ownership and control interest forms from providers as part of the initial credentialing or recredentialing process. All findings were related to deficiencies for one or more of **HAP**'s delegates, which also suggest a lack of adequate oversight and monitoring of delegated functions.

Recommendation: While **HAP** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **HAP** continually evaluate its processes, procedures, and monitoring efforts, including oversight of delegated entities, to ensure compliance with all federal and MDHHS-set standards specific to the credentialing and recredentialing of network providers.

Weakness #2: HAP received a *Not Met* score for 10 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. [Quality, Timeliness, and Access]

Why the weakness exists: Several gaps in **HAP**'s grievance and appeal processes were identified; specifically, those related to written acknowledgement of grievances and appeals, written grievance and appeal resolution notices, written notice of grievance and appeal resolution time frame extensions, the member appeal process versus provider payment dispute, the member's right to request a copy of the case file, notice of ABD for denial of payment, notice of appeal dismissals, and information provided to subcontractors related to the member grievance and appeal systems.

Recommendation: While **HAP** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **HAP** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member grievances and appeals. HSAG further recommends that **HAP** implement procedures to ensure model notice language used is the most current version required by MDHHS, and that **HAP** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for processing of grievances and appeals and use of required model notices.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG’s NAV results indicated that **HAP** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. Table 3-34 presents **HAP**’s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS’ exception determinations.

Table 3-34—SFY 2023 NAV Results for HAP, by Region and Provider Type

| Provider Type | Region 7 Validation Result | Region 9 Validation Result |
|--|-------------------------------|-------------------------------|
| Provider Types With Travel Time and Distance Requirements | | |
| Adult Day Program | <i>Met</i> | <i>Met</i> |
| Dental | <i>Met</i> | <i>Met</i> |
| Eye Examinations | <i>Met</i> | <i>Met</i> |
| Eye Wear | <i>Met</i> | <i>Met</i> |
| Hearing Aids | <i>Met</i> | <i>Met</i> |
| Hearing Examinations | <i>Met</i> | <i>Met</i> |
| Provider Types Rendering Home-Based Services | | |
| Adaptive Medical Equipment and Supplies | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Devices | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Van Lifts and Tie Downs | <i>Met</i> | <i>Met</i> |
| Chore Services | <i>Met</i> | <i>Met</i> |
| Community Transition Services | <i>Met</i> | <i>Met</i> |
| ECLS | <i>Met</i> | <i>Met</i> |
| Environmental Modifications | <i>Met</i> | <i>Met</i> |
| Fiscal Intermediary | <i>Met</i> | <i>Met</i> |
| Home-Delivered Meals | <i>Met</i> | <i>Met</i> |
| MIHP Agency | <i>Met</i> | <i>Met</i> |
| Medical Supplies | <i>Met</i> | <i>Met</i> |
| NEMT | <i>Met</i> | <i>Met</i> |
| Non-Medical Transportation | <i>Met</i> | <i>Met</i> |
| Personal Care Services | <i>Met</i> | <i>Met</i> |

| Provider Type | Region 7 Validation Result | Region 9 Validation Result |
|--------------------------------------|-------------------------------|-------------------------------|
| Personal Emergency Response System | Met | Met |
| Preventive Nursing Services | Met | Met |
| Private Duty Nursing | Met | Met |
| Respite | Met | Met |
| Skilled Nursing Home | Met | Met |
| Percentage of Total Requirements Met | 100% | 100% |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

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

Weaknesses and Recommendations

Weakness #1: HSAG identified no substantial weaknesses for HAP based on the SFY 2023 NAV results.

Why the weakness exists: NA

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

Secret Shopper Survey

Performance Results

HSAG attempted to contact 365 sampled provider locations (i.e., “cases”) for **HAP**, with an overall response rate of 85.5 percent (312 cases) among **HAP**’s two MI Health Link regions. Table 3-35 summarizes the SFY 2023 secret shopper survey response rates for **HAP**, and for each of **HAP**’s contracted MI Health Link regions.

Table 3-35—Summary of HAP Secret Shopper Survey Results for Routine Dental Visits, by Region³⁻²⁴

| | | Response Rate | | Accepting ICO | | Accepting MI Health Link | | Accepting New Patients | |
|------------------|--------------------|---------------|-----------------------|---------------|-----------------------|--------------------------|-----------------------|------------------------|-----------------------|
| Region | Total Survey Cases | Cases Reached | Rate (%) ¹ | Accepting ICO | Rate (%) ² | Accepting MI Health Link | Rate (%) ² | Accepting New Patients | Rate (%) ² |
| Region 7 | 182 | 159 | 87.4% | 97 | 61.0% | 79 | 49.7% | 74 | 46.5% |
| Region 9 | 183 | 153 | 83.6% | 82 | 53.6% | 76 | 49.7% | 75 | 49.0% |
| HAP Total | 365 | 312 | 85.5% | 179 | 57.4% | 155 | 49.7% | 149 | 47.8% |

¹ The denominator includes total survey cases.

² The denominator includes cases reached.

Table 3-36 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **HAP**, and for each of **HAP**’s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

³⁻²⁴ Denominators used for the 2023 accepting MI Health Link and accepting new patient rates include cases reached. In 2022 and 2021, denominators for these rates were different. The accepting MI Health Link rate’s denominator included cases responding to the survey and indicating that at least one practitioner at the location accepted the requested ICO. The accepting new patient rate’s denominator included cases responding to the survey that accepted the ICO and MI Health Link. Caution should be exercised when comparing the 2023 results to the 2022 and 2021 results.

Table 3-36—Summary of HAP Secret Shopper Survey Appointment Availability Results, by Region

| Region | Total Survey Cases | Cases Contacted and Accepting New Patients | Cases Offered an Appointment | | | Appointment Wait Time (Days) ³ | | | |
|------------------|--------------------|--|------------------------------|--|--|---|------------|-----------|----------|
| | | | Number | Rate Among All Surveyed Cases ¹ (%) | Rate Among Cases Accepting New Patients ² (%) | Min | Max | Average | Median |
| Region 7 | 182 | 74 | 68 | 37.4% | 91.9% | 1 | 245 | 25 | 14 |
| Region 9 | 183 | 75 | 58 | 31.7% | 77.3% | 0 | 205 | 21 | 9 |
| HAP Total | 365 | 149 | 126 | 34.5% | 84.6% | 0 | 245 | 23 | 9 |

¹ The denominator includes total survey cases.

² The denominator includes cases reached that accept the ICO, MI Health Link, and new patients.

³ MDHHS' wait time standard for initial dental appointments is eight weeks.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Of the 365 total survey cases, 85.5 percent (n=312) of the provider locations could be contacted. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: Of the cases reached, 57.4 percent of provider locations accepted HAP, 49.7 percent accepted the MI Health Link program, and 47.8 percent accepted new patients. [Access]

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

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

Weakness #2: Among all surveyed cases, the overall appointment rate was 34.5 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 being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

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

Encounter Data Validation

Performance Results

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

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

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

Table 3-37—EDV Results for HAP

| Analysis | Key Findings |
|------------------------------------|---|
| IS Review | |
| Encounter Data Sources and Systems | <ul style="list-style-type: none"> HAP used Facets and Change Healthcare as its primary software for claim adjudication and encounter preparation. However, it used Sterling Integrator and Optum EDI Transaction Integrity for dental. HAP had processes in place to detect and identify duplicate claims. Regarding its submission practices, HAP indicated that it does not submit encounters for specific scenarios such as pharmacy claims that were reversed out, paid, and voided in the same cycle; administrative expense claims; non-U.S. billing providers; duplicates; member ineligibility; missing data; and invalid diagnoses. In cases requiring adjustments, such as errors, voided claims, or new paid claims, HAP had implemented systems to track and manage these adjustments. HAP and its subcontractors were responsible for collecting and maintaining provider information. Additionally, HAP handled enrollment data received from MDHHS via 834 files. Subcontractors received these files from HAP and utilized them in the adjudication process. |
| Payment Structures | <ul style="list-style-type: none"> HAP employed various claim payment methods for different encounter types. In inpatient encounters, it utilized the line-by-line, per diem/variable per diem, capitation, DRG, negotiated (flat) rates, and Ambulatory Payment Classification and CMS pricing methods for claim payment. For outpatient encounters, the methods included line-by-line, capitation, and negotiated (flat) rate. Pharmacy encounters were processed using ingredient cost method. In general, HAP managed TPL claims by recouping overpayments from primary payers within specified time frames and coordinating with providers when necessary. Pharmacy claims were cost avoided at the point of sale, and members with other primary coverage were flagged for rejection or message generation. Claims were reviewed for potential TPL, and recovered payments were routed through a subrogation process for additional recovery opportunities. HAP's subrogation vendor handled all lien inquiries. |
| Encounter Data Quality Monitoring | <ul style="list-style-type: none"> HAP indicated it edited or made modifications to some of the subcontractor data. HAP and/or its subcontractors performed various data quality checks on the encounter data collected. These checks included but were not limited to analyzing claim volume by submission month (for all subcontractor encounters except for dental), assessing field-level completeness and validity (for all |

| Analysis | Key Findings |
|---------------------------------------|---|
| | <p>subcontractor encounters), and ensuring alignment between payment fields in claims and financial reports (all subcontractor encounters).</p> <ul style="list-style-type: none"> For encounters collected by HAP, it conducted data quality checks including analyzing claim volume by submission month, conducting EDI compliance edits, and evaluating whether the payment fields in the claims align with the financial reports. |
| Administrative Profile | |
| Encounter Data Completeness | <ul style="list-style-type: none"> HAP displayed consistent encounter volume for institutional, dental, and pharmacy encounters throughout the measurement year. HAP experienced a substantial increase in professional encounter volume in May 2022, with the number of unique encounters more than doubling, despite the number of lines remaining consistent. This is likely due to a change in processing personal at-home services, in which HAP changed from grouping multiple lines under one unique encounter to a separate encounter for each line. This increase in volume, however, did not affect the paid amount per member per month (PMPM). HAP had a low volume of duplicate encounters, with 0.1 percent of professional encounters, 0.5 percent of institutional encounters, 0.3 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative. |
| Encounter Data Timeliness | <ul style="list-style-type: none"> HAP demonstrated timely submission of professional, institutional, and dental encounters. Within 30 days, HAP submitted 99.8 percent of professional encounters and 99.2 percent of institutional encounters to MDHHS after the payment date. Within 60 days, HAP submitted 99.9 percent of dental encounters to MDHHS after the payment date. HAP did not demonstrate timely submission of pharmacy encounters, with 66.9 percent of pharmacy encounters submitted to MDHHS within 30 days of the payment date. Within 360 days, HAP remained constant with 67.1 percent of pharmacy encounters submitted to MDHHS after the payment date. However, HAP's submitted data had the submit date prior to the payment date for 32.8 percent of pharmacy encounters. |
| Field-Level Completeness and Accuracy | <ul style="list-style-type: none"> In HAP's submitted professional encounters, the billing provider NPI was populated 51.2 percent of the time, and the rendering provider NPI was populated 0 percent of the time. In HAP's submitted pharmacy encounters, the submit date was valid 67.2 percent of the time. |

| Analysis | Key Findings |
|---------------------------------|--|
| | <ul style="list-style-type: none"> All other data elements in HAP's submitted data had high rates of population and validity. |
| Encounter Referential Integrity | <ul style="list-style-type: none"> Of all identified member IDs in HAP's submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the enrollment data. Of all identified member IDs in HAP's submitted pharmacy data, 99.5 percent were identified in the enrollment data. Of all identified provider NPIs in HAP's submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the provider data. Of all identified provider NPIs in HAP's submitted pharmacy encounter data, 96.1 percent were identified in the provider data. |
| Encounter Data Logic | <ul style="list-style-type: none"> No major concerns were noted for HAP. |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Strength #2: HAP submitted professional, institutional, and dental encounters in a timely manner from the payment date, with greater than 99 percent of all encounters submitted within 60 days of the payment date. [Quality and Timeliness]

Strength #3: Across all categories of service, all key data elements for **HAP** were populated at high rates, and all but one was greater than 99 percent valid. [Quality]

Weaknesses and Recommendations

Weakness #1: HAP modified encounters from its subcontractors before submitting them to MDHHS. [Quality]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: **HAP** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: **HAP** did not indicate timeliness quality checks were performed for claims/encounters originating from all of its subcontractors. **[Quality]**

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: **HAP** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Weakness #3: Although 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, 96.1 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. **[Quality]**

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: **HAP** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #4: Approximately 33 percent of **HAP** pharmacy encounters had a submit date prior to the payment date. **[Quality]**

Why the weakness exists: Inaccurate date fields can lead to inaccurate timeliness metrics.

Recommendation: **HAP** should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date field is after the payment date field.

Weakness #5: Although not required to be populated, 51.2 percent of professional encounters contained a billing provider NPI, and 0 percent contained a rendering provider NPI. **[Quality]**

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

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

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: While no **HAP**-specific results could be presented, the statewide analysis identified that the 2023 top-box score for the *Recommend Personal Assistance/Behavioral Health Staff* measure was statistically significantly lower than the 2021 top-box score. This demonstrates a statistically significant decline from 2023, indicating opportunities for improvement for the MI Health Link program. Additionally, the lowest performing measure was *Planning Your Time and Activities* with a 2023 top-box score of 63.70 percent, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. Therefore, HSAG recommends that **HAP** develop and implement interventions to improve member experience related to the *Recommend Personal Assistance/Behavioral Health Staff* and *Planning Your Time and Activities* measures. HSAG further recommends that **HAP** develop innovative approaches to increase the number of members participating in future survey administrations.

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

HSAG performed a comprehensive assessment of **HAP**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **HAP** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **HAP**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-38 displays each MDHHS CQS goal and EQR activity results that indicate whether the ICO positively (✓) or negatively (✗) impacted the MI Health Link program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **HAP**'s Medicaid members.

Table 3-38—Overall Performance Impact to CQS and Quality, Timeliness, and Access

| Performance Area | Overall Performance Impact | Performance Domain |
|---|--|---|
| Goal #1 —Ensure high quality and high levels of access to care | <ul style="list-style-type: none"> ✓ The ICO met all minimum network requirements for all provider types with capacity-based requirements and for all provider types with travel time and distance requirements. ✓ Nearly 86 percent of dental provider locations could be contacted through secret shopper calls. ✓ The median wait time for a dental appointment was nine calendar days, which was within MDHHS' initial dental appointment standard of eight weeks. ✓ The ICO's rates for the <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systematic Corticosteroid and Bronchodilator</i> measure indicators increased by more than 5 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✓ The ICO's rate for the <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> measure indicator increased by more than 8 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✓ The ICO's rates for the <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i> and <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i> measure indicators increased by more than 3 percentage points and 5 percentage points, respectively, from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide averages. ✓ The ICO's rates for the <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)</i> and <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)</i> measure indicators decreased by more than 21 percentage points and increased by more than 19 percentage points, respectively, from MY 2021 to MY 2022 | <ul style="list-style-type: none"> ☑ Quality ☑ Timeliness ☑ Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|--|---|
| | <p>and exceeded the HEDIS MY 2022 MI Health Link statewide average.</p> <ul style="list-style-type: none"> ✓ The ICO's rate for the <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> measure indicator increased by more than 5 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✓ The ICO's rate for the <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i> measure indicator increased by more than 21 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✗ Only 57.4 percent of dental providers reported accepting the ICO, 49.7 percent of dental providers reported accepting the MI Health Link program, and 47.8 percent of dental providers reported accepting new patients during the secret shopper calls. ✗ The overall dental appointment rate among all surveyed providers was 34.5 percent. ✗ The maximum wait time for a dental appointment was 245 days, which exceeded MDHHS' initial dental appointment standard of eight weeks (i.e., 56 calendar days). ✗ Although the ICO improved the MI5.6 <i>Care for Adults—Medication Review</i> performance measure rate from the prior year's rate, the ICO continued to have a low MI5.6 rate in comparison to the other Michigan ICOs' reported rates. ✗ While only 13 of the 40 reported HEDIS measures rates (33 percent) indicated worse performance than the statewide average, opportunity exists for the ICO to further improve performance across multiple HEDIS domains impacting quality and high levels of access to care. | |
| Goal #2 —Strengthen person and family-centered approaches | The ICO's findings for the EQR activities did not substantially impact Goal #2. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |
| Goal #3 —Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external) | <ul style="list-style-type: none"> ✓ The ICO implemented the Patient Access API and the Provider Directory API. ✓ The ICO significantly improved the MI2.6 <i>Timely Transmission of Care Transition Record to Health Care Professional</i> performance measure rate from the prior year due to expanded access to a health system EHR. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|--|---|
| Goal #4 —Reduce racial and ethnic disparities in healthcare and health outcomes | <ul style="list-style-type: none"> ✓ The ICO’s QAPI program addressed social determinants of health and included initiatives targeting members experiencing health disparities. ✓ The ICO met the QIP goal of eliminating the existing disparity between Black or African-American and White/Caucasian members 18–85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled. ✗ The rate decreased for White/Caucasian members 18–85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled. ✗ The ICO included incorrect race and ethnicity stratification data counts for the MI7.3 <i>Annual Dental Visit</i> performance measure. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |
| Goal #5 —Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | The ICO’s findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact value-based initiatives and payment reform had on improving quality outcomes for the ICO’s members. However, Table 5-5—CMS Core Measure Quality Withhold Results within Section 5 provides information on the results of MDHHS’ quality withhold program for the ICO. The information for the quality withhold program was provided by MDHHS and not assessed through the EQR activities. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

MeridianComplete

Validation of Quality Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **Meridian**’s QIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., the QIP Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-39 displays the overall validation rating, the baseline and Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-39—Overall Validation Rating for MER

| QIP Topic | Validation Rating ¹ | Performance Indicator | Performance Indicator Results | | | |
|---|--------------------------------|--|-------------------------------|---------|----|-----------|
| | | | Baseline | R1 | R2 | Disparity |
| <i>Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes</i> | <i>Met</i> | HEDIS SPD adherence performance—African American/Black population—all regions. | 74.2% | 75% ⇔ | | Yes |
| | | HEDIS SPD adherence performance—White population—all regions. | 85.8% | 82.5% ⇔ | | |

R1 = Remeasurement 1

R2 = Remeasurement 2

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)

⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)

↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

¹ The QIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its QIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the QIP adhered to an acceptable methodology for all phases of design and data collection, and the ICO conducted accurate data analysis and interpretation of QIP results; overall confidence that the QIP produced significant evidence of improvement.)

The goals for **Meridian**’s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-40 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

Table 3-40—Remeasurement 1 Barriers and Interventions for MER

| Barriers | Interventions |
|--|--|
| Members may not have been seen or have not had an annual visit with their PCP. | <p>Identified members who were not seen by their PCP in 2021 or 2022. The Quality Improvement department conducted a member outreach campaign to assist with appointment scheduling and/or transportation needs.</p> <p>Utilized provider-facing staff for communication with providers about members who have not been seen.</p> <p>Offered My Meridian Rewards, a member incentive program for annual wellness visits.</p> |
| Members may not have received any cardiovascular testing, at minimum a low-density lipoprotein (LDL) test. | <p>Identified members who have not received cardiovascular testing (minimum LDL test). The Quality Improvement department conducted member outreach and offered assistance with appointment scheduling and/or transportation needs.</p> <p>Utilized provider-facing staff for communication with providers about members who are in need of cardiovascular testing (minimum LDL test).</p> |
| Members may have limited or no access to transportation for medical needs. Members may forget to take medication or pick up the prescribed medication. | <p>Identified members who have a 30-day supply of statin therapy medication for conversion to a 90-day supply.</p> <p>Promoted the option for the mail order prescription program.</p> <p>Conducted a member outreach campaign to distribute transportation resources.</p> |
| Member education material is not culturally sensitive for the African-American/Black population. | Developed and distributed culturally sensitive education material to the African-American/Black population. |
| Members may not receive education or reminder communications from the ICO. | Addressed unable-to-reach members for education communication as well as appointment and testing reminders by using a phased method approach of communication. Methods included phone, text messages, mail, email, vendor support, and in-home visit options. |
| Providers may not practice within the current evidence-based guidelines for the HEDIS <i>SPD</i> measure. | Developed a provider pay-for-performance (P4P) bonus for HEDIS <i>SPD</i> adherence at 80 percent compliance. Identified low-performing PCPs and utilized provider-facing staff to promote evidence-based guidelines, Meridian’s Provider HEDIS Quick Reference Guide, and Meridian’s P4P program. |

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Meridian met 100 percent of the requirements for data analysis and implementation of improvement strategies. The ICO conducted accurate statistical testing between the two subgroups for the first remeasurement period and provided a narrative interpretation of the results. **Meridian** used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

Strength #2: Meridian demonstrated programmatically significant improvement for the disparate subgroup through the initiation of an intervention strategy. The intervention targeted unable to reach members through chronic call campaigns and/or care manager outreach to provide education and appointment/testing reminders. [Quality, Timeliness and Access]

Weaknesses and Recommendations

Weakness #1: Meridian did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period, and the comparison subgroup demonstrated a decline in performance as compared to the baseline. [Quality and Access]

Why the weakness exists: While it is unclear why the goal was not achieved or why the comparison subgroup declined in performance, **Meridian** has made progress in improving performance among the disparate subgroup, demonstrating a non-statistically significant increase in performance as compared to the baseline.

Recommendation: HSAG recommends **Meridian** revisit its causal barrier analysis to determine if any new barriers exist for both the disparate and comparison subgroups that require the development of targeted strategies to improve performance. In accordance with direction from MDHHS, **Meridian** is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the African-American/Black population.

Performance Measure Validation

Performance Results

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

Meridian received a measure designation of *Reportable (R)* for all measures, signifying that **Meridian** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-41 includes the validation designation for each performance measure as well as the validated SFY 2023 performance measure rates.

Table 3-41—Measure-Specific Validation Designation for MER

| Performance Measure | Validation Designation | SFY 2023 Rate |
|--|---|---------------|
| Core Measure 9.3: <i>Minimizing Institutional Length of Stay</i> | REPORTABLE (R) The ICO reported this measure in alignment with the MMP Core Reporting Requirements. | 1.51 |
| MI2.6: <i>Timely Transmission of Care Transition Record to Health Care Professional</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 23.10% |
| MI5.6: <i>Care for Adults—Medication Review</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 68.40% |
| MI7.3: <i>Annual Dental Visit</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 25.40% |

Performance Measure Rates

Table 3-42 shows each of **Meridian**'s audited HEDIS measures, rates for HEDIS MY 2021 and HEDIS MY 2022 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2022 with HEDIS MY 2021, and the HEDIS MY 2021 and HEDIS MY 2022 MI Health Link statewide average performance rates. HEDIS MY 2021 and HEDIS MY 2022 measure rates performing better than the MY 2021 and MY 2022 statewide averages are notated by green font.

Table 3-42—Measure-Specific Percentage Rates for MER

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------------|-------------------------|------------------------------------|--|--|
| Prevention and Screening | | | | | |
| <i>BCS—Breast Cancer Screening</i> | 52.53 | 55.86 | +3.33 | 52.74 | 56.70 |
| <i>COL—Colorectal Cancer Screening</i> | 56.45 | 58.05 | +1.60 | 56.03 | 57.59 |
| <i>COA—Care for Older Adults—Medication Review</i> | 77.13 | 66.18 | −10.95 | 74.85 | 80.41 |
| <i>COA—Care for Older Adults—Functional Status Assessment</i> | 28.47 | 35.04 | +6.57 | 58.42 | 62.71 |
| <i>COA—Care for Older Adults—Pain Assessment</i> | 74.21 | 64.96 | −9.25 | 75.25 | 78.04 |
| Respiratory Conditions | | | | | |
| <i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i> | 22.22 | 20.11 | −2.11 | 22.93 | 22.01 |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i> | 42.67 | 77.51 | +34.84 | 68.65 | 74.10 |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i> | 87.33 | 89.00 | +1.67 | 89.67 | 88.82 |
| Cardiovascular Conditions | | | | | |
| <i>CBP—Controlling High Blood Pressure</i> | 66.18 | 66.42 | +0.24 | 60.52 | 66.14 |
| <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> | 100 | 90.63 | −9.37 | 95.25 | 90.85 |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i> | 79.74 | 79.01 | −0.73 | 82.00 | 80.90 |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i> | 77.35 | 81.82 | +4.47 | 84.22 | 79.55 |
| Diabetes | | | | | |
| <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*</i> | 37.23 | 33.09 | −4.14 | 43.53 | 34.07 |
| <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)</i> | 54.26 | 58.88 | +4.62 | 49.06 | 58.51 |
| <i>EED—Eye Exam for Patients With Diabetes</i> | 61.07 | 62.04 | +0.97 | 57.33 | 62.89 |
| <i>BPD—Blood Pressure Control for Patients With Diabetes</i> | 66.18 | 69.83 | +3.65 | 60.82 | 68.13 |
| <i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i> | 80.70 | 78.10 | −2.60 | 76.83 | 76.44 |
| <i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i> | 80.39 | 79.97 | −0.42 | 82.46 | 78.95 |
| Musculoskeletal Conditions | | | | | |
| <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> | 0.00 | 6.25 | +6.25 | 16.12 | 11.18 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------------|-------------------------|------------------------------------|--|--|
| Behavioral Health | | | | | |
| AMM—Antidepressant Medication Management—Effective Acute Phase Treatment | 72.46 | 72.89 | +0.43 | 75.06 | 73.66 |
| AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment | 53.89 | 59.34 | +5.45 | 60.75 | 57.94 |
| FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up | 26.32 | 34.00 | +7.68 | 26.13 | 32.79 |
| FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up | 42.11 | 58.00 | +15.89 | 50.22 | 58.91 |
| FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up | 47.62 | 35.71 | −11.91 | 33.87 | 32.06 |
| FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up | 65.48 | 56.25 | −9.23 | 51.71 | 54.39 |
| Medication Management and Care Coordination | | | | | |
| TRC—Transitions of Care—Medication Reconciliation Post-Discharge | 62.29 | 38.69 | −23.60 | 43.96 | 47.59 |
| TRC—Transitions of Care—Notification of Inpatient Admission | 29.68 | 25.79 | −3.89 | 13.11 | 16.53 |
| TRC—Transitions of Care—Receipt of Discharge Information | 29.93 | 27.74 | −2.19 | 12.77 | 15.38 |
| TRC—Transitions of Care—Patient Engagement After Inpatient Discharge | 84.67 | 77.62 | −7.05 | 74.60 | 77.74 |
| Overuse/Appropriateness | | | | | |
| PSA—Non-Recommended PSA-Based Screening in Older Men* | 20.74 | 21.84 | +1.10 | 24.68 | 26.71 |
| DDE—Potentially Harmful Drug-Disease Interactions in Older Adults* | 30.70 | 30.61 | −0.09 | 31.94 | 33.45 |
| DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid* | 18.55 | 15.23 | −3.32 | 17.81 | 18.16 |
| DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis* | 5.92 | 4.97 | −0.95 | 5.50 | 5.23 |
| DAE—Use of High-Risk Medications in Older Adults—Total* | 22.53 | 18.79 | −3.74 | 21.56 | 21.78 |
| Access/Availability of Care | | | | | |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years | 84.73 | 81.80 | −2.93 | 84.27 | 84.90 |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years | 93.65 | 91.87 | −1.78 | 93.49 | 93.83 |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 and Older | 93.26 | 90.42 | −2.84 | 91.45 | 91.69 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------|-------------------|---------------------------|-------------------------------|-------------------------------|
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 91.62 | 89.12 | –2.50 | 90.77 | 91.08 |
| Risk-Adjusted Utilization | | | | | |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i> | 1.27 | 1.03 | –0.24 | 1.17 | 1.07 |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i> | 1.31 | 1.02 | –0.29 | 1.20 | 1.21 |

* Measures for which lower rates indicate better performance.

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Meridian demonstrated a proactive approach to addressing MI5.6 and MI7.3 by implementing internal performance improvement plans to focus on root cause barriers and methods to improve performance and member outcomes. [Quality, Timeliness, and Access]

Strength #2: Meridian demonstrated adequate systems and processes to ensure timely ingestion and storage of data within the management information system for subsequent extraction and validation for rate reporting. [Quality and Timeliness]

Strength #3: In the Respiratory Conditions domain, **Meridian**’s rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systematic Corticosteroid* measure indicator increased by more than 34 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in adult members 40 years of age and older receiving appropriate medication therapy to manage exacerbations. COPD exacerbations make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication.³⁻²⁵ [Quality and Access]

³⁻²⁵ National Committee for Quality Assurance. Pharmacotherapy Management of COPD Exacerbation (PCE). Available at: <https://www.ncqa.org/hedis/measures/pharmacotherapy-management-of-copd-exacerbation/>. Accessed on: Apr 1, 2024.

Strength #4: In the Behavioral Health domain, **Meridian**'s rate for the *AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment* measure indicator increased by more than 5 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in adults with a diagnosis of major depression, who were newly treated with antidepressant medication, remaining on antidepressant medication for at least 84 and 180 days. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects.³⁻²⁶ [**Quality, Access, and Timeliness**]

Weaknesses and Recommendations

Weakness #1: The member-level data provided to HSAG for PMV contained errors that resulted in resubmission of Core Measure 9.3 data to HPMS. [**Quality**]

Why the weakness exists: It was identified in **Meridian**'s member-level data submission to HSAG for Core Measure 9.3 that the file was erroneously populated with members who had admissions to institutional facilities between January 1, 2021, and June 30, 2021. The measure specifications for Core Measure 9.3 define the admission period for the measure as July 1, 2021, through June 30, 2022. This error accounted for an additional 211 members being included into element A of the measure, resulting in inaccurate rate reporting. **Meridian** updated and resubmitted its Core Measure 9.3 member-level detail file and programming logic.

Recommendation: HSAG recommends that **Meridian** review the annual release of the Core Reporting Requirements in comparison to current source code for Core Measure 9.3. HSAG also recommends that **Meridian** implement more stringent quality assurance checks and increased frequency of validation checks prior to submission of member-level data.

Weakness #2: While only 17 of the 40 reported HEDIS measures rates (43 percent) indicated worse performance than the statewide average, opportunity exists for **Meridian** to further improve performance across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, and Access/Availability of Care. [**Quality**]

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

³⁻²⁶ National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: <https://www.ncqa.org/hedis/measures/antidepressant-medication-management/>. Accessed on: Apr 1, 2024.

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

Weakness #3: In the Prevention and Screening domain, **Meridian**'s rate for the *COA—Care for Older Adults—Medication Review* measure indicator decreased by more than 10 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that adult members ages 66 years and older were not always having medication reviews conducted during the measurement year. Older adults may have more complex medication regimens. This measure ensures that older adults receive the care they need to optimize quality of life.³⁻²⁷

[Quality]

Why the weakness exists: The rate for the *COA—Care for Older Adults—Medication Review* measure indicator decreasing by more than 10 percentage points from MY 2021 to MY 2022 suggests that barriers exist for some adults ages 66 years and older to have medication reviews completed.

Recommendation: HSAG recommends that **Meridian** conduct a root cause analysis or focused study to determine why some adults ages 66 years and older are not having medication reviews completed. **Meridian** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).

Weakness #4: In the Cardiovascular Conditions domain, **Meridian**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased by more than 9 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adult members were not using a beta-blocker as treatment after a heart attack. Clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. This reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.³⁻²⁸ **[Quality, Access, and Timeliness]**

Why the weakness exists: The rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreasing by more than 9 percentage points from MY 2021 to MY 2022 suggests that barriers exist for some adult members to use a beta-blocker as treatment after a heart attack.

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

³⁻²⁷ National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/hedis/measures/care-for-older-adults/>. Accessed on: Mar 28, 2024.

³⁻²⁸ National Committee for Quality Assurance. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH). Available at: <https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack/>. Accessed on: Mar 28, 2024.

issues related to barriers such as a lack of patient and provider communication or provider education).

Weakness #5: In the Medication Management and Care Coordination domain, **Meridian**'s rates for the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge* and *Patient Engagement After Inpatient Discharge* measure indicators decreased by more than 7 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that there was not always evidence of medication reconciliations and patient engagement being provided within 30 days after discharge. Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs.³⁻²⁹ [**Quality, Access, and Timeliness**]

Why the weakness exists: The rates for the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge* and *Patient Engagement After Inpatient Discharge* measure indicators decreasing by more than 7 percentage points from MY 2021 to MY 2022 suggests that barriers exist regarding evidence of medication reconciliation and patient engagement within 30 days after discharge for some members.

Recommendation: HSAG recommends that **Meridian** conduct a root cause analysis or focused study to determine why there was not always evidence of medication reconciliation or patient engagement being provided within 30 days after discharge. Upon identification of a root cause, **Meridian** should implement appropriate interventions to improve the performance related to the *TRC—Transitions of Care—Medication Reconciliation Post-Discharge* and *Patient Engagement After Inpatient Discharge* measure indicators. **Meridian** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of care coordination or provider education).

³⁻²⁹ National Committee for Quality Assurance. Transitions of Care (TRC). Available at: <https://www.ncqa.org/hedis/measures/transitions-of-care/>. Accessed on: Mar 28, 2024.

Compliance Review

Performance Results

Table 3-43 presents **Meridian**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Meridian** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Meridian**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-43—SFY 2022 and SFY 2023 Standard Compliance Scores for MER

| Compliance Review Standard | Compliance Score |
|---|------------------|
| Year One (SFY 2022) | |
| Standard I—Disenrollment: Requirements and Limitations ¹ | 100% |
| Standard II—Member Rights and Member Information | 70% |
| Standard III—Emergency and Poststabilization Services ¹ | 100% |
| Standard IV—Availability of Services | 100% |
| Standard V—Assurances of Adequate Capacity and Services | 75% |
| Standard VI—Coordination and Continuity of Care | 73% |
| Standard VII—Coverage and Authorization of Services | 78% |
| Year Two (SFY 2023) | |
| Standard VIII—Provider Selection | 87% |
| Standard IX—Confidentiality | 91% |
| Standard X—Grievance and Appeal Systems | 78% |
| Standard XI—Subcontractual Relationships and Delegation | 80% |
| Standard XII—Practice Guidelines | 83% |
| Standard XIII—Health Information Systems ² | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 95% |
| Year Three (SFY 2024) | |
| Review of ICO's implementation of Year One and Year Two CAPs | |

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

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

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

Table 3-44 presents **Meridian**'s scores for each standard evaluated during the SFY 2023 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Meridian**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2023 compliance review activity demonstrated how successful **Meridian** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-44—SFY 2023 Standard Compliance Scores for MER

| Standard | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|----------------|---------------------------|--------------------|-----------|-----------|------------------------|
| | | | <i>M</i> | <i>NM</i> | <i>NA</i> | |
| Standard VIII—Provider Selection | 23 | 23 | 20 | 3 | 0 | 87% |
| Standard IX—Confidentiality | 11 | 11 | 10 | 1 | 0 | 91% |
| Standard X—Grievance and Appeal Systems | 45 | 45 | 35 | 10 | 0 | 78% |
| Standard XI—Subcontractual Relationships and Delegation | 6 | 5 | 4 | 1 | 1 | 80% |
| Standard XII—Practice Guidelines | 6 | 6 | 5 | 1 | 0 | 83% |
| Standard XIII—Health Information Systems ¹ | 9 | 9 | 9 | 0 | 0 | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 21 | 21 | 20 | 1 | 0 | 95% |
| Total | 121 | 120 | 103 | 17 | 1 | 86% |

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

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

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

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

¹This standard includes a comprehensive assessment of the ICO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Meridian achieved full compliance in the Health Information Systems program area, demonstrating that the ICO maintained adequate IS that collects, analyzes, integrates, and reports data to achieve the ICO's contractual obligations with MDHHS. [**Quality, Timeliness, and Access**]

Weaknesses and Recommendations

Weakness #1: Meridian received a *Not Met* score for three elements within the Provider Selection program area, indicating providers were not being credentialed in accordance with the ICO's contractual obligations with MDHHS. [Quality]

Why the weakness exists: Meridian was not reviewing all required performance data at the time of recredentialing. Additionally, **Meridian's** delegates were not consistently confirming providers were reviewed and approved by an accrediting body, or that it conducted an on-site quality assessment in lieu of an accreditation. Lastly, **Meridian** was not consistently collecting disclosures of ownership and control interest forms as part of the initial credentialing and recredentialing process.

Recommendation: While **Meridian** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **Meridian** continually evaluate its processes, procedures, and monitoring efforts, including oversight of delegated entities, to ensure compliance with all federal and MDHHS-set standards specific to the credentialing and recredentialing of network providers.

Weakness #2: Meridian received a *Not Met* score for 10 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. [Quality, Timeliness, and Access]

Why the weakness exists: Several gaps in **Meridian's** grievance and appeal processes were identified; specifically, those related to written acknowledgement of grievances and appeals, written grievance and appeal resolution notices, written notice of grievance resolution time frame extensions, member written consent for filing appeals, the member's right to request a copy of the case file, timely oral and written notice of expedited appeal resolutions, untimely appeal resolution decisions, and information provided to subcontractors related to the member grievance and appeal systems.

Recommendation: While **Meridian** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **Meridian** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to grievances and appeals. HSAG further recommends that **Meridian** implement procedures to ensure model notices used are the most current version required by MDHHS, and that **Meridian** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG’s NAV results indicated that **Meridian** met all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. For Region 4, **Meridian** submitted additional data updates and final requests for exceptions to address provider types not meeting the minimum network requirements. MDHHS approved **Meridian**’s requested exception for the Adult Day Program provider type in Region 4. Table 3-45 presents **Meridian**’s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS’ exception determinations.

Table 3-45—SFY 2023 NAV Results for MER, by Region and Provider Type

| Provider Type | Region 4 Validation Result | Region 7 Validation Result | Region 9 Validation Result |
|--|-------------------------------|-------------------------------|-------------------------------|
| Provider Types With Travel Time and Distance Requirements | | | |
| Adult Day Program | <i>Exception Granted</i> | <i>Met</i> | <i>Met</i> |
| Dental | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Eye Examinations | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Eye Wear | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Hearing Aids | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Hearing Examinations | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Provider Types Rendering Home-Based Services | | | |
| Adaptive Medical Equipment and Supplies | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Devices | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Van Lifts and Tie Downs | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Chore Services | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Community Transition Services | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| ECLS | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Environmental Modifications | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Fiscal Intermediary | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Home-Delivered Meals | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| MIHP Agency | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Medical Supplies | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| NEMT | <i>Met</i> | <i>Met</i> | <i>Met</i> |

| Provider Type | Region 4 Validation Result | Region 7 Validation Result | Region 9 Validation Result |
|---|-------------------------------|-------------------------------|-------------------------------|
| Non-Medical Transportation | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Personal Care Services | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Personal Emergency Response System | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Preventive Nursing Services | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Private Duty Nursing | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Respite | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Skilled Nursing Home | <i>Met</i> | <i>Met</i> | <i>Met</i> |
| Percentage of Total Requirements Met* | 96% | 100% | 100% |
| Percentage of Total Requirements Met Inclusive of Granted Exceptions | 100% | 100% | 100% |

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: For all Medicaid and LTSS minimum network requirements in Region 4, **Meridian** either met the minimum network requirements or was granted an exception to the minimum network requirements from MDHHS. [Access]

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

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

Weaknesses and Recommendations

Weakness #1: HSAG identified no substantial weaknesses for **Meridian** based on the SFY 2023 NAV, as **Meridian** demonstrated that it contracted with all available providers for the provider types that did not meet minimum network requirements and supplied evidence of additional supports (e.g.,

community supports and resources) to provide adequate care to MI Health Link members in Region 4.

Why the weakness exists: NA

Recommendation: **Meridian** should maintain an internal data verification process to continually identify and contract with Adult Day Program providers as they become available in Region 4 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 161 sampled provider locations (i.e., “cases”) for **Meridian**, with an overall response rate of 90.1 percent (145 cases) among **Meridian**’s three MI Health Link regions. Table 3-46 summarizes the SFY 2023 secret shopper survey response rates for **Meridian**, and for each of **Meridian**’s contracted MI Health Link regions.

Table 3-46—Summary of MER Secret Shopper Survey Results for Routine Dental Visits, by Region³⁻³⁰

| | | Response Rate | | Accepting ICO | | Accepting MI Health Link | | Accepting New Patients | |
|-----------------------|--------------------|---------------|-----------------------|---------------|-----------------------|--------------------------|-----------------------|------------------------|-----------------------|
| Region | Total Survey Cases | Cases Reached | Rate (%) ¹ | Accepting ICO | Rate (%) ² | Accepting MI Health Link | Rate (%) ² | Accepting New Patients | Rate (%) ² |
| Region 4 | 11 | 11 | 100% | 5 | 45.5% | 1 | 9.1% | 1 | 9.1% |
| Region 7 | 101 | 88 | 87.1% | 60 | 68.2% | 50 | 56.8% | 47 | 53.4% |
| Region 9 | 49 | 46 | 93.9% | 17 | 37.0% | 14 | 30.4% | 14 | 30.4% |
| Meridian Total | 161 | 145 | 90.1% | 82 | 56.6% | 65 | 44.8% | 62 | 42.8% |

¹ The denominator includes total survey cases.

² The denominator includes cases reached.

³⁻³⁰ Denominators used for the 2023 accepting MI Health Link and accepting new patient rates include cases reached. In 2022 and 2021, denominators for these rates were different. The accepting MI Health Link rate’s denominator included cases responding to the survey and indicating that at least one practitioner at the location accepted the requested ICO. The accepting new patient rate’s denominator included cases responding to the survey that accepted the ICO and MI Health Link. Caution should be exercised when comparing the 2023 results to the 2022 and 2021 results.

Table 3-47 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **Meridian**, and for each of **Meridian**'s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-47—Summary of MER Secret Shopper Survey Appointment Availability Results, by Region

| Region | Total Survey Cases | Cases Contacted and Accepting New Patients | Cases Offered an Appointment | | | Appointment Wait Time (Days) ³ | | | |
|-----------------------|--------------------|--|------------------------------|--|--|---|-----------|-----------|-----------|
| | | | Number | Rate Among All Surveyed Cases ¹ (%) | Rate Among Cases Accepting New Patients ² (%) | Min | Max | Average | Median |
| Region 4 | 11 | 1 | 1 | 9.1% | 100% | 25 | 25 | 25 | 25 |
| Region 7 | 101 | 47 | 36 | 35.6% | 76.6% | 0 | 69 | 25 | 22 |
| Region 9 | 49 | 14 | 13 | 26.5% | 92.9% | 0 | 77 | 18 | 13 |
| Meridian Total | 161 | 62 | 50 | 31.1% | 80.6% | 0 | 77 | 23 | 21 |

¹ The denominator includes total survey cases.

² The denominator includes cases reached that accept the ICO, MI Health Link, and new patients.

³ MDHHS' wait time standard for initial dental appointments is eight weeks.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Of the 161 total survey cases, 90.1 percent (n=145) of the provider locations could be contacted. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: Of the cases reached, 56.6 percent of provider locations accepted **Meridian**, 44.8 percent accepted the MI Health Link program, and 42.8 percent accepted new patients. [Access]

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

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

Weakness #2: Among all surveyed cases, the overall appointment rate was 31.1 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 being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

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

Encounter Data Validation

Performance Results

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

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

Table 3-48 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-48—EDV Results for Meridian

| Analysis | Key Findings |
|------------------------------------|--|
| IS Review | |
| Encounter Data Sources and Systems | <ul style="list-style-type: none"> Meridian used Edifecs (X-Engine) as its primary software for claim adjudication and encounter preparation. Meridian had processes in place to detect and identify duplicate claims. Regarding its submission practices, Meridian clarified that it does not submit rejected or voided claims. For adjustments, when a claim receives a new paid date, Meridian checks if it has been previously accepted. If accepted, the claim is updated as a replacement or void with the new information. In the case of pharmacy claims, adjustments follow a sequence of paid, void, and then new paid. Meridian and its subcontractors were responsible for collecting and maintaining provider information. Additionally, Meridian handled enrollment data received from MDHHS via 834 files. Subcontractors received these files from Meridian and utilized them for processing encounter data. |
| Payment Structures | <ul style="list-style-type: none"> Meridian employed diverse claim payment methods for different encounter types. In inpatient encounters, it employed capitation and negotiated (flat) rate methods. For outpatient encounters, the methods included line-by-line, per diem/variable per diem, capitation, and negotiated (flat) rate. |

| Analysis | Key Findings |
|-----------------------------------|---|
| | <p>Pharmacy encounters were processed using the transparent pricing model method.</p> <ul style="list-style-type: none"> Meridian collected other insurance data from various sources, including customer service interactions, state-provided TPL files, and a partnership with Health Management Solutions (HMS). These data were shared with subcontractors. Claims for members with active TPL were denied if explanation of benefit information was missing and the claim/service did not meet cost avoidance criteria. Meridian used source tables to identify other payers and payment details, incorporating data from customer interactions, state files, and the HMS partnership. This information was included in the 837 encounter file for commercial and Medicare claims. |
| Encounter Data Quality Monitoring | <ul style="list-style-type: none"> Meridian indicated it did not store any of its subcontractor data. Meridian and/or its subcontractors performed various data quality checks on the encounter data collected. These checks included but were not limited to analyzing claim volume by submission month (for all subcontractor encounters except for behavioral health and pharmacy), assessing field-level completeness and validity (for all subcontractor encounters), and evaluating timeliness (for all subcontractor encounters except for behavioral health and pharmacy). For encounters collected by Meridian, it conducted data quality checks including analyzing claim volume by submission month, assessing field-level completeness and accuracy, and evaluating timeliness. |
| Administrative Profile | |
| Encounter Data Completeness | <ul style="list-style-type: none"> Meridian exhibited a sharp increase in encounter volume in January 2022 for professional, institutional, and pharmacy encounters. This large increase was likely due to Meridian merging with Michigan Complete Health in January 2022. Meridian exhibited a sharp decline in the paid amount PMPM in January 2022 for pharmacy encounters. Meridian did not have dental encounter data included in this analysis due to the ICO submitting its dental data marked as Medicare. Meridian had a low volume of duplicate encounters, with 1.0 percent of professional encounters, 0.3 percent of institutional encounters, and 0 percent of pharmacy encounters identified as duplicative. |

| Analysis | Key Findings |
|---------------------------------------|---|
| Encounter Data Timeliness | <ul style="list-style-type: none"> Meridian did not demonstrate timely submission of professional or pharmacy encounters. Within 60 days of payment, Meridian submitted 77.3 percent of professional encounters, and within 180 days, Meridian submitted 82.4 percent of professional encounters. Within 300 days, Meridian submitted 99.6 percent of encounters to MDHHS after the payment date. Within 60 days, Meridian submitted 68.9 percent of pharmacy encounters to MDHHS, and within 180 days of the payment date, Meridian submitted 94.3 percent of encounters to MDHHS. Within 360 days of the payment date, Meridian submitted 94.4 percent of pharmacy encounters to MDHHS. Meridian demonstrated a relatively more timely submission of professional and pharmacy encounters compared to institutional encounters. Within 30 days, Meridian submitted 64.0 percent of institutional encounters; however, within 60 days, Meridian submitted 90.2 percent of institutional encounters to MDHHS. Within 180 days, Meridian submitted 93.7 percent of institutional encounters to MDHHS after the payment date. Additionally, Meridian's submitted data contained a missing paid or submission date for 1.8 percent of institutional encounters. |
| Field-Level Completeness and Accuracy | <ul style="list-style-type: none"> In Meridian's submitted professional encounters, the billing provider NPI was populated 64.4 percent of the time, and the rendering provider NPI was populated 16.2 percent of the time. All other data elements in Meridian's submitted data had high rates of population and validity. |
| Encounter Referential Integrity | <ul style="list-style-type: none"> Of all identified member IDs in Meridian's submitted professional, institutional, and dental encounter data, 99.8 percent were identified in the enrollment data. Of all identified member IDs in Meridian's submitted pharmacy data, 99.5 percent were identified in the enrollment data. Of all identified provider NPIs in Meridian's submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. Of all identified provider NPIs in Meridian's submitted pharmacy encounter data, 99.2 percent were identified in the provider data. |
| Encounter Data Logic | <ul style="list-style-type: none"> No major concerns were noted for Meridian. |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Strength #2: Across all categories of service, all key data elements for **Meridian** were populated at high rates, and all but one was greater than 96 percent valid. [Quality]

Weaknesses and Recommendations

Weakness #1: Meridian indicated that it did not store any of its subcontractor data.

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

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

Weakness #2: Meridian did not indicate timeliness quality checks were performed for claims/encounters originating from its behavioral health and pharmacy subcontractors. [Quality]

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: Meridian should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Weakness #3: Meridian took slightly longer than other ICOs to submit its data to MDHHS. At 180 days from payment date, **Meridian** had submitted 82.4 percent of professional encounters, 93.7 percent of institutional encounters, and 94.3 percent of pharmacy encounters. [Quality and Timeliness]

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

Recommendation: **Meridian** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #4: Although not required to be populated, 64.4 percent of professional encounters contained a billing provider NPI, and 16.2 percent contained a rendering provider NPI. **[Quality]**

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

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

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: While no **Meridian**-specific results could be presented, the statewide analysis identified that the 2023 top-box score for the *Recommend Personal Assistance/Behavioral Health Staff* measure was statistically significantly lower than the 2021 top-box score. This demonstrates a statistically significant decline from 2023, indicating opportunities for improvement for the MI Health Link program. Additionally, the lowest performing measure was *Planning Your Time and Activities* with a 2023 top-box score of 63.70 percent, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together

with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. Therefore, HSAG recommends that **Meridian** develop and implement interventions to improve member experience related to the *Recommend Personal Assistance/Behavioral Health Staff* and *Planning Your Time and Activities* measures. HSAG further recommends that **Meridian** develop innovative approaches to increase the number of members participating in future survey administrations.

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

HSAG performed a comprehensive assessment of **Meridian**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Meridian** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Meridian**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-49 displays each MDHHS CQS goal and EQR activity results that indicate whether the ICO positively (✓) or negatively (✗) impacted the MI Health Link program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Meridian**'s Medicaid members.

Table 3-49—Overall Performance Impact to CQS and Quality, Timeliness, and Access

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| Goal #1 —Ensure high quality and high levels of access to care | <ul style="list-style-type: none"> ✓ The ICO met all minimum network requirements for all provider types with capacity-based requirements and either met the minimum travel time and distance requirements or was granted an exception to the minimum network requirements from MDHHS for all provider types. ✓ Over 90 percent of dental provider locations could be contacted through secret shopper calls. ✓ The median wait time for a dental appointment was 21 calendar days, which was within MDHHS' initial dental appointment standard of eight weeks. ✓ The ICO demonstrated a proactive approach to addressing the MI5.6 <i>Care for Adults—Medication Review</i> and MI7.3 <i>Annual Dental Visit</i> performance measure rates by implementing internal performance improvement plans to focus on root cause barriers and methods to improve performance and member outcomes. ✓ The ICO's rate for the <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systematic Corticosteroid</i> measure indicator increased by more than 34 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✓ The ICO's rate for the <i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment</i> | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| | <p>measure indicator increased by more than 5 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average.</p> <ul style="list-style-type: none"> ✗ Only 56.6 percent of dental providers reported accepting the ICO, 44.8 percent of dental providers reported accepting the MI Health Link program, and 42.8 percent of dental providers reported accepting new patients during the secret shopper calls. ✗ The overall dental appointment rate among all surveyed providers was 31.1 percent. ✗ The maximum wait time for a dental appointment was 77 days, which exceeded MDHHS' initial dental appointment standard of eight weeks (i.e., 56 calendar days). ✗ The ICO's rate for the <i>COA—Care for Older Adults—Medication Review</i> measure indicator decreased by more than 10 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ The ICO's rate for the <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> measure indicator decreased by more than 9 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ While only 17 of the 40 reported HEDIS measures rates (43 percent) indicated worse performance than the statewide average, opportunity exists for the ICO to further improve performance across multiple HEDIS domains impacting quality and high levels of access to care. | |
| Goal #2 —Strengthen person and family-centered approaches | The ICO's findings for the EQR activities did not substantially impact Goal #2. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |
| Goal #3 —Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external) | <ul style="list-style-type: none"> ✓ The ICO implemented the Patient Access API and the Provider Directory API. ✗ The ICO's rates for the <i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i> and <i>Patient Engagement After Inpatient Discharge</i> measure indicators decreased by more than 7 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |
| Goal #4 —Reduce racial and ethnic disparities in | <ul style="list-style-type: none"> ✓ The ICO's QAPI program addressed social determinants of health to reduce health disparities and included initiatives targeting members experiencing health disparities. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| healthcare and health outcomes | <p>✓ The ICO demonstrated programmatically significant improvement for the disparate African-American/Black member population through the initiation of targeted outreach interventions providing education and appointment/testing reminders.</p> <p>✗ The ICO did not meet the QIP goal of eliminating the existing disparity between African-American/Black and White members diagnosed with diabetes who received statin therapy.</p> | |
| Goal #5 —Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | The ICO’s findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact value-based initiatives and payment reform had on improving quality outcomes for the ICO’s members. However, Table 5-5—CMS Core Measure Quality Withhold Results within Section 5 provides information on the results of MDHHS’ quality withhold program for the ICO. The information for the quality withhold program was provided by MDHHS and not assessed through the EQR activities. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

Molina Dual Options MI Health Link

Validation of Quality Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **Molina**’s QIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., the QIP Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-50 displays the overall validation rating, the baseline and Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-50—Overall Validation Rating for MOL

| QIP Topic | Validation Rating ¹ | Performance Indicator | Performance Indicator Results | | | |
|---|--------------------------------|--|-------------------------------|---------|----|-----------|
| | | | Baseline | R1 | R2 | Disparity |
| <i>Addressing Disparities in Controlling Blood Pressure</i> | <i>Met</i> | Controlling high blood pressure—Black members. | 36.4% | 45.1% ↑ | | Yes |
| | | Controlling high blood pressure—White members. | 47.3% | 53.3% ↑ | | |

R1 = Remeasurement 1

R2 = Remeasurement 2

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)

↔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)

↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

¹ The QIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its QIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the QIP adhered to an acceptable methodology for all phases of design and data collection, and the ICO conducted accurate data analysis and interpretation of QIP results; overall confidence that the QIP produced significant evidence of improvement.)

The goals for **Molina**’s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-51 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

Table 3-51—Remeasurement 1 Barriers and Interventions for MOL

| Barriers | Interventions |
|--|---|
| Many Black members do not have a blood pressure monitor to use at home to monitor their progress toward managing their blood pressure. | Provided digital blood pressure monitors to members with a diagnosis of hypertension and who are assigned to the Michigan Community Health Network. |
| Many providers do not properly document the blood pressure reading in the medical record (failure to take a second reading if the first one is elevated, frequently round up the reading, do not take the lowest systolic and/or diastolic reading when multiple readings are done during the same visit). | Conducted hypertension education during quarters 1 and 2, followed by a Quarter 3 medical record audit, scoring each site for compliance related to documentation and member blood pressure level compliance. |
| Many Black members do not know how to take an accurate blood pressure reading while at home. | Provided members with educational materials showing how to sit and position their arm when using a digital blood pressure monitor. Also provided tracking tools and instructions on when to call the provider if the reading is elevated. |
| Member education sent by mail to Black members may be perceived as junk mail and not opened or read. | Provided hypertension education to members electronically by email to Black members. |
| Providers need to have the blood pressure monitor used at home by their Black patients so they can teach their patients how to use the blood pressure monitor. | Provided medical sites with two blood pressure monitor units to use to teach patients with hypertension the method they should use to take an accurate blood pressure reading at home. |
| Many providers do not routinely submit CPT II codes to report blood pressure readings. This increases the need to perform a manual review of the medical record. | Encouraged providers—during virtual visits, on tip sheets within the HEDIS Provider Manual, and through fax blast reminders—to use CPT II codes to report blood pressure readings. |
| Many providers do not capture the blood pressure reading during a telehealth visit with Black patients. | Educated providers—during virtual visits, on tip sheets within the HEDIS Provider Manual, and through fax blast reminders—that they are allowed to collect blood level readings during telehealth/virtual visits. |

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina used appropriate quality improvement tools to conduct a causal/barrier analysis and to prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

Strength #2: Molina demonstrated statistically significant improvement over the baseline performance for both performance indicators during the first remeasurement period. [Quality, Access and Timeliness]

Weaknesses and Recommendations

Weakness #1: Molina did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period. [Quality and Access]

Why the weakness exists: Molina had opportunities for improvement related to identifying barriers specific to the disparate subgroup and the development of interventions to address those barriers. Molina developed several interventions that target all members regardless of race/ethnicity rather than efforts that may eliminate the existing disparity.

Recommendation: HSAG recommends **Molina** revisit its causal/barrier analysis to determine if barriers exist for the disparate subgroup that require the development of interventions. In accordance with direction from MDHHS, **Molina** is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the Black population.

Performance Measure Validation

Performance Results

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

Molina received a measure designation of *Reportable (R)* for all measures, signifying that **Molina** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-52 includes the validation designation for each performance measure as well as the validated SFY 2023 performance measure rates.

Table 3-52—Measure-Specific Validation Designation for MOL

| Performance Measure | Validation Designation | SFY 2023 Rate |
|--|---|---------------|
| Core Measure 9.3: <i>Minimizing Institutional Length of Stay</i> | REPORTABLE (R) The ICO reported this measure in alignment with the MMP Core Reporting Requirements. | 1.07 |
| MI2.6: <i>Timely Transmission of Care Transition Record to Health Care Professional</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 34.50% |
| MI5.6: <i>Care for Adults—Medication Review</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 80.50% |
| MI7.3: <i>Annual Dental Visit</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 24.70% |

Performance Measure Rates

Table 3-53 shows each of **Molina**'s audited HEDIS measures, rates for HEDIS MY 2021 and HEDIS MY 2022 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2022 with HEDIS MY 2021, and the HEDIS MY 2021 and HEDIS MY 2022 MI Health Link statewide average performance rates. HEDIS MY 2021 and HEDIS MY 2022 measure rates performing better than the MY 2021 and MY 2022 statewide averages are notated by green font.

Table 3-53—Measure-Specific Percentage Rates for MOL

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------------|-------------------------|------------------------------------|--|--|
| Prevention and Screening | | | | | |
| BCS—Breast Cancer Screening | 54.67 | 59.22 | +4.55 | 52.74 | 56.70 |
| COL—Colorectal Cancer Screening | 60.34 | 63.19 | +2.85 | 56.03 | 57.59 |
| COA—Care for Older Adults—Medication Review | 77.62 | 79.08 | +1.46 | 74.85 | 80.41 |
| COA—Care for Older Adults—Functional Status Assessment | 53.04 | 65.69 | +12.65 | 58.42 | 62.71 |
| COA—Care for Older Adults—Pain Assessment | 78.10 | 82.24 | +4.14 | 75.25 | 78.04 |
| Respiratory Conditions | | | | | |
| SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 27.60 | 21.73 | –5.87 | 22.93 | 22.01 |
| PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid | 71.31 | 63.77 | –7.54 | 68.65 | 74.10 |
| PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator | 91.64 | 83.48 | –8.16 | 89.67 | 88.82 |
| Cardiovascular Conditions | | | | | |
| CBP—Controlling High Blood Pressure | 57.91 | 64.48 | +6.57 | 60.52 | 66.14 |
| PBH—Persistence of Beta-Blocker Treatment After a Heart Attack | 97.06 | 91.18 | –5.88 | 95.25 | 90.85 |
| SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy | 81.96 | 83.81 | +1.85 | 82.00 | 80.90 |
| SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80% | 95.35 | 75.36 | –19.99 | 84.22 | 79.55 |
| Diabetes | | | | | |
| HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* | 43.55 | 41.36 | –2.19 | 43.53 | 34.07 |
| HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) | 47.93 | 53.53 | +5.60 | 49.06 | 58.51 |
| EED—Eye Exam for Patients With Diabetes | 58.64 | 64.72 | +6.08 | 57.33 | 62.89 |
| BPD—Blood Pressure Control for Patients With Diabetes | 62.29 | 65.45 | +3.16 | 60.82 | 68.13 |
| SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy | 76.56 | 77.87 | +1.31 | 76.83 | 76.44 |
| SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80% | 90.83 | 78.65 | –12.18 | 82.46 | 78.95 |
| Musculoskeletal Conditions | | | | | |
| OMW—Osteoporosis Management in Women Who Had a Fracture | 26.09 | 13.79 | –12.30 | 16.12 | 11.18 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------------|-------------------------|------------------------------------|--|--|
| Behavioral Health | | | | | |
| AMM—Antidepressant Medication Management—Effective Acute Phase Treatment | 84.70 | 71.35 | −13.35 | 75.06 | 73.66 |
| AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment | 75.14 | 53.44 | −21.70 | 60.75 | 57.94 |
| FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up | 28.85 | 37.43 | +8.58 | 26.13 | 32.79 |
| FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up | 59.13 | 62.57 | +3.44 | 50.22 | 58.91 |
| FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up | 28.89 | 22.88 | −6.01 | 33.87 | 32.06 |
| FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up | 43.56 | 47.03 | +3.47 | 51.71 | 54.39 |
| Medication Management and Care Coordination | | | | | |
| TRC—Transitions of Care—Medication Reconciliation Post-Discharge | 28.71 | 28.71 | +/−0.00 | 43.96 | 47.59 |
| TRC—Transitions of Care—Notification of Inpatient Admission | 6.57 | 2.92 | −3.65 | 13.11 | 16.53 |
| TRC—Transitions of Care—Receipt of Discharge Information | 7.06 | 4.14 | −2.92 | 12.77 | 15.38 |
| TRC—Transitions of Care—Patient Engagement After Inpatient Discharge | 66.67 | 78.83 | +12.16 | 74.60 | 77.74 |
| Overuse/Appropriateness | | | | | |
| PSA—Non-Recommended PSA-Based Screening in Older Men* | 31.93 | 35.52 | +3.59 | 24.68 | 26.71 |
| DDE—Potentially Harmful Drug-Disease Interactions in Older Adults* | 30.17 | 31.38 | +1.21 | 31.94 | 33.45 |
| DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid* | 19.63 | 19.57 | −0.06 | 17.81 | 18.16 |
| DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis* | 4.22 | 4.23 | +0.01 | 5.50 | 5.23 |
| DAE—Use of High-Risk Medications in Older Adults—Total* | 22.28 | 22.21 | −0.07 | 21.56 | 21.78 |
| Access/Availability of Care | | | | | |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years | 87.86 | 88.36 | +0.50 | 84.27 | 84.90 |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years | 95.36 | 96.14 | +0.78 | 93.49 | 93.83 |
| AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 and Older | 93.07 | 93.97 | +0.90 | 91.45 | 91.69 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------|-------------------|---------------------------|-------------------------------|-------------------------------|
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 92.98 | 93.76 | +0.78 | 90.77 | 91.08 |
| Risk-Adjusted Utilization | | | | | |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i> | 0.98 | 1.11 | +0.13 | 1.17 | 1.07 |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i> | 1.14 | 1.17 | +0.03 | 1.20 | 1.21 |

* Measures for which lower rates indicate better performance.

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina demonstrated continued strength through its claims completeness factor calculation process, which provided assurance that **Molina’s** Core Measure 9.3 data were accurate, since they are based on claims data. It is critical that administrative data are completed for Core Measure 9.3 so that **Molina** can readily identify any claims within 60 days of a member’s discharged to the community (i.e., readmission to an institution, hospital admission, or claims for continued nursing facility stays), ensuring the accuracy of data element B. [**Quality, Timeliness, and Access**]

Strength #2: Molina addressed issues identified during the prior year’s source review. No further issues were identified, and no source code resubmissions were necessary. [**Quality, Timeliness, and Access**]

Strength #3: Molina significantly improved the MI2.6 reported rate by assigning a single point of contact to monitor inpatient discharges and the transmission of the discharge summaries. [**Quality and Access**]

Strength #4: In the Prevention and Screening domain, **Molina’s** rate for the *COA—Care for Older Adults—Functional Status Assessment* measure indicator increased by more than 12 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in adult members 66 years and older having functional status assessments conducted during the measurement year. As the population ages,

physical and cognitive function can decline, and pain becomes more prevalent. Screening of elderly patients is effective in identifying functional decline.³⁻³¹ [Quality and Access]

Strength #5: In the Medication Management and Care Coordination domain, **Molina**'s rate for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator increased by more than 12 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in patient engagement within 30 days after discharge. Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs. Inadequate care coordination and poor care transitions can result in unnecessary spending.³⁻³² [Quality and Timeliness]

Weaknesses and Recommendations

Weakness #1: For MI7.3, **Molina** did not incorporate any race and ethnicity data other than the data submitted by the State in the 834 enrollment file. Nearly all members were identified with an unknown race. [Quality]

Why the weakness exists: **Molina** only used the race and ethnicity data submitted by the State in the 834 enrollment file.

Recommendation: HSAG recommends that **Molina** explore additional sources for race and ethnicity data, as MDHHS expects that the ICOs will validate and supplement the data provided in 834 files through other sources including care coordination activities, member surveys, and EHR data.

Weakness #2: For 21 of the 40 reported HEDIS measures (53 percent), **Molina**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Risk-Adjusted Utilization. [Quality]

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

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

³⁻³¹ National Committee for Quality Assurance. Care for Older Adults (COA). Available at: <https://www.ncqa.org/hedis/measures/care-for-older-adults/>. Accessed on: Mar 28, 2024.

³⁻³² National Committee for Quality Assurance. Transitions of Care (TRC). Available at: <https://www.ncqa.org/hedis/measures/transitions-of-care/>. Accessed on: Mar 28, 2024.

Weakness #3: In the Respiratory Conditions domain, **Molina**'s rates for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, and the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators decreased by more than 5 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide averages, indicating that some adult members with newly diagnosed or active COPD were not always receiving spirometry testing to confirm the diagnosis, and that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. Approximately 15 million adults in the United States have COPD, an irreversible disease that limits airflow to the lungs. Despite being the gold standard for diagnosis and assessment of COPD, spirometry testing is underused. Earlier diagnosis using spirometry testing supports a treatment plan that may protect against worsening symptoms and decrease the number of exacerbations.³⁻³³ COPD exacerbations make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD.³⁻³⁴ **[Quality and Access]**

Why the weakness exists: The rates for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, and the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators decreasing by more than 5 percentage points from MY 2021 to MY 2022 suggest that barriers exist for receiving spirometry testing and appropriate medication therapy to manage exacerbation for some adult members with COPD.

Recommendation: HSAG recommends that **Molina** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving spirometry testing and appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **Molina** should implement appropriate interventions to improve the performance related to the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, and the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators. **Molina** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).

Weakness #4: In the Cardiovascular Conditions domain, **Molina**'s rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* measure indicator decreased by more than 19 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adults with clinical ASCVD were not adhering to statin therapy. Cardiovascular disease is the leading cause of death in the United States.

³⁻³³ National Committee for Quality Assurance. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR). Available at: <https://www.ncqa.org/hedis/measures/use-of-spirometry-testing-in-the-assessment-and-diagnosis-of-copd/>. Accessed on: Apr 1, 2024.

³⁻³⁴ National Committee for Quality Assurance. Pharmacotherapy Management of COPD Exacerbation (PCE). Available at: <https://www.ncqa.org/hedis/measures/pharmacotherapy-management-of-copd-exacerbation/>. Accessed on: Apr 1, 2024.

ACC/AHA guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD.³⁻³⁵ [Quality and Access]

Why the weakness exists: The rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* measure indicator decreasing by more than 19 percentage points from MY 2021 to MY 2022 suggests that barriers exist for some adults with ASCVD to adhere to statin therapy.

Recommendation: HSAG recommends that **Molina** conduct a root cause analysis or focused study to determine why some adults with ASCVD were not adhering to statin therapy. Upon identification of a root cause, **Molina** should implement appropriate interventions to improve the performance related to the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%* measure indicator. **Molina** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).

Weakness #5: In the Cardiovascular Conditions domain, **Molina**'s rate for the *SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%* measure indicator decreased by more than 12 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adults with diabetes were not adhering to statin therapy. The American Diabetes Association (ADA) and ACC/AHA guidelines recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. Guidelines also state that adherence to statins will aid in ASCVD risk reduction.³⁻³⁶ [Quality and Access]

Why the weakness exists: The rate for the *SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%* measure indicator decreasing by more than 12 percentage points from MY 2021 to MY 2022 suggests that barriers exist for some adults with diabetes to adhere to statin therapy.

Recommendation: HSAG recommends that **Molina** conduct a root cause analysis or focused study to determine why some adults with diabetes were not adhering to statin therapy. Upon identification of a root cause, **Molina** should implement appropriate interventions to improve the performance related to the *SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%* measure indicator. **Molina** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).

Weakness #6: In the Behavioral Health domain, **Molina**'s rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adults with a diagnosis of major depression, who were newly treated with antidepressant medication, did not remain on antidepressant medication for at least 84 and 180 days. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns,

³⁻³⁵ National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: <https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/>. Accessed on: Mar 28, 2024.

³⁻³⁶ Ibid.

appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects.³⁻³⁷ [Quality, Access, and Timeliness]

Why the weakness exists: The rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreasing by more than 13 percentage points from MY 2021 to MY 2022 suggest that barriers exist for some adult members with a diagnosis of major depression to remain on antidepressant medication.

Recommendation: HSAG recommends that **Molina** conduct a root cause analysis or focused study to determine why some adults with a diagnosis of major depression did not remain on antidepressant medication. Upon identification of a root cause, **Molina** should implement appropriate interventions to improve the performance related to the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. **Molina** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or patient education).

³⁻³⁷ National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: <https://www.ncqa.org/hedis/measures/antidepressant-medication-management/>. Accessed on: Apr 1, 2024.

Compliance Review

Performance Results

Table 3-54 presents **Molina**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Molina** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Molina**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-54—SFY 2022 and SFY 2023 Standard Compliance Scores for MOL

| Compliance Review Standard | Compliance Score |
|---|------------------|
| Year One (SFY 2022) | |
| Standard I—Disenrollment: Requirements and Limitations ¹ | 100% |
| Standard II—Member Rights and Member Information | 70% |
| Standard III—Emergency and Poststabilization Services ¹ | 100% |
| Standard IV—Availability of Services | 100% |
| Standard V—Assurances of Adequate Capacity and Services | 100% |
| Standard VI—Coordination and Continuity of Care | 80% |
| Standard VII—Coverage and Authorization of Services | 85% |
| Year Two (SFY 2023) | |
| Standard VIII—Provider Selection | 87% |
| Standard IX—Confidentiality | 100% |
| Standard X—Grievance and Appeal Systems | 71% |
| Standard XI—Subcontractual Relationships and Delegation | 80% |
| Standard XII—Practice Guidelines | 100% |
| Standard XIII—Health Information Systems ² | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 81% |
| Year Three (SFY 2024) | |
| Review of ICO's implementation of Year One and Year Two CAPs | |

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

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

Table 3-55 presents **Molina**'s scores for each standard evaluated during the SFY 2023 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Molina**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2023 compliance review activity demonstrated how successful **Molina** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-55—SFY 2023 Standard Compliance Scores for MOL

| Standard | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|----------------|---------------------------|--------------------|-----------|-----------|------------------------|
| | | | <i>M</i> | <i>NM</i> | <i>NA</i> | |
| Standard VIII—Provider Selection | 23 | 23 | 20 | 3 | 0 | 87% |
| Standard IX—Confidentiality | 11 | 11 | 11 | 0 | 0 | 100% |
| Standard X—Grievance and Appeal Systems | 45 | 45 | 32 | 13 | 0 | 71% |
| Standard XI—Subcontractual Relationships and Delegation | 6 | 5 | 4 | 1 | 1 | 80% |
| Standard XII—Practice Guidelines | 6 | 6 | 6 | 0 | 0 | 100% |
| Standard XIII—Health Information Systems ¹ | 9 | 9 | 9 | 0 | 0 | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 21 | 21 | 17 | 4 | 0 | 81% |
| Total | 121 | 120 | 99 | 21 | 1 | 83% |

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

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

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

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

¹This standard includes a comprehensive assessment of the ICO's IS capabilities.

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 achieved full compliance in the Confidentiality program area, demonstrating that the ICO established and implemented adequate procedures for the use and disclosure of individually identifiable health information in accordance with privacy requirements in 45 CFR parts 160 and 164. **[Quality]**

Strength #2: Molina achieved full compliance in the Practice Guidelines program area, demonstrating that the ICO maintained adequate processes for the adoption, dissemination, and application of CPGs. [Quality]

Strength #3: Molina achieved full compliance in the Health Information Systems program area, demonstrating that the ICO maintained adequate IS that collects, analyzes, integrates, and reports data to achieve the ICO's contractual obligations with MDHHS. [Quality, Timeliness, and Access]

Weaknesses and Recommendations

Weakness #1: Molina received a *Not Met* score for three elements within the Provider Selection program area, indicating providers were not being credentialed in accordance with the ICO's contractual obligations with MDHHS. [Quality]

Why the weakness exists: Molina was not reviewing all required performance data at the time of recredentialing. Additionally, **Molina** did not consistently confirm providers were reviewed and approved by an accrediting body, or that it conducted an on-site quality assessment in lieu of an accreditation. Lastly, **Molina** was not collecting disclosure of ownership and control interest forms as part of the initial and recredentialing process.

Recommendation: While **Molina** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **Molina** continually evaluate its processes, procedures, and monitoring efforts, including oversight of delegated entities, to ensure compliance with all federal and MDHHS-set standards specific to the credentialing and recredentialing of network providers.

Weakness #2: Molina received a *Not Met* score for 13 elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. [Quality, Timeliness, and Access]

Why the weakness exists: Several gaps in **Molina's** grievance and appeal processes were identified; specifically, those related to written acknowledgement of grievances and appeals, written grievance resolution notices, the expedited grievance process, grievance resolution extension time frames, oral and written notice of grievance resolution time frame extensions, member written consent for filing appeals, timely expedited appeal written resolution notices, oral and written notice of appeal resolution time frame extensions, untimely appeal resolution decisions, written notice of appeal dismissals, timely reinstatement of services, and information provided to subcontractors related to the member grievance and appeal systems.

Recommendation: While **Molina** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **Molina** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to grievances and appeals. HSAG further recommends that **Molina** implement procedures to ensure model notices used are the most current version required by MDHHS, and that **Molina** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.

Weakness #3: Molina received a *Not Met* score for four elements within the Quality Assessment and Performance Improvement program area, indicating the ICO has not implemented a QAPI program in accordance with the ICO’s contractual obligations with MDHHS related to the quality program structure, and quality improvement functions, responsibilities, and projects. [Quality]

Why the weakness exists: Molina’s QAPI program was not separate from other lines of business and did not establish an MRR process for monitoring provider network compliance with policies and procedures, specifications, and the appropriateness of care consistent with the utilization control requirements. Additionally, the ICO’s QAPI evaluation lacked comprehensive quantitative and qualitative analysis for some activities and did not include outcomes and trended results of each PIP, the results of any efforts to support community integration for members using LTSS, or the effectiveness of LTSS.

Recommendation: While **Molina** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **Molina** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the QAPI program.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG’s NAV results indicated that **Molina** did not meet all Medicaid and LTSS minimum network requirements for Region 7 and Region 9. **Molina** submitted an exception request for Assistive Technology—Van Lifts and Tie Downs for Region 7 and Region 9. MDHHS did not approve **Molina**’s requested exception for the Assistive Technology—Van Lifts and Tie Downs network requirement in Region 7 and Region 9. Table 3-56 presents **Molina**’s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS’ exception determinations.

Table 3-56—SFY 2023 NAV Results for MOL, by Region and Provider Type

| Provider Type | Region 7 Validation Result | Region 9 Validation Result |
|--|-------------------------------|-------------------------------|
| Provider Types With Travel Time and Distance Requirements | | |
| Adult Day Program | <i>Met</i> | <i>Met</i> |
| Dental | <i>Met</i> | <i>Met</i> |
| Eye Examinations | <i>Met</i> | <i>Met</i> |
| Eye Wear | <i>Met</i> | <i>Met</i> |
| Hearing Aids | <i>Met</i> | <i>Met</i> |
| Hearing Examinations | <i>Met</i> | <i>Met</i> |

| Provider Type | Region 7 Validation Result | Region 9 Validation Result |
|---|-------------------------------|-------------------------------|
| Provider Types Rendering Home-Based Services | | |
| Adaptive Medical Equipment and Supplies | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Devices | <i>Met</i> | <i>Met</i> |
| Assistive Technology—Van Lifts and Tie Downs | <i>Not Met</i> | <i>Not Met</i> |
| Chore Services | <i>Met</i> | <i>Met</i> |
| Community Transition Services | <i>Met</i> | <i>Met</i> |
| ECLS | <i>Met</i> | <i>Met</i> |
| Environmental Modifications | <i>Met</i> | <i>Met</i> |
| Fiscal Intermediary | <i>Met</i> | <i>Met</i> |
| Home-Delivered Meals | <i>Met</i> | <i>Met</i> |
| MIHP Agency | <i>Met</i> | <i>Met</i> |
| Medical Supplies | <i>Met</i> | <i>Met</i> |
| NEMT | <i>Met</i> | <i>Met</i> |
| Non-Medical Transportation | <i>Met</i> | <i>Met</i> |
| Personal Care Services | <i>Met</i> | <i>Met</i> |
| Personal Emergency Response System | <i>Met</i> | <i>Met</i> |
| Preventive Nursing Services | <i>Met</i> | <i>Met</i> |
| Private Duty Nursing | <i>Met</i> | <i>Met</i> |
| Respite | <i>Met</i> | <i>Met</i> |
| Skilled Nursing Home | <i>Met</i> | <i>Met</i> |
| Percentage of Total Requirements Met | 96% | 96% |

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina met 96 percent of all Medicaid and LTSS minimum network requirements for Region 7. [Access]

Strength #2: Molina met 96 percent of all Medicaid and LTSS minimum network requirements for Region 9. [Access]

Weaknesses and Recommendations

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

Why the weakness exists: MDHHS did not approve **Molina**'s exception request for the Assistive Technology—Van Lifts and Tie Downs provider type in Region 7, as **Molina** had not contracted with all available providers in the region. **Molina** reported that it has offered contracts with other providers, but the providers have declined contracting with the ICO.

Recommendation: HSAG recommends that **Molina** identify and contract with additional Assistive Technology—Van Lifts and Tie Downs providers in Region 7 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 7 will be evaluated during the SFY 2024 NAV. Additionally, **Molina** should continue to make all reasonable attempts to mitigate barriers to why available providers will not contract with the ICO.

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

Why the weakness exists: MDHHS did not approve **Molina**'s exception request for the Assistive Technology—Van Lifts and Tie Downs providers in Region 9, as **Molina** had not contracted with all available providers in the region. **Molina** reported that it has offered contracts with other providers, but the providers have declined contracting with the ICO.

Recommendation: HSAG recommends that **Molina** identify and contract with additional Assistive Technology—Van Lifts and Tie Downs providers in Region 9 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region. Updated compliance for this provider type in Region 9 will be evaluated during the SFY 2024 NAV. Additionally, **Molina** should continue to make all reasonable attempts to mitigate barriers to why available providers will not contract with the ICO.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 144 sampled provider locations (i.e., “cases”) for **Molina**, with an overall response rate of 87.5 percent (126 cases) among **Molina**’s two MI Health Link regions. Table 3-57 summarizes the SFY 2023 secret shopper survey response rates for **Molina**, and for each of **Molina**’s contracted MI Health Link regions.

Table 3-57—Summary of MOL Secret Shopper Survey Results for Routine Dental Visits, by Region³⁻³⁸

| | | Response Rate | | Accepting ICO | | Accepting MI Health Link | | Accepting New Patients | |
|---------------------|--------------------|---------------|-----------------------|---------------|-----------------------|--------------------------|-----------------------|------------------------|-----------------------|
| Region | Total Survey Cases | Cases Reached | Rate (%) ¹ | Accepting ICO | Rate (%) ² | Accepting MI Health Link | Rate (%) ² | Accepting New Patients | Rate (%) ² |
| Region 7 | 98 | 85 | 86.7% | 54 | 63.5% | 54 | 63.5% | 51 | 60.0% |
| Region 9 | 46 | 41 | 89.1% | 21 | 51.2% | 20 | 48.8% | 18 | 43.9% |
| Molina Total | 144 | 126 | 87.5% | 75 | 59.5% | 74 | 58.7% | 69 | 54.8% |

¹ The denominator includes total survey cases.

² The denominator includes cases reached.

Table 3-58 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for **Molina**, and for each of **Molina**’s contracted MI Health Link regions. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

³⁻³⁸ Denominators used for the 2023 accepting MI Health Link and accepting new patient rates include cases reached. In 2022 and 2021, denominators for these rates were different. The accepting MI Health Link rate’s denominator included cases responding to the survey and indicating that at least one practitioner at the location accepted the requested ICO. The accepting new patient rate’s denominator included cases responding to the survey that accepted the ICO and MI Health Link. Caution should be exercised when comparing the 2023 results to the 2022 and 2021 results.

Table 3-58—Summary of MOL Secret Shopper Survey Appointment Availability Results, by Region

| Region | Total Survey Cases | Cases Contacted and Accepting New Patients | Cases Offered an Appointment | | | Appointment Wait Time (Days) ³ | | | |
|---------------------|--------------------|--|------------------------------|--|--|---|-----------|-----------|-----------|
| | | | Number | Rate Among All Surveyed Cases ¹ (%) | Rate Among Cases Accepting New Patients ² (%) | Min | Max | Average | Median |
| Region 7 | 98 | 51 | 42 | 42.9% | 82.4% | 1 | 96 | 21 | 11 |
| Region 9 | 46 | 18 | 15 | 32.6% | 83.3% | 1 | 53 | 17 | 12 |
| Molina Total | 144 | 69 | 57 | 39.6% | 82.6% | 1 | 96 | 20 | 11 |

¹ The denominator includes total survey cases.

² The denominator includes cases reached that accept the ICO, MI Health Link, and new patients.

³ MDHHS' wait time standard for initial dental appointments is eight weeks.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Of the 144 total survey cases, 87.5 percent (n=126) of the provider locations could be contacted. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: Of the cases reached, 59.5 percent of provider locations accepted **Molina**, 58.7 percent accepted the MI Health Link program, and 54.8 percent accepted new patients. [Access]

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

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

Weakness #2: Among all surveyed cases, the overall appointment rate was 39.6 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 being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

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

Encounter Data Validation

Performance Results

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

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

Table 3-59 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-59—EDV Results for Molina

| Analysis | Key Findings |
|------------------------------------|--|
| IS Review | |
| Encounter Data Sources and Systems | <ul style="list-style-type: none"> Molina used Microsoft Solutions (MS SQL and BizTalk) as its primary software for claim adjudication and encounter preparation. Molina had processes in place to detect and identify duplicate claims. Regarding its submission practices, Molina clarified that it does not resubmit denied claims unless they are administrative denials, and voided claims are also not resubmitted. For adjustments, if a claim has been adjusted after the original payment, an adjusted encounter will be sent to MDHHS. Moreover, if Molina identifies an overpayment and no adjustment is made in QNXT, Molina will adjust the encounter to remove the overpayment. Molina and its subcontractors were responsible for collecting and maintaining provider information. Additionally, Molina handled enrollment data received from MDHHS via 834 files. Subcontractors received these files from Molina and utilized them for processing encounter data. |
| Payment Structures | <ul style="list-style-type: none"> Molina utilized a variety of claim payment methods tailored to different encounter types. For inpatient encounters, it employed DRG and skilled, short stay, and custodial pricing methods. Outpatient encounters were processed using line-by-line and per diem/variable per diem methods, while pharmacy encounters followed the ingredient cost method. Molina gathered other insurance data from various sources, including MDHHS TPL weekly supplemental files, 834 COB data, and provider-provided TPL information, which were then transmitted to subcontractors via eligibility extracts. Claims were coordinated if other insurance information was available during initial processing, but if submitted later, payments were recovered by requesting providers to coordinate benefits, automatically adjusting the encounter submitted to MDHHS. Molina adhered to MDHHS TPL Processing Guidelines, populating TPL information onto submitted encounters in specific segments of the 837 Institutional (837I) and 837 Professional (837P) files, including details like other payer paid amount, payer ID, and payer name. Claims adjusted reason codes were populated based on service paid amount and charge amount. |
| Encounter Data Quality Monitoring | <ul style="list-style-type: none"> Molina indicated it did not store its pharmacy subcontractor data. Molina indicated it edited or made modifications to all subcontractor data except pharmacy. |

| Analysis | Key Findings |
|-------------------------------|--|
| | <ul style="list-style-type: none"> Molina and/or its subcontractors performed various data quality checks on the encounter data collected. These checks included but were not limited to analyzing claim volume by submission month (for all subcontractor encounters except for pharmacy), assessing field-level completeness and validity (for all subcontractor encounters), evaluating timeliness (for all subcontractor encounters except for pharmacy), and evaluating whether the payment fields in the claims align with the financial reports (for all subcontractor encounters). For encounters collected by Molina, it conducted data quality checks including analyzing claim volume by submission month, assessing field-level completeness and accuracy, evaluating timeliness, and ensuring that the payment fields in the claims align with the financial reports. |
| Administrative Profile | |
| Encounter Data Completeness | <ul style="list-style-type: none"> Molina displayed consistent encounter volume for professional, dental, and pharmacy encounters throughout the measurement year. Molina exhibited variability in institutional encounter volume during the measurement year, with a higher volume of encounters in January 2022, and a lower encounter volume in May 2022, compared to other months. Molina had a low volume of duplicate encounters, with 0.4 percent of professional encounters, 0.2 percent of institutional encounters, 0.3 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative. |
| Encounter Data Timeliness | <ul style="list-style-type: none"> Molina demonstrated timely submission for pharmacy encounters. Within 30 days, Molina submitted 99.2 percent of professional encounters to MDHHS after the payment date. Molina did not demonstrate timely submission of professional, institutional, or dental encounters; however, Molina demonstrated a relatively more timely submission of professional and institutional encounters compared to dental encounters. Within 60 days of payment, Molina submitted 54.9 percent of professional encounters, and within 180 days, Molina submitted 60.2 percent of professional encounters. Within 360 days of payment, Molina submitted 87.4 percent of professional encounters to MDHHS. Within 60 days of payment, Molina submitted 83.3 percent of institutional encounters to MDHHS, and within 180 days, Molina submitted 85.5 percent of institutional encounters. Within 360 days of payment, Molina submitted 95.5 percent of institutional encounters to MDHHS. |

| Analysis | Key Findings |
|---------------------------------------|---|
| | <ul style="list-style-type: none"> Within 60 days of payment, Molina submitted 2.0 percent of dental encounters to MDHHS, and within 180 days, Molina submitted 13.1 percent of institutional encounters. Within 360 days of payment, Molina submitted 67.0 percent of institutional encounters to MDHHS. |
| Field-Level Completeness and Accuracy | <ul style="list-style-type: none"> In Molina's submitted professional encounters, the billing provider NPI was populated 34.6 percent of the time, and the rendering provider NPI was populated 16.9 percent of the time. All other data elements in Molina's submitted data had high rates of population and validity. |
| Encounter Referential Integrity | <ul style="list-style-type: none"> Of all identified member IDs in Molina's submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the enrollment data. Of all identified member IDs in Molina's submitted pharmacy data, 99.6 percent were identified in the enrollment data. Of all identified provider NPIs in Molina's submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. Of all identified provider NPIs in Molina's submitted pharmacy encounter data, 95.3 percent were identified in the provider data. |
| Encounter Data Logic | <ul style="list-style-type: none"> No major concerns were noted for Molina. |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Strength #2: Molina submitted pharmacy encounters in a timely manner from the payment date, with 99.2 percent of all encounters submitted within 30 days of the payment date. [Quality and Timeliness]

Strength #3: Across all categories of service, all key data elements for **Molina** were populated at high rates, and most data elements were greater than 95 percent valid. [Quality]

Weaknesses and Recommendations

Weakness #1: **Molina** indicated that it did not store its pharmacy subcontractor data. [Quality]

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

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

Weakness #2: **Molina** modified encounters from its subcontractors before submitting them to MDHHS. [Quality]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: **Molina** should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #3: **Molina** did not indicate timeliness quality checks were performed for claims/encounters originating from its pharmacy subcontractors. [Quality]

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: **Molina** should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Weakness #4: **Molina** took the longest to submit encounters to MDHHS after the payment date in three of the four categories of service out of all ICOs. At 180 days from payment date, **Molina** submitted 60.2 percent of professional encounters, 85.5 percent of institutional encounters, and 13.1 percent of dental encounters. [Quality and Timelines]

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

Recommendation: **Molina** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #5: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95.3 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [Quality]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: **Molina** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #6: Although not required to be populated, 34.6 percent of professional encounters contained a billing provider NPI, and 16.9 percent contained a rendering provider NPI. **[Quality]**

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

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

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: While no **Molina**-specific results could be presented, the statewide analysis identified that the 2023 top-box score for the *Recommend Personal Assistance/Behavioral Health Staff* measure was statistically significantly lower than the 2021 top-box score. This demonstrates a statistically significant decline from 2023, indicating opportunities for improvement for the MI Health Link program. Additionally, the lowest performing measure was *Planning Your Time and*

Activities with a 2023 top-box score of 63.70 percent, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. Therefore, HSAG recommends that **Molina** develop and implement interventions to improve member experience related to the *Recommend Personal Assistance/Behavioral Health Staff* and *Planning Your Time and Activities* measures. HSAG further recommends that **Molina** develop innovative approaches to increase the number of members participating in future survey administrations.

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

HSAG performed a comprehensive assessment of **Molina**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Molina** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Molina**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-60 displays each MDHHS CQS goal and EQR activity results that indicate whether the ICO positively (✓) or negatively (✗) impacted the MI Health Link program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Molina**'s Medicaid members.

Table 3-60—Overall Performance Impact to CQS and Quality, Timeliness, and Access

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| Goal #1 —Ensure high quality and high levels of access to care | <ul style="list-style-type: none"> ✓ The ICO met most minimum network requirements for provider types with capacity-based requirements and all network requirements for all provider types with travel time and distance requirements. ✓ Nearly 90 percent of dental provider locations could be contacted through secret shopper calls. ✓ The median wait time for a dental appointment was 11 calendar days, which is within MDHHS' initial dental appointment standard of eight weeks. ✓ The ICO's rate for the <i>COA—Care for Older Adults—Functional Status Assessment</i> measure indicator increased by more than 12 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✗ The ICO did not meet the minimum network requirements for Assistive Technology—Van Lifts and Tie Downs in regions 7 and 9. ✗ Only 59.5 percent of dental providers reported accepting the ICO, only 58.7 percent of dental providers reported accepting the MI Health Link program, and only 54.8 percent of dental | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|--|---|
| | <p>providers reported accepting new patients during secret shopper calls.</p> <ul style="list-style-type: none"> ✗ The overall dental appointment rate among all surveyed providers was only 39.6 percent. ✗ The maximum wait time for a dental appointment was 96 days, which exceeded MDHHS' initial dental appointment standard of eight weeks (i.e., 56 calendar days). ✗ The ICO's rates for the <i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i>, and the <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator</i> measure indicators decreased by more than 5 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide averages. ✗ The ICO's rate for the <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i> measure indicator decreased by more than 19 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ The ICO's rate for the <i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i> measure indicator decreased by more than 12 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ The ICO's rates for the <i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i> measure indicators decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ For 21 of the 40 reported HEDIS measures (53 percent), the ICO's rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple HEDIS domains impacting quality and high levels of access to care. | |
| Goal #2—Strengthen person and family-centered approaches | <ul style="list-style-type: none"> ✓ The ICO demonstrated continued strength in its reporting of Core Measure 9.3: <i>Minimizing Institutional Length of Stay</i> through the ICO's claims completeness factor calculation process. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

| Performance Area | 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) | <ul style="list-style-type: none"> ✓ The ICO implemented the Patient Access API and the Provider Directory API. ✓ The ICO demonstrated significant improvement in its MI2.6 <i>Timely Transmission of Care Transition Record to Health Care Professional</i> performance measure rate over the prior year by assigning a single point of contact to monitor inpatient discharges and the transmission of the discharge summaries. ✓ The ICO's rate for the <i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i> measure indicator increased by more than 12 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |
| Goal #4 —Reduce racial and ethnic disparities in healthcare and health outcomes | <ul style="list-style-type: none"> ✓ The ICO's QAPI program addressed social determinants of health to reduce health disparities experienced by different subpopulations of members. ✓ The ICO's QIP demonstrated significant improvement over the baseline performance for Black members with a diagnosis of hypertension and whose blood pressure was adequately controlled. ✗ The ICO did not incorporate any race and ethnicity data other than the data submitted by MDHHS in the 834 enrollment file for the MI7.3 <i>Annual Dental Visit</i> performance measure, as nearly all members were identified with an unknown race. ✗ The ICO did not meet the QIP goal of eliminating the existing disparity for controlling high blood pressure among Black members and White members. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |
| Goal #5 —Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | The ICO's findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact value-based initiatives and payment reform had on improving quality outcomes for the ICO's members. However, Table 5-5—CMS Core Measure Quality Withhold Results within Section 5 provides information on the results of MDHHS' quality withhold program for the ICO. The information for the quality withhold program was provided by MDHHS and not assessed through the EQR activities. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

Upper Peninsula Health Plan MI Health Link

Validation of Quality Improvement Projects

Performance Results

HSAG’s validation evaluated the technical methods of **UPHP**’s QIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., the QIP Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of the QIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-61 displays the overall validation rating, the baseline and Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-61—Overall Validation Rating for UPHP

| QIP Topic | Validation Rating ¹ | Performance Indicator | Performance Indicator Results | | | |
|---------------------------|--------------------------------|--|-------------------------------|---------|----|-----------|
| | | | Baseline | R1 | R2 | Disparity |
| <i>Annual Dental Care</i> | <i>Met</i> | Annual dental visit for UPHP American Indian/Alaskan Native MHL members. | 22.7% | 21.2% ⇄ | | Yes |
| | | Annual dental visit for UPHP White MHL members. | 34.6% | 35.1% ⇄ | | |

R1 = Remeasurement 1

R2 = Remeasurement 2

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05)

⇄ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05)

↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05)

¹ The QIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its QIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the QIP adhered to an acceptable methodology for all phases of design and data collection, and the ICO conducted accurate data analysis and interpretation of QIP results; overall confidence that the QIP produced significant evidence of improvement.)

The goals for **UPHP**’s QIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (American Indian/Alaskan Native) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White) or achieve clinically or programmatically significant improvement as a result of initiated intervention(s). Table 3-62 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the ICO to support achievement of the QIP goals and address the barriers.

Table 3-62—Remeasurement 1 Barriers and Interventions for UPHP

| Barriers | Interventions |
|---|--|
| Members have dentures or lack teeth. | Specific education was provided during member outreach regarding the importance of dental visits even when no teeth are present or when dentures are being used as well as education on the denture benefit. |
| Members lack desire to see a dentist. | General education was provided to members on the importance of preventive dental care and benefit availability. |
| Members lack dentists in their area, lack of transportation to appointments, or lack of understanding of dental benefits. | Members were provided education on the provider network and connection with the ICO transportation service. |
| Out-of-network dental providers. | The ICO collected data during member outreach to determine any impact of out-of-network dental providers for 2023 interventions. |

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: UPHP met 100 percent of the requirements for data analysis and implementation of improvement strategies. The ICO conducted accurate statistical testing between the two subgroups for the first remeasurement period and provided a narrative interpretation of the results. **UPHP** used appropriate quality improvement tools to conduct a causal/barrier analysis and prioritize the identified barriers, and interventions were implemented in a timely manner. [Quality and Timeliness]

Strength #2: UPHP demonstrated programmatically significant improvement for the disparate subgroup through the initiation of an intervention strategy. The intervention strategy targeted the disparate subgroup and provided the targeted members with educational telephonic outreach calls. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: UPHP did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups with the first remeasurement period. [Quality and Access]

Why the weakness exists: While it is unclear why the goal was not achieved, the data suggest that barriers exist for the disparate subgroup in the receipt of annual dental care.

Recommendation: HSAG recommends **UPHP** revisit its causal barrier analysis to determine if any new barriers exist for the disparate subgroup that require the development of targeted strategies to improve performance. In accordance with direction from MDHHS, **UPHP** is required to identify at least three barriers to care and develop three interventions to address those barriers, specifically for the American Indian/Alaska Native population.

Performance Measure Validation

Performance Results

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

UPHP received a measure designation of *Reportable (R)* for all measures, signifying that **UPHP** had reported the measures in compliance with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements and that rates could be reported. Table 3-63 includes the validation designation for each performance measure as well as the validated SFY 2023 performance measure rates.

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

| Performance Measure | Validation Designation | SFY 2023 Rate |
|--|---|---------------|
| Core Measure 9.3: <i>Minimizing Institutional Length of Stay</i> | REPORTABLE (R) The ICO reported this measure in alignment with the MMP Core Reporting Requirements. | 1.35 |
| MI2.6: <i>Timely Transmission of Care Transition Record to Health Care Professional</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 69.10% |
| MI5.6: <i>Care for Adults—Medication Review</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 93.20% |
| MI7.3: <i>Annual Dental Visit</i> | REPORTABLE (R) The ICO reported this measure in compliance with the Michigan-Specific Reporting Requirements. | 34.30% |

Performance Measure Rates

Table 3-64 shows each of **UPHP**'s audited HEDIS measures, rates for HEDIS MY 2021 and HEDIS MY 2022 to demonstrate year-over-year performance, the percentage point increase or decrease in rates when comparing HEDIS MY 2022 with HEDIS MY 2021, and the HEDIS MY 2021 and HEDIS MY 2022 MI Health Link statewide average performance rates. HEDIS MY 2021 and HEDIS MY 2022 measure rates performing better than the MY 2021 and MY 2022 statewide averages are notated by green font.

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

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------|-------------------|---------------------------|-------------------------------|-------------------------------|
| Prevention and Screening | | | | | |
| <i>BCS—Breast Cancer Screening</i> | 62.90 | 65.49 | +2.59 | 52.74 | 56.70 |
| <i>COL—Colorectal Cancer Screening</i> | 65.94 | 64.12 | –1.82 | 56.03 | 57.59 |
| <i>COA—Care for Older Adults—Medication Review</i> | 92.46 | 94.16 | +1.70 | 74.85 | 80.41 |
| <i>COA—Care for Older Adults—Functional Status Assessment</i> | 84.43 | 83.94 | –0.49 | 58.42 | 62.71 |
| <i>COA—Care for Older Adults—Pain Assessment</i> | 92.21 | 92.70 | +0.49 | 75.25 | 78.04 |
| Respiratory Conditions | | | | | |
| <i>SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD</i> | 19.59 | 24.07 | +4.48 | 22.93 | 22.01 |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid</i> | 87.80 | 89.76 | +1.96 | 68.65 | 74.10 |
| <i>PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i> | 91.87 | 90.55 | –1.32 | 89.67 | 88.82 |
| Cardiovascular Conditions | | | | | |
| <i>CBP—Controlling High Blood Pressure</i> | 84.91 | 80.05 | –4.86 | 60.52 | 66.14 |
| <i>PBH—Persistence of Beta-Blocker Treatment After a Heart Attack</i> | 88.89 | 90.00 | +1.11 | 95.25 | 90.85 |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i> | 89.86 | 80.12 | –9.74 | 82.00 | 80.90 |
| <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%</i> | 84.21 | 80.45 | –3.76 | 84.22 | 79.55 |
| Diabetes | | | | | |
| <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)*</i> | 25.79 | 21.90 | –3.89 | 43.53 | 34.07 |
| <i>HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)</i> | 65.21 | 68.86 | +3.65 | 49.06 | 58.51 |
| <i>EED—Eye Exam for Patients With Diabetes</i> | 69.83 | 66.91 | –2.92 | 57.33 | 62.89 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|--|-------------------------|-------------------------|------------------------------------|--|--|
| <i>BPD—Blood Pressure Control for Patients With Diabetes</i> | 85.16 | 85.64 | +0.48 | 60.82 | 68.13 |
| <i>SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy</i> | 73.60 | 71.22 | –2.38 | 76.83 | 76.44 |
| <i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i> | 81.07 | 86.53 | +5.46 | 82.46 | 78.95 |
| Musculoskeletal Conditions | | | | | |
| <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> | 23.08 | 10.00 | –13.08 | 16.12 | 11.18 |
| Behavioral Health | | | | | |
| <i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment</i> | 67.62 | 82.79 | +15.17 | 75.06 | 73.66 |
| <i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment</i> | 53.33 | 71.31 | +17.98 | 60.75 | 57.94 |
| <i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i> | 39.39 | 41.54 | +2.15 | 26.13 | 32.79 |
| <i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i> | 65.15 | 73.85 | +8.70 | 50.22 | 58.91 |
| <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i> | 48.78 | 29.55 | –19.23 | 33.87 | 32.06 |
| <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i> | 65.85 | 61.36 | –4.49 | 51.71 | 54.39 |
| Medication Management and Care Coordination | | | | | |
| <i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i> | 79.56 | 74.94 | –4.62 | 43.96 | 47.59 |
| <i>TRC—Transitions of Care—Notification of Inpatient Admission</i> | 48.66 | 60.83 | +12.17 | 13.11 | 16.53 |
| <i>TRC—Transitions of Care—Receipt of Discharge Information</i> | 42.09 | 45.99 | +3.90 | 12.77 | 15.38 |
| <i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i> | 89.54 | 89.78 | +0.24 | 74.60 | 77.74 |
| Overuse/Appropriateness | | | | | |
| <i>PSA—Non-Recommended PSA-Based Screening in Older Men*</i> | 23.10 | 21.19 | –1.91 | 24.68 | 26.71 |
| <i>DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*</i> | 41.28 | 41.20 | –0.08 | 31.94 | 33.45 |
| <i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*</i> | 20.42 | 21.18 | +0.76 | 17.81 | 18.16 |
| <i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*</i> | 9.77 | 9.54 | –0.23 | 5.50 | 5.23 |

| HEDIS Measure | HEDIS MY 2021 (%) | HEDIS MY 2022 (%) | HEDIS MY 2021 vs. MY 2022 | MY 2021 Statewide Average (%) | MY 2022 Statewide Average (%) |
|---|-------------------|-------------------|---------------------------|-------------------------------|-------------------------------|
| <i>DAE—Use of High-Risk Medications in Older Adults—Total*</i> | 26.99 | 28.19 | +1.20 | 21.56 | 21.78 |
| Access/Availability of Care | | | | | |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years</i> | 89.32 | 91.09 | +1.77 | 84.27 | 84.90 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years</i> | 95.86 | 95.55 | –0.31 | 93.49 | 93.83 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 and Older</i> | 95.76 | 94.93 | –0.83 | 91.45 | 91.69 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 94.69 | 94.48 | –0.21 | 90.77 | 91.08 |
| Risk-Adjusted Utilization | | | | | |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i> | 1.10 | 0.51 | –0.59 | 1.17 | 1.07 |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i> | 0.93 | 0.97 | +0.04 | 1.20 | 1.21 |

* Measures for which lower rates indicate better performance.

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: As applicable to MI2.6, **UPHP** demonstrated improvement increasing timely care transition record notifications through continued facility engagement and focus on the Upper Peninsula Health Information Exchange (UPHIE) to include admission, discharge, transfer (ADT) alerts. All **UPHP**’s in-network hospitals within the Upper Peninsula Region submitted ADTs through the UPHIE portal for timely notifications. In addition, **UPHP** continued to engage its contracted clinics, tribal health centers, community mental health centers, and skilled nursing facilities connected to UPHIE. Furthermore, the audit review found that **UPHP**’s Altruista care management system supported **UPHP**’s efforts to identify and track ICO admissions and discharge information. [Quality and Timeliness]

Strength #2: **UPHP** was able to report valid data for MI7.3, which was a new measure for reporting. The audit found that **UPHP** continued to be a high performer in providing annual dental visits to its

ICO members, which is attributed to several quality initiatives focused on outreach to members to educate them on the dental benefit. [Quality and Access]

Strength #3: In the Diabetes domain, UPHP's rate for the SPD—*Statin Therapy for Patients With Diabetes—Statin Adherence 80%* measure indicator increased by more than 5 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average, suggesting strength and improvement in adult members with diabetes receiving statin therapy. The ADA and ACC/AHA guidelines recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. Guidelines also state that adherence to statins will aid in ASCVD risk reduction.³⁻³⁹ [Quality and Access]

Strength #4: In the Behavioral Health domain, UPHP's rates for the AMM—*Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators increased by more than 15 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide averages, suggesting strength and improvement in adults with a diagnosis of major depression, who were newly treated with antidepressant medication, remaining on antidepressant medication for at least 84 and 180 days. Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide, the 10th leading cause of death in the United States each year. Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects.³⁻⁴⁰ [Quality, Access, and Timeliness]

Weaknesses and Recommendations

Weakness #1: While UPHP had processes to audit claims processing, UPHP did not have formalized performance benchmarks to convey the results of its performance. [Quality]

Why the weakness exists: UPHP focused on the individual claims audit results.

Recommendation: HSAG recommends that UPHP consider establishing internal performance benchmarks related to procedural and financial accuracy as a mechanism to assess performance and communicate results more formally.

Weakness #2: UPHP did not have a formalized delegation oversight process of Delta Dental related to the delegation of claims processing, which could impact the accuracy and completeness of dental data used for MI7.3. [Quality]

³⁻³⁹ National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: <https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/>. Accessed on: Mar 28, 2024.

³⁻⁴⁰ National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: <https://www.ncqa.org/hedis/measures/antidepressant-medication-management/>. Accessed on: Apr 1, 2024.

Why the weakness exists: UPHP's previous clinical services manager—utilization management became the UPHP compliance officer in January of 2023 and identified the need for delegated oversight, but this was not functional in 2022.

Recommendation: HSAG recommends that UPHP formalize its delegation oversight of Delta Dental to include the review of claims processing timeliness and accuracy.

Weakness #3: UPHP was required to update its Core Measure 9.3 source code and to resubmit its Core Measure 9.3 data to HPMS. [Quality, Timeliness, and Access]

Why the weakness exists: UPHP's source code was incorrectly removing members with diagnoses that did not map to the risk adjustment weights value set.

Recommendation: HSAG recommends that UPHP review its member-level detail file for any potential errors, including the review of any blank data to determine if this is valid for a given field. UPHP should also review its results against the prior year's data results and review any significant changes, and explore factors impacting the change to determine if there was a coding error or if the performance is consistent with its expectations.

Weakness #4: UPHP was required to update its MI2.6 sampling methodology and resubmit its data to HPMS due to the hybrid sampling methodology not adhering to oversample substitution to keep the sample at 411 members.

Why the weakness exists: UPHP did not fully understand how to implement the hybrid oversample related to substitution.

Recommendation: HSAG recommends that UPHP implement its processes to incorporate the guidance related to hybrid sampling and use of the oversample in future years for all measures that use hybrid reporting.

Weakness #5: UPHP did not integrate PIHP data from behavioral health discharges to be considered for sampling.

Why the weakness exists: With the removal of Core Measure 9.1 from reporting, UPHP failed to identify that behavioral health data needed to be considered for other measures during the reporting period.

Recommendation: HSAG recommends that UPHP ensure it carefully reviews the annual release of the Michigan-Specific Reporting Requirements and ensure all data necessary for reporting are integrated. UPHP should ensure that there is a process to review the potential unanticipated consequences of removing any data from reporting to help mitigate the introduction of material bias due to data integration errors.

Weakness #6: UPHP only incorporated race and ethnicity data from the data submitted by the State in the 834 enrollment file.

Why the weakness exists: UPHP only used the race and ethnicity data submitted by the State in the 834 enrollment file.

Recommendation: HSAG recommends that **UPHP** explore additional sources for race and ethnicity data, as MDHHS expects that the ICOs will validate and supplement the data provided in 834 files through other sources including care coordination activities, member surveys, and EHR data.

Weakness #7: While only 9 of the 40 reported HEDIS measures rates (22 percent) indicated worse performance than the statewide average, opportunity exists for **UPHP** to further improve performance across multiple domains including Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, and Behavioral Health. [Quality]

Why the weakness exists: Some measures included in the Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, and Behavioral Health domains demonstrated worse performance than the statewide average, indicating **UPHP** was not performing as well as the other ICOs for some measures within these domains.

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

Weakness #8: In the Cardiovascular Conditions domain, **UPHP**'s rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator decreased by more than 9 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some adults with clinical ASCVD were not receiving statin therapy. Cardiovascular disease is the leading cause of death in the United States. ACC/AHA guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD.³⁻⁴¹ [Quality and Access]

Why the weakness exists: The rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator decreasing by more than 9 percentage points from MY 2021 to MY 2022 suggests that barriers exist for some adults with ASCVD to receive statin therapy.

Recommendation: HSAG recommends that **UPHP** conduct a root cause analysis or focused study to determine why some adults with ASCVD were not receiving statin therapy. Upon identification of a root cause, **UPHP** should implement appropriate interventions to improve the performance related to the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator. **UPHP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).

Weakness #9: In the Musculoskeletal Conditions domain, **UPHP**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, suggesting that some women who suffered a fracture did not receive a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. Osteoporosis is a serious disease affecting mostly older adults that can impact their quality of life.

³⁻⁴¹ National Committee for Quality Assurance. Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD). Available at: <https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/>. Accessed on: Mar 28, 2024.

Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. With appropriate screening and treatment, the risk of future osteoporosis-related fractures can be reduced.³⁻⁴² [Quality, Timeliness, and Access]

Why the weakness exists: The rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreasing by more than 13 percentage points from MY 2021 to MY 2022 suggests that barriers exist for women to receive timely bone mineral density tests or prescriptions to treat osteoporosis within six months of a fracture.

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

Weakness #10: In the Behavioral Health domain, **UPHP**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator decreased by more than 19 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average, indicating that some members were not receiving follow-up care for mental illness within seven days of an ED visit. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.³⁻⁴³ [Quality, Timeliness, and Access]

Why the weakness exists: The rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator decreasing by more than 19 percentage points from MY 2021 to MY 2022 suggests that barriers exist for some members to receive follow-up care for mental illness within seven days of an ED visit.

Recommendation: HSAG recommends that **UPHP** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness within seven days of an ED visit. Upon identification of a root cause, **UPHP** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* measure indicator. **UPHP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider education or staffing shortages).

³⁻⁴² National Committee for Quality Assurance. Osteoporosis Management In Women Who Had a Fracture (OMW). Available at: <https://www.ncqa.org/hedis/measures/osteoporosis-management-in-women-who-had-a-fracture/>. Accessed on: Mar 28, 2024.

³⁻⁴³ National Committee for Quality Assurance. Follow-Up After Emergency Department Visit for Mental Illness (FUM). Available at: <https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/>. Accessed on: Apr 1, 2024.

Compliance Review

Performance Results

Table 3-65 presents **UPHP**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **UPHP** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **UPHP**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-65—SFY 2022 and SFY 2023 Standard Compliance Scores for UPHP

| Compliance Review Standard | Compliance Score |
|---|------------------|
| Year One (SFY 2022) | |
| Standard I—Disenrollment: Requirements and Limitations ¹ | 89% |
| Standard II—Member Rights and Member Information | 73% |
| Standard III—Emergency and Poststabilization Services ¹ | 100% |
| Standard IV—Availability of Services | 85% |
| Standard V—Assurances of Adequate Capacity and Services | 75% |
| Standard VI—Coordination and Continuity of Care | 77% |
| Standard VII—Coverage and Authorization of Services | 100% |
| Year Two (SFY 2023) | |
| Standard VIII—Provider Selection | 87% |
| Standard IX—Confidentiality | 64% |
| Standard X—Grievance and Appeal Systems | 80% |
| Standard XI—Subcontractual Relationships and Delegation | 60% |
| Standard XII—Practice Guidelines | 83% |
| Standard XIII—Health Information Systems ² | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 90% |
| Year Three (SFY 2024) | |
| Review of ICO's implementation of Year One and Year Two CAPs | |

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

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

Table 3-66 presents **UPHP**'s scores for each standard evaluated during the SFY 2023 compliance review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **UPHP**'s written documents (e.g., policies, procedures, reports, and meeting minutes) and interviews with ICO staff members. The SFY 2023 compliance review activity demonstrated how successful **UPHP** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with MDHHS.

Table 3-66—SFY 2023 Standard Compliance Scores for UPHP

| Standard | Total Elements | Total Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|----------------|---------------------------|--------------------|-----------|-----------|------------------------|
| | | | <i>M</i> | <i>NM</i> | <i>NA</i> | |
| Standard VIII—Provider Selection | 23 | 23 | 20 | 3 | 0 | 87% |
| Standard IX—Confidentiality | 11 | 11 | 7 | 4 | 0 | 64% |
| Standard X—Grievance and Appeal Systems | 45 | 45 | 36 | 9 | 0 | 80% |
| Standard XI—Subcontractual Relationships and Delegation | 6 | 5 | 3 | 2 | 1 | 60% |
| Standard XII—Practice Guidelines | 6 | 6 | 5 | 1 | 0 | 83% |
| Standard XIII—Health Information Systems ¹ | 9 | 9 | 9 | 0 | 0 | 100% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 21 | 21 | 19 | 2 | 0 | 90% |
| Total | 121 | 120 | 99 | 21 | 1 | 83% |

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

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

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

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

¹This standard includes a comprehensive assessment of the ICO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: UPHP achieved full compliance in the Health Information Systems program area, demonstrating that the ICO maintained adequate IS that collects, analyzes, integrates, and reports data to achieve the ICO's contractual obligations with MDHHS. [**Quality, Timeliness, and Access**]

Weaknesses and Recommendations

Weakness #1: UPHP received a *Not Met* score for three elements within the Provider Selection program area, indicating providers were not being credentialed in accordance with the ICO's contractual obligations with MDHHS. [Quality]

Why the weakness exists: UPHP was not reviewing all required provider performance data at the time of recredentialing. Additionally, UPHP did not consistently provide evidence to confirm providers were reviewed and approved by an accrediting body, that it conducted an on-site quality assessment in lieu of an accreditation, or that the provider was exempt from the requirement. Lastly, UPHP was not consistently collecting disclosure of ownership and control interest forms as part of the initial and recredentialing process.

Recommendation: While UPHP was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that UPHP continually evaluate its processes, procedures, and monitoring efforts, including oversight of delegated entities, to ensure compliance with all federal and MDHHS-set standards specific to the credentialing and recredentialing of network providers.

Weakness #2: UPHP received a *Not Met* score for four elements within the Confidentiality program area, indicating inadequate processes related to the use and disclosure of individually identifiable health information in accordance with privacy requirements in 45 CFR parts 160 and 164. [Quality, and Access]

Why the weakness exists: UPHP's confidentiality policies and procedures did not adequately address exceptions to the minimum necessary rule, member rights to request privacy protection of their PHI, and an accounting of disclosures of PHI. Additionally, the content of UPHP's notice of privacy practices was not complete.

Recommendation: While UPHP was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that UPHP continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to privacy requirements. HSAG further recommends UPHP continue to implement procedures to ensure all policies clearly delineate how UPHP complies with confidential communication requests and restrictions of PIHP requests.

Weakness #3: UPHP received a *Not Met* score for nine elements within the Grievance and Appeal Systems program area, indicating members may not have access to all rights and required information when filing a grievance or requesting an appeal. [Quality, Timeliness, and Access]

Why the weakness exists: Several gaps in UPHP's grievance and appeal processes were identified. Specifically, identified gaps were related to written acknowledgement of grievances and appeals; adequate review and resolution of grievances; written notice of grievance resolution time frame extensions; an appeals committee; timely denied requests for expedited appeals and notice to members; appropriate review of dental appeals and potential dental emergency conditions; and pre-service authorization requests for dental services, the member's right to request a copy of the case file, and information provided to subcontractors related to the member's grievance and appeal systems.

Recommendation: While **UPHP** was required to submit a CAP to address each of the identified deficiencies, HSAG recommends that **UPHP** continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to grievances and appeals. HSAG further recommends that **UPHP** implement procedures to ensure model notices used are the most current version required by MDHHS, and that **UPHP** follow requirements of the Three-Way Contract to guarantee adherence to Medicaid managed care rules for grievance and appeal notices.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Performance Results

HSAG’s NAV results indicated that **UPHP** did not meet all Medicaid and LTSS minimum network requirements for Region 1. **UPHP** submitted requests for exceptions to address provider types that did not meet the minimum network requirements. MDHHS approved **UPHP**’s requested exceptions for the Adult Day Program, Dental, Eye Examinations, Hearing Aids, Hearing Examinations, and NEMT provider types in Region 1. Table 3-67 presents **UPHP**’s region-specific NAV results by Medicaid and LTSS provider type following all data resubmissions and MDHHS’ exception determinations.

Table 3-67—SFY 2023 NAV Results for UPHP, by Region and Provider Type

| Provider Type | Region 1 Validation Result |
|--|----------------------------|
| Provider Types With Travel Time and Distance Requirements | |
| Adult Day Program | <i>Exception Granted</i> |
| Dental | <i>Exception Granted</i> |
| Eye Examinations | <i>Exception Granted</i> |
| Eye Wear | <i>Met</i> |
| Hearing Aids | <i>Exception Granted</i> |
| Hearing Examinations | <i>Exception Granted</i> |
| Provider Types Rendering Home-Based Services | |
| Adaptive Medical Equipment and Supplies | <i>Met</i> |
| Assistive Technology—Devices | <i>Met</i> |
| Assistive Technology—Van Lifts and Tie Downs | <i>Met</i> |
| Chore Services | <i>Met</i> |
| Community Transition Services | <i>Met</i> |
| ECLS | <i>Met</i> |
| Environmental Modifications | <i>Met</i> |

| Provider Type | Region 1 Validation Result |
|---|----------------------------|
| Fiscal Intermediary | Met |
| Home-Delivered Meals | Met |
| MIHP Agency | Met |
| Medical Supplies | Met |
| NEMT | Exception Granted |
| Non-Medical Transportation | Met |
| Personal Care Services | Met |
| Personal Emergency Response System | Met |
| Preventive Nursing Services | Met |
| Private Duty Nursing | Met |
| Respite | Met |
| Skilled Nursing Home | Met |
| Percentage of Total Requirements Met* | 76% |
| Percentage of Total Requirements Met Inclusive of Granted Exceptions | 100% |

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: For all Medicaid and LTSS minimum network requirements for Region 1, **UPHP** either met the minimum network requirements or supplied additional documentation to detail the alternative approaches used to ensure adequate services for MI Health Link members (e.g., community supports and resources). [Access]

Weaknesses and Recommendations

Weakness #1: HSAG identified no specific weaknesses for **UPHP** based on the SFY 2023 NAV, as **UPHP** demonstrated that it contracted with all available providers for the provider types that did not meet minimum network requirements and supplied evidence of additional supports (e.g., community supports and resources) to provide adequate care to MI Health Link members in Region 1.

Why the weakness exists: NA

Recommendation: UPHP should maintain an internal data verification process to continually identify and contract with Adult Day Program, Dental, Eye Examinations, Hearing Aids, Hearing Examinations, and NEMT providers as they become available in Region 1 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.

Secret Shopper Survey

Performance Results

HSAG attempted to contact 21 sampled provider locations (i.e., “cases”) for UPHP, with an overall response rate of 85.7 percent (18 cases) among UPHP’s one MI Health Link region. Table 3-68 summarizes the SFY 2023 secret shopper survey response rates for UPHP, and for UPHP’s contracted MI Health Link region.

Table 3-68—Summary of UPHP Secret Shopper Survey Results for Routine Dental Visits, by Region³⁻⁴⁴

| | | Response Rate | | Accepting ICO | | Accepting MI Health Link | | Accepting New Patients | |
|-------------------|--------------------|---------------|-----------------------|---------------|-----------------------|--------------------------|-----------------------|------------------------|-----------------------|
| Region | Total Survey Cases | Cases Reached | Rate (%) ¹ | Accepting ICO | Rate (%) ² | Accepting MI Health Link | Rate (%) ² | Accepting New Patients | Rate (%) ² |
| Region 1 | 21 | 18 | 85.7% | 12 | 66.7% | 12 | 66.7% | 9 | 50.0% |
| UPHP Total | 21 | 18 | 85.7% | 12 | 66.7% | 12 | 66.7% | 9 | 50.0% |

¹ The denominator includes total survey cases.

² The denominator includes cases reached.

Table 3-69 displays the number of cases in which the survey respondent offered appointments to new patients for routine dental visits, as well as summary wait time statistics for UPHP, and for UPHP’s contracted MI Health Link region. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

³⁻⁴⁴ Denominators used for the 2023 accepting MI Health Link and accepting new patient rates include cases reached. In 2022 and 2021, denominators for these rates were different. The accepting MI Health Link rate’s denominator included cases responding to the survey and indicating that at least one practitioner at the location accepted the requested ICO. The accepting new patient rate’s denominator included cases responding to the survey that accepted the ICO and MI Health Link. Caution should be exercised when comparing the 2023 results to the 2022 and 2021 results.

Table 3-69—Summary of UPHP Secret Shopper Survey Appointment Availability Results, by Region

| Region | Total Survey Cases | Cases Contacted and Accepting New Patients | Cases Offered an Appointment | | | Appointment Wait Time (Days) ³ | | | |
|-------------------|--------------------|--|------------------------------|--|--|---|------------|------------|------------|
| | | | Number | Rate Among All Surveyed Cases ¹ (%) | Rate Among Cases Accepting New Patients ² (%) | Min | Max | Average | Median |
| Region 1 | 21 | 9 | 6 | 28.6% | 66.7% | 1 | 228 | 147 | 177 |
| UPHP Total | 21 | 9 | 6 | 28.6% | 66.7% | 1 | 228 | 147 | 177 |

¹ The denominator includes total survey cases.

² The denominator includes cases reached that accept the ICO, MI Health Link, and new patients.

³ MDHHS' wait time standard for initial dental appointments is eight weeks.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Of the 21 total survey cases, 85.7 percent (n=18) of the provider locations could be contacted. [Quality and Access]

Weaknesses and Recommendations

Weakness #1: Of the cases reached, 66.7 percent of provider locations accepted UPHP and the MI Health Link program, and 50.0 percent accepted new patients. [Access]

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

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

Weakness #2: Among all surveyed cases, the overall appointment rate was 28.6 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 being required to complete pre-registration or provide additional personal information to schedule an appointment and being required to verify eligibility by providing a member Medicaid ID number. While callers did not specifically ask about limitations to appointment availability, HSAG notes that these considerations may represent common processes among providers' offices to facilitate practice operations.

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

Encounter Data Validation

Performance Results

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

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

Table 3-70 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-70—EDV Results for UPHP

| Analysis | Key Findings |
|------------------------------------|---|
| IS Review | |
| Encounter Data Sources and Systems | <ul style="list-style-type: none"> • UPHP used Python and Peter Chang Enterprise, Inc. (PCE)/ELMER as its primary software for claim adjudication and encounter preparation. • UPHP had established procedures to identify and manage duplicate claims. Regarding its submission practices, UPHP clarified that it does not submit encounters for claims denied due to primary insurance, member ineligibility, inappropriate providers, or those failing Community Health Automated Medicaid Processing System (CHAMPS) editing. For adjustments, UPHP reviewed encounter rejections weekly for necessary adjustments, ensuring accepted headers and line-level accuracy. Incorrectly submitted encounters are adjusted to ensure acceptance. • UPHP and its subcontractors were responsible for collecting and maintaining provider information. Additionally, UPHP handled enrollment data received from MDHHS via 834 files. Subcontractors received these files from UPHP and utilized them for processing encounter data. |
| Payment Structures | <ul style="list-style-type: none"> • UPHP utilized various claim payment methods for different encounter types. In inpatient encounters, it employed line-by-line, per diem/variable per diem, and DRG methods. For outpatient encounters, the methods included percent billed, line-by-line, and negotiated (flat) rate. Pharmacy encounters were processed using the ingredient cost method, as well as an unspecified method. • UPHP obtained primary insurance information from MDHHS files and provider claims. If it was missing, UPHP requested MDHHS to include it. When a member's primary insurance was billed, UPHP paid up to Medicaid's rate but not more than cost sharing. If the primary insurer paid more, the claim was approved at \$0. If not billed, the claim was denied. If other insurance details come later, UPHP recouped the payment and denied the claim. UPHP confirmed primary insurance through CHAMPS using MDHHS files and stored the data on its network. TPL details were included in encounter files. |
| Encounter Data Quality Monitoring | <ul style="list-style-type: none"> • UPHP and/or its subcontractors performed several data quality checks on the encounter data collected. These checks included analyzing claim volume by submission month (for pharmacy subcontractor encounters), assessing field-level completeness and validity (for all subcontractor encounters), and evaluating whether the payment fields in the claims align with the financial reports (for dental subcontractor encounters). |

| Analysis | Key Findings |
|---------------------------------------|--|
| | <ul style="list-style-type: none"> For encounters collected by UPHP, it only conducted data quality checks solely by assessing field-level completeness and accuracy for the encounters collected. |
| Administrative Profile | |
| Encounter Data Completeness | <ul style="list-style-type: none"> UPHP displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. UPHP had a low volume of duplicate encounters, with 0.1 percent of professional encounters, less than 0.1 percent of institutional encounters, 0.3 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative. |
| Encounter Data Timeliness | <ul style="list-style-type: none"> UPHP demonstrated timely submission of professional, institutional, and pharmacy encounters. Within 60 days, UPHP submitted 98.8 percent of professional encounters and 97.5 percent of institutional encounters to MDHHS after the payment date. Within 90 days, UPHP submitted 97.7 percent of pharmacy encounters to MDHHS after the payment date. UPHP did not demonstrate timely submission of dental encounters, with 29.1 percent of dental encounters submitted to MDHHS within 60 days of the payment date. Within 180 days of payment, UPHP submitted 57.9 percent of dental encounters to MDHHS, and within 330 days, UPHP submitted 95.9 percent of dental encounters to MDHHS. |
| Field-Level Completeness and Accuracy | <ul style="list-style-type: none"> In UPHP's submitted professional encounters, the billing provider NPI was populated 55.9 percent of the time, and the rendering provider NPI was populated 2.4 percent of the time. All other data elements in UPHP's submitted data had high rates of population and validity. |
| Encounter Referential Integrity | <ul style="list-style-type: none"> Of all identified member IDs in UPHP's submitted professional, institutional, and dental encounter data, 100 percent were identified in the enrollment data. Of all identified member IDs in UPHP's submitted pharmacy data, 99.9 percent were identified in the enrollment data. Of all identified provider NPIs in UPHP's submitted professional, institutional, and dental encounter data, 100 percent were identified in the provider data. Of all identified provider NPIs in UPHP's submitted pharmacy encounter data, 91.3 percent were identified in the provider data. |
| Encounter Data Logic | <ul style="list-style-type: none"> No major concerns were noted for UPHP. |

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Strength #2: UPHP submitted professional, institutional, and pharmacy encounters in a timely manner from the payment date, with greater than 97 percent of these encounters submitted within 90 days of the payment date. [Quality and Timeliness]

Strength #2: Across all categories of service, all key data elements for **UPHP** were populated at high rates, and all but one was greater than 99 percent valid. [Quality]

Weaknesses and Recommendations

Weakness #1: UPHP did not indicate timeliness quality checks were performed for claims/encounters originating from all of its subcontractors. [Quality]

Why the weakness exists: Timeliness quality checks are crucial to ensuring that claims and encounters are submitted within the stipulated time frames.

Recommendation: UPHP should enhance its timeliness quality checks by considering, among other actions, the implementation of regular timeliness audits, the adoption of automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions, and periodic reviews and adjustments of timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

Weakness #2: UPHP reported only conducting the field-level completeness and accuracy quality check for claims/encounters stored in its data warehouses. [Quality]

Why the weakness exists: No other checks, such as the monthly claim volume submission or timeliness, were mentioned.

Recommendation: UPHP should enhance its quality checks for claims and encounters collected and stored by **UPHP** by considering the following, among other actions:

- Implement timeliness checks to ensure that submissions comply with State or contractual deadlines.
- Create a standardized process for checking claim volume submissions to confirm that they align with expected volumes.

- Implement automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions.
- Periodically review and adjust timeliness quality checks based on performance data and any changes in regulations or contractual requirements.

Weakness #3: Although **UPHP** submitted professional, institutional, and pharmacy encounters in a timely manner, **UPHP** did not submit dental encounters timely. About 58 percent of dental encounters were submitted within 180 days of payment. [**Quality and Timeliness**]

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

Recommendation: **UPHP** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #4: Although 100 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 91.3 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: **UPHP** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #5: Although not required to be populated, 55.9 percent of professional encounters contained a billing provider NPI, and 2.4 percent contained a rendering provider NPI. [**Quality**]

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

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

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

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

Why the weakness exists: NA

Recommendation: While no **UPHP**-specific results could be presented, the statewide analysis identified that the 2023 top-box score for the *Recommend Personal Assistance/Behavioral Health Staff* measure was statistically significantly lower than the 2021 top-box score. This demonstrates a statistically significant decline from 2023, indicating opportunities for improvement for the MI Health Link program. Additionally, the lowest performing measure was *Planning Your Time and Activities* with a 2023 top-box score of 63.70 percent, indicating opportunities to promote community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day. Therefore, HSAG recommends that **UPHP** develop and implement interventions to improve member experience related to the *Recommend Personal Assistance/Behavioral Health Staff* and *Planning Your Time and Activities* measures. HSAG further recommends that **UPHP** develop innovative approaches to increase the number of members participating in future survey administrations.

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

HSAG performed a comprehensive assessment of **UPHP**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **UPHP** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **UPHP**'s overall performance contributed to the MI Health Link program's progress in achieving the CQS goals and objectives. Table 3-71 displays each MDHHS CQS goal and EQR activity results that indicate whether the ICO positively (✓) or negatively (✗) impacted the MI Health Link program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **UPHP**'s Medicaid members.

Table 3-71—Overall Performance Impact to CQS and Quality, Timeliness, and Access

| Performance Area | Overall Performance Impact | Performance Domain |
|---|--|---|
| Goal #1 —Ensure high quality and high levels of access to care | <ul style="list-style-type: none"> ✓ The ICO either met, or was granted an exception, for all minimum network requirements for all provider types with capacity-based requirements and for all provider types with travel time and distance requirements. ✓ Nearly 90 percent of dental provider locations could be contacted through secret shopper calls. ✓ The ICO was a high performer in providing annual dental visits to its ICO members, which is attributed to several quality initiatives focused on outreach to members to educate them on the dental benefit for the MI7.3 <i>Annual Dental Visit</i> performance measure. ✓ The ICO's rate for the <i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i> measure indicator increased by more than 5 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. ✓ The ICO's rates for the <i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i> measure indicators increased by more than 15 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide averages. ✗ Only 66.7 percent of dental providers reported accepting the ICO and accepting MI Health Link, and only 50 percent of dental providers reported accepting new patients during secret shopper calls. ✗ The overall dental appointment rate among all surveyed providers was only 28.6 percent. ✗ The median wait time for a dental appointment was 177 days, and the maximum wait time for a dental appointment was | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| | <p>228 days, both of which exceeded MDHHS' initial dental appointment standard of eight weeks (i.e., 56 calendar days).</p> <ul style="list-style-type: none"> ✗ The ICO's rate for the <i>SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy</i> measure indicator decreased by more than 9 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ The ICO's rate for the <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> measure indicator decreased by more than 13 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ The ICO's rate for the <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i> measure indicator decreased by more than 19 percentage points from MY 2021 to MY 2022 and fell below the HEDIS MY 2022 MI Health Link statewide average. ✗ While only 9 of the 40 reported HEDIS measures rates (22 percent) indicated worse performance than the statewide average, opportunity exists for the ICO to further improve performance across multiple HEDIS domains impacting quality and high levels of access to care. | |
| Goal #2 —Strengthen person and family-centered approaches | The ICO's findings for the EQR activities did not substantially impact Goal #2. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |
| Goal #3 —Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external) | <ul style="list-style-type: none"> ✓ The ICO implemented the Patient Access API and the Provider Directory API. ✓ The ICO demonstrated improvement in the MI2.6 <i>Timely Transmission of Care Transition Record to Health Care Professional</i> performance measure with increasing timely care transition record notifications through continued facility engagement and focus on health information exchanges to include ADT alerts. | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |
| Goal #4 —Reduce racial and ethnic disparities in healthcare and health outcomes | <ul style="list-style-type: none"> ✓ The ICO's QAPI program addressed social determinants of health to reduce health disparities experienced by different subpopulations of members. ✓ The ICO's QIP demonstrated significant improvement for American Indian/Alaska Native members receiving an annual dental visit. | <input type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Performance Area | Overall Performance Impact | Performance Domain |
|---|---|---|
| | <ul style="list-style-type: none"> ✗ The ICO did not incorporate any race and ethnicity data other than the data submitted by MDHHS in the 834 enrollment file for the MI7.3 <i>Annual Dental Visit</i> performance measure. ✗ The ICO did not achieve the QIP goal of eliminating the existing disparity between the two subgroups with the first remeasurement period. | |
| Goal #5 —Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | The ICO’s findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact value-based initiatives and payment reform had on improving quality outcomes for the ICO’s members. However, Table 5-5—CMS Core Measure Quality Withhold Results within Section 5 provides information on the results of MDHHS’ quality withhold program for the ICO. The information for the quality withhold program was provided by MDHHS and not assessed through the EQR activities. | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

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

From the findings of each ICO’s performance for the SFY 2022 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the MI Health Link program. The recommendations provided to each ICO for the EQR activities in the *State Fiscal Year 2022 External Quality Review Technical Report for Integrated Care Organizations* are summarized in Table 4-1 through Table 4-6. The ICO’s summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-6.

Aetna Better Health Premier Plan

Table 4-1—Prior Year Recommendations and Responses for AET

| 1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects |
|---|
| <p>HSAG recommended the following:</p> <ul style="list-style-type: none"> • Aetna received a <i>Met</i> score for only 75 percent of the requirements in the Design stage of the project, indicating gaps in the ICO’s documentation which led to the overall validation rating of <i>Partially Met</i>. Aetna had opportunities for improvement within the analysis and reporting of plan-specific data used to select the QIP topic and the reporting of the sampling method used in the generation of the performance indicators. Specifically, Aetna did not conduct or report statistical testing between the subpopulations to confirm an existing disparity and did not report an accurate eligible population size. Additionally, without an accurate eligible population size, the margin of error and whether the sample was generalizable to the eligible population could not be verified. HSAG recommends that Aetna review the QIP Completion Instructions to ensure that all requirements for each completed evaluation element have been addressed. Aetna should seek technical assistance from HSAG throughout the QIP process to address any questions or concerns. |
| <p>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)</p> |
| <p>a. Describe initiatives implemented based on recommendations <i>(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)</i>:</p> <ul style="list-style-type: none"> • Since initial submission technical assistance was requested from the HSAG team in December 2022, March 2023, and August 2023. Missing statistical analysis and narrative summaries were completed using HSAG preferred statistical testing calculators. |
| <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> • PIP validation submission in July 2023 showed all critical elements met for an overall validation score of 86%. Statistical testing was completed and Aetna anticipates receiving a “met” score on any unmet/partially met items from the 2023 remeasurement report in the final review. MDHHS responded |

1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects

favorably to Aetna's assessment and re-evaluation of barriers/interventions to address health equity and asked the plan to present its project approach at the 10/2023 ICO quality workgroup.

- c. Identify any barriers to implementing initiatives:
- None.

HSAG Assessment: HSAG has determined that [Aetna](#) addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. The ICO revised and improved its documentation for all evaluation elements that received a partially met score within the Design stage of the QIP.

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

HSAG recommended the following:

- Although [Aetna](#) improved the MI5.6 rate since SFY 2021, it continued to have a low MI5.6 rate in comparison to the other ICOs' reported rates. [Aetna](#) did not leverage any of the medication reviews conducted by a clinical pharmacist. HSAG recommends that [Aetna](#) prioritize leveraging its ICO clinical pharmacist to conduct medication reviews for members, as discussed during the virtual audit review. Leveraging clinical pharmacists to complete medication reviews will support timely quality care for members and provide [Aetna](#) with additional MI5.6 numerator compliant members, improving its overall rate.
- [Aetna](#) was required to update its Core Measure 9.3 source code and to resubmit Core Measure 9.3 data to HPMS. [Aetna](#) did not update its source code to align with the Core Measure 9.3 FAQs that were released in December 2021, and [Aetna](#) incorrectly identified members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original institutional facility admission (IFA) discharge. HSAG recommends that [Aetna](#) ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. [Aetna](#) should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.
- [Aetna](#) could not use data from one of its delegated PIHPs in the MI2.6 sample. The PIHP had incorrectly reported a discharge status code that indicated the members were still inpatient; therefore, [Aetna](#) could not appropriately identify if a member had been discharged for inclusion in MI2.6. HSAG therefore recommends that [Aetna](#) issue a formal CAP to the PIHP to ensure it provides accurate data reflecting members' hospital discharges so that [Aetna](#) can include these members in future MI2.6 reporting.
- For 33 of the 45 reported HEDIS measures (73 percent), [Aetna](#)'s rates indicated worse performance than the statewide average across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization. HSAG recommends that [Aetna](#) focus on improving performance for measures included in these domains.
- In the Prevention and Screening domain, [Aetna](#)'s rate for the *COA—Care for Older Adults—Advance Care Planning* measure indicator decreased by more than 14 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that adult members 66 years of age and older were not always having advance care planning conducted to help optimize quality of life.

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

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

- In the Access/Availability of Care domain, **Aetna**'s rate for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator decreased by more than 7 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults with a new episode of alcohol or other drug dependence were not always receiving timely treatment. HSAG recommends that **Aetna** conduct a root cause analysis or focused study to determine why some adults with a new episode of alcohol or other drug dependence were not accessing timely treatment. Upon identification of a root cause, **Aetna** should implement appropriate interventions to improve the performance related to the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator. **Aetna** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).
- **Aetna** identified a discrepancy with Core Measure 9.3 data element C after data had already been finalized in HPMS, following the conclusion of the SFY 2022 PMV activity. HSAG recommends that **Aetna** ensure all appropriate quality checks and assurance steps are in place in order to avoid this issue from recurring in the future. While this recommendation is related to appropriately recalculating Core Measure 9.3 data element C at any point when data element A is updated, this recommendation also applies to submission of any Michigan-specific and MMP Core measures to the FAI DCS and HPMS.

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)

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - 5.6: In Q4 2021, Aetna implemented an ongoing clinical pharmacist review program. This intervention improved rates in 2023 reporting. Aetna expects similar impacts in 2024 reporting. The reviews conducted by the clinical pharmacists are captured in a supplemental data file and therefore appear in our reporting as administrative numerator events.
 - 2.6: On 11/2/2022, Aetna met with [Name of Staff Member] of the Detroit Wayne Integrated Health Network (DWIHN) to discuss omission of inpatient discharges from the DWIHN in our MI 2.6 data. On 11/17/2022 we received notice from DWIHN that the issue was corrected through a software change to the UB40 as of 11/10/2022. However, it was later determined that the encounters continued to reflect an incorrect discharge status code. Therefore, on 9/18/23, Aetna initiated the internal process to request a formal Corrective Action Plan from the DWIHN PIHP on the encounter data they are submitting to Aetna.

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

- HEDIS Measures Overall: After review of 2022 MY HEDIS rates, interventions were implemented addressing access to care, preventive care, experience, medication management, and condition management. Aetna is also addressing areas of health equity both internally and externally as well as addressing ways to best utilize Social Determinants of Health (“SDoH”) data collected from members to overcome unique barriers to care.
- HEDIS Advanced Directive: In 2022 members who had an IP stay were specifically targeted to address advance care planning. Additionally, advanced care planning is a part of every new or updated care plan.
- HEDIS IET [Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment]: Aetna reviewed the data and the recommendations and initiated the creation of a workgroup to address these rates and development of SUD condition specific interventions.
- 9.3 bullet 1 Source Code: Aetna was directed to change the reporting logic to include denied claims when looking to determine if a member was discharged to the community in respect to Element B. Aetna had been reporting on paid claims only for both Element A and Element B, as stated in the reporting guidance.
- Aetna reviews reporting guidance and supporting materials as they are issued to evaluate if updates are required for our reporting logic. Updates are documented and tracked through an internal tool (QuickBase), which identifies the source of the code updates, tracks the changes made and undergoes a secondary quality check of the logic, as well as the results. When completing our deliverables, we complete a technical review of the report when it is developed and have the business area responsible complete a business assurance quality check.
- In addition to our standard review process, Aetna has implemented internal audits of regulatory deliverables and additional quality reviews of processes to support continued efforts for improvements. These processes went into effect in September 2023.
- 9.3 bullet 2 Element C discrepancy: Aetna implemented additional levels of review for regulatory deliverables and an internal audit process to ensure we are consistently following our procedures for documenting, producing, reviewing and submitting our reports. For Core 9.3, a dashboard was produced to support this measure that calculates the elements that will be uploaded and the supporting detail that will be used for validating the results in real time. The tool will minimize the need for manual calculations when producing the data for review. Changes to this dashboard will be documented and tracked through a QuickBase tool that we use, which documents the source of the changes, technical quality checks and business approval.

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- 5.6: From 2021 to 2022 Aetna saw a rate of improvement of 44% with a final rate of 87.83% compared to the prior year final rate of 49.64%
 - 2.6: Aetna continues to work with DWIHN to correct the issue with encounter submissions.
 - HEDIS Measures Overall: Overall, HEDIS rates from 2021MY to 2022MY showed improvements with some of the strongest improvements in the areas of Prevention and Screening (COA [Care for Older Adults] – Med [medication] reviews), Respiratory Conditions (PCE [Pharmacotherapy Management of COPD Exacerbation] – both numerators), Diabetes (control, poor control, eye exams, and blood pressure), Behavioral Health (AMM [Antidepressant Medication Management], FUH [Follow-Up After Hospitalization for Mental Illness], and FUM [Follow-Up After Emergency Department Visit for Mental Illness]), and Med Management and Care Coordination (Transition of

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

Care (“TRC”) – Med Reviews). For all HEDIS metrics, Aetna is still evaluating 2022 MY results and assessing effectiveness of programming to adjust strategies as appropriate.

- HEDIS Advanced Directive: Performance for the advanced care measure (now a standalone measure) for the 2022MY improved by 43% over 2021MY rates.

c. Identify any barriers to implementing initiatives:

- 5.6: Creating gap reporting for internal teams is a manual process. TRC post discharge med-reviews do not meet criteria for the metric so there remains some duplication of work.
- 2.6: Reoccurrence of discharge status on DWIHN PIHP encounters incorrectly defaulting to “30,” which is not a discharge status code that identifies discharges for inclusion in the MI 2.6 measure.
- HEDIS Measures Overall: Health equity and SDoH barriers remain. Additionally, difficulty reaching and/or engaging members in services necessary for best health remains a concern.
- HEDIS Advanced Directive: No barriers to intervention.
- HEDIS IET: Adjusting to the BH [behavioral health] changes as two PIHPs left the demonstration in addition to ongoing vacancy of the BH Liaison position on the CM [care management] team.
- 9.3 bullet 1 Source Code: The code was not written to eliminate denied claims as a means to identify discharges to the community, but rather to follow the reporting guidance. The code logic Aetna used for calculating Element B takes all hospital and facility claims and lines the spans up sequentially to check for readmissions and hospitalizations that occur after the facility discharges identified in Element A. By including denied claims, we not only identified readmissions and hospitalizations that were not reported, but we also identified claims that eliminated discharges that were previously reported as occurring within 100 days (due to the denied claim showing that the stay extended beyond the 100 days), which also impacted the reporting results for Element B.
- The FAQ was ambiguous in that it only spoke to looking at denied claims as it relates to being discharged to the community but did not address the fact that this contradicts the guidance given for determining inclusion Element B, which states to only include paid claims. This contradiction was not corrected to remove the language that stated to “Report on all paid claims only” until the CY2023 reporting guidance was issued.
- 9.3 bullet 2 Element C discrepancy: No barriers identified.

HSAG Assessment: HSAG has determined that [Aetna](#) partially addressed the prior year’s recommendations. [Aetna](#) addressed the prior year’s recommendation for MI5.6 to prioritize leveraging its ICO clinical pharmacist to conduct medication reviews for members. [Aetna](#) incorporated supplemental data from clinical pharmacist medication reviews that were maintained in the Dynamo Case Tracker system. This significantly improved the reported rate from the prior year.

[Aetna](#) addressed the prior year’s recommendation for Core Measure 9.3 to carefully review newly released FAQs as well as the annual release of the MMP Core Reporting Requirements to identify whether source code requires updates, test the output of any revised source code by reviewing the raw data in comparison to the source system, and involve input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements. HSAG did not identify any findings related to [Aetna](#)’s Core Measure 9.3 source code, and resubmission of Core Measure 9.3 data was not required for the SFY 2023 PMV activity.

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

Aetna has put forth effort to address the prior year's recommendation for MI2.6 to issue a formal CAP to the PIHP to ensure it provides accurate data reflecting members' hospital discharges so that **Aetna** could include these members in future MI2.6 reporting. **Aetna** continued working with the PIHP to correct the issue with encounter submissions. However, similar to the prior year, **Aetna** could not use data from one of its delegated PIHPs in the MI2.6 sample. During the SFY 2023 PMV activity, the PIHP had incorrectly reported a discharge status code that indicated the members were still inpatient; therefore, **Aetna** could not appropriately identify if a member had been discharged for inclusion in MI2.6. As such, HSAG continues to recommend that **Aetna** issue a formal CAP to the PIHP to ensure it provides accurate data reflecting member hospital discharges so that **Aetna** can include these members in future MI2.6 reporting. Although this data gap had a marginal impact on the eligible population, the denominator sample, and the numerator, the MI2.6 data were still underreported as a result of this issue.

Aetna has put forth effort to improve performance for measures in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization domains. **Aetna** implemented interventions to address access to care, preventative care, experience, medication management, and condition management. Additionally, **Aetna** worked to address areas of health equity and its use of social determinants of health data to overcome barriers to care. However, some measures in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, Access/Availability of Care, and Risk-Adjusted Utilization domains were below the statewide average for MY 2022. As such, **Aetna** should continue to monitor and focus its efforts on improving measures in these domains. This should include timely application of interventions when performance continues to be low.

NCQA removed the *Advanced Care Planning* measure indicator for HEDIS MY 2022, so an assessment of **Aetna**'s performance for the measure was not able to be performed, however it should be noted that **Aetna** put forth effort towards improving performance for the *COA—Care for Older Adults—Advance Care Planning* measure indicator by targeting members who had an inpatient stay to address advance care planning and incorporated advanced care planning as part of every new or updated care plan.

Data were not available for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator for HEDIS MY 2022, however it should be noted that **Aetna** put forth effort towards improving performance for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator by creating a workgroup to address the rates and development of SUD condition specific interventions.

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

HSAG recommended the following:

- **Aetna** received a *Not Met* score for eight elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. As **Aetna** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and,

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

as such, HSAG further recommends that **Aetna** ensure it consistently uses the most current version of the model member materials.

- **Aetna** received a score of *Not Met* for eight elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. As **Aetna** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members. These efforts should support improved member health outcomes.

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 completed the below activities to address the Member Rights and Member Information recommendations:
 - Aetna updated its Member Rights and Responsibilities policy to include all member rights specified in Appendix B of the Contract.
 - Aetna updated its Annual Materials Process Desktop to include the 30-day notification of change timeframe.
 - Aetna updated its CY23 Member Handbook with the member rights identified as missing by HSAG as well as all necessary information as specified in the Contract and 42 CFR §438.10(g).
 - Aetna enlarged the disclaimer to 18-point, bold font in the required CY23 materials explaining the availability of written translation or oral interpretation.
 - Aetna added a description of the roles of the Integrated Care Team (ICT) and the process for members to select and change their PCP to its website provider directory.
 - Aetna's website now includes an additional version of our provider directory and formulary drug list in a machine-readable format.
 - Aetna completed the below activities to address the Coordination and Continuity of Care recommendations:
 - Aetna updated the Outreach and Enrollment desktop and ICM [Integrated Care Management] Program Description, and retrained care coordinators on the member file review process.
 - Aetna re-educated staff on the Initial Screening Tool process and Outreach and Enrollment desktop. Aetna also re-educated our clinical health services management team on the dashboard reporting features and required monitoring of timeliness of the Initial Screening Tool completion.
 - Aetna updated procedures to include the correct 5 business day Level II assessment referral timeframes and re-educated staff on the requirement.
 - Aetna updated procedures to include the Level II assessment completion within 15 calendar days of referral and re-educated staff on the requirement.
 - Aetna's low-risk care plan was discontinued and a standard IICSP [integrated individualized care and supports plan] is used for all members, inclusive of goals, objectives, and outcomes, including each specific intervention's due date and the name of the person responsible for that intervention. Staff were re-educated on the IICSP required elements and an IICSP toolkit was implemented as a

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

resource for all IICSP requirements. The IICSP audit process was updated to include review of all IICSP required elements.

- Aetna's Care Management dashboard reporting system has been updated to include ABD notifications from delegated entities in a single source as a care coordinator real-time notification tool.
- Aetna developed a documented process to include notification to the clinical leadership team of instances of suspected or confirmed member fraud, waste, and abuse. Aetna's clinical teams developed a documented process to review the notifications and determine the appropriate action, including shortening the period of advance notice as applicable.
- Aetna updated our process and systems to send an IDN [integrated denial notice] for every claim denial regardless of member financial liability.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- None noted at this time.

c. Identify any barriers to implementing initiatives:

- No barriers identified.

HSAG Assessment: HSAG has determined that [Aetna](#) addressed the prior year's recommendations based on the responses provided by the ICO, and HSAG's review of the ICO's CAP and CAP progress updates. [Aetna](#) submitted appropriate action plans to address each deficiency, which were approved by HSAG and MDHHS. [Aetna](#)'s implementation of its action plans to address the requirements under the Member Rights and Member Information and Coordination and Continuity of Care program areas will be reviewed during the SFY 2024 CAP review. [Aetna](#) should also implement any recommendations made by HSAG through the CAP and CAP progress updates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- [Aetna](#) should maintain an internal data verification process to continually identify and contract with Adult Day Program and MIHP Agency provider types as they become available in Region 4 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations (*include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation*):

- The Aetna Better Health Premier Plan network [ABHPP] management team reviews on a quarterly basis to identify if any new providers have entered Region 4 under either Adult Day or Maternal Infant Health Provider specialties. If new providers are available to join the network the ABHPP network manager will initiate the contracting process.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Not applicable as additional providers did not join the network in Region 4 to aid in the deficiency of Maternal Infant Health Providers nor Adult Day Health.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

c. Identify any barriers to implementing initiatives:

- There are no providers available for the health plan to contract with in the failed zip codes of Region 4. Due to a lack of providers this gap in network deficiency cannot be remediated unless a new provider enters the market in either of those specialties.

HSAG Assessment: HSAG has determined that **Aetna** partially addressed the prior year's recommendations, as **Aetna** met the minimum network requirements for the MIHP Agency provider type in Region 4; however, **Aetna** did not meet the minimum network requirements for the Adult Day Program provider type in Region 4. As such, HSAG recommends that **Aetna** continue strategizing innovative ways to identify and contract with Adult Day Program provider types as they become available in Region 4. Additionally, **Aetna** should assess barriers to contracting with available Adult Day Program providers in Region 4 and identify opportunities to mitigate those barriers.

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Of the 331 total survey cases, only 65.3 percent (n=216) of provider locations could be contacted. **Aetna's** dental provider data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program. HSAG recommends that **Aetna** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies. Additionally, as MDHHS required Aetna to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Only 39.2 percent of sampled provider locations accepted and/or recognized the MI Health Link program. **Aetna's** data included inaccurate information regarding the provider location's acceptance of the MI Health Link program. HSAG recommends that **Aetna** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **Aetna** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Of cases in which the survey respondent reported that the provider location accepted **Aetna**, the MI Health Link program, and new patients, appointment availability was reported for 34.0 percent of cases. However, this results in appointment availability for 5.4 percent of **Aetna's** total sample. 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. HSAG recommends that **Aetna** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Aetna** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

- DentaQuest implemented access and appointment availability surveys on a quarterly basis to generate reminders to provider offices to keep their provider office information current and up to date.
- DentaQuest send a provider educational bulletin to their Michigan dental network to provide education about the Michigan Health Link program as name recognition was a barrier to office staff and the secret shopper caller. This education material is sent every quarter and is intended to garner name recognition to the state name of the MMP program. Additionally, providers will receive education regarding Michigan Health Link during provider training webinars offered every quarter.
- For provider offices where the fax number was not validated, DentaQuest will contact each office to ensure updated information within their system so future faxes can be successfully sent to the correct number.
- For offices where a phone number was incorrect, or the phone number did not connect DentaQuest will outreach each of those offices to ensure the correct phone number is listed.
- For location that does not exist the provider information was removed from the DentaQuest provider network, location is a medical facility, location unavailable all included DentaQuest phone outreach to validate provider information.
- For instances of location does not accept MI Health Link, location does not accept new patients.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- 2023 Secret shopper is underway and based upon those results will determine if the DentaQuest initiatives were successful.

c. Identify any barriers to implementing initiatives:

- No barriers to implementing initiatives; however, barriers remain with dental office administrative staff turnover and knowledge gaps. Reliance on dental providers to keep updated office data.

HSAG Assessment: HSAG has determined that [Aetna](#) addressed the prior year's recommendations. [Aetna](#)'s dental delegate implemented appropriate interventions, and the results of the SFY 2023 activity demonstrated some improvement from the prior year. Specifically, the percentage of provider locations able to be contacted increased; the percentage of sampled provider locations who accepted and/or recognized the MI Health Link program increased; and the appointment availability rate increased for survey respondents who reported the provider location accepted [Aetna](#), the MI Health Link program, and new patients. In addition, appointment availability for [Aetna](#)'s total survey sample increased. However, as continued opportunities for improvement exist, HSAG recommends that [Aetna](#) continue to monitor for provider-related data concerns and continue any interventions resulting in performance improvement.

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

- While no [Aetna](#)-specific results could be presented, the statewide analysis identified four measures that had a mean score below 90 percent, with one of those measures, *Reliable and Helpful Staff*, demonstrating a statistically significant decline from the prior year, indicating opportunities for improvement for the MI Health Link program. Therefore, HSAG recommends that [Aetna](#) develop and implement interventions to improve member experience related to the *Reliable and Helpful Staff*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommend Homemaker* HCBS CAHPS Survey measures. Of note, the lowest performing CAHPS measure was *Planning Your Time and Activities* with a mean score of 73.5 percent, indicating that [Aetna](#) should prioritize its efforts to promote community

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.

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)*:
 - Through our Health risk assessment process, we identify members who might benefit from additional services. We assess social determinants of health needed which is inclusive of social isolation. Those members are referred for internal and external supportive services such as Wider Circle, which promotes community inclusion. We also support members through utilization of social support within the waiver benefit. Members can access Adult Day Programs, utilize non-medical transportation for non-medical social events. Members are also identified for waiver services by claims reviews, responses within the health risk assessment, self-referral, and provider referrals.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Nothing additional identified.
- c. Identify any barriers to implementing initiatives:
 - No barriers identified.

HSAG Assessment: HSAG has determined that [Aetna](#) addressed the prior year's recommendations. [Aetna](#) reported implementing interventions to identify and refer members for additional services which may improve member experience with care. The SFY 2023 CAHPS activity also demonstrated a rate increase in top-box scores for the MI Health Link program from the prior year for *Reliable and Helpful Staff*, *Planning Your Time and Activities*, and *Recommend Homemaker*. However, as the 2023 top-box score for *Transportation to Medical Appointments* demonstrated a rate decline from the prior year, HSAG recommends that [Aetna](#) continue to monitor measures to ensure significant decreases in scores over time do not occur and continue any efforts resulting in performance improvement.

AmeriHealth Caritas VIP Care Plus

Table 4-2—Prior Year Recommendations and Responses for AMI

| 1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects |
|---|
| <p>HSAG recommended the following:</p> <ul style="list-style-type: none"> AmeriHealth received a <i>Met</i> score for only 82 percent of the requirements in the Design stage of the project, indicating gaps in the ICO’s documentation. AmeriHealth had opportunities for improvement in its documentation of its sampling methods. Specifically, AmeriHealth reported the sample size rather than the sampling frame size. For the sampling frame size, AmeriHealth should have reported how many members met the eligible population prior to sampling specific to each racial/ethnic subgroup. Additionally, without an accurate sampling frame size, the margin of error and whether the sample was generalizable to the eligible population could not be verified. HSAG recommends that AmeriHealth review the QIP Completion Instructions to ensure that all requirements for each completed evaluation element have been addressed. AmeriHealth should seek technical assistance from HSAG throughout the QIP process to address any questions or concerns. |
| <p>MCE’s Response: <i>(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)</i></p> |
| <p>a. Describe initiatives implemented based on recommendations <i>(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)</i>:</p> <ul style="list-style-type: none"> AmeriHealth Michigan had a technical assistance call with HSAG on 12-14-2022. As a result, we resubmitted the QIP document on 1-6-2023 with corrections identified on that call. Corrections were made to the previously reported sample size for measurement period 1-01-2021 through 12-31-2021. Of the total eligible population of 822 members, there were 279 members identified as Black/African American and 183 members identified as White. Of the 279 Black/African American members in the eligible population, 145 of them were selected in the sample for a confidence level of 95% and a margin of error of 6%. Of the 183 White members in the eligible population, 95 of them were selected in the sample for a confidence level of 95% and a margin of error of 7%. |
| <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> None. |
| <p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> None. |
| <p>HSAG Assessment: HSAG has determined that AmeriHealth addressed the prior year’s recommendations based on the responses provided by the ICO and HSAG’s review of the ICO’s annual QIP submission. The ICO revised and improved its documentation for all evaluation elements that received a partially met score within the Design stage of the QIP.</p> |
| 2. Prior Year Recommendation From the EQR Technical Report for Performance Measures |
| <p>HSAG recommended the following:</p> <ul style="list-style-type: none"> AmeriHealth was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. AmeriHealth had numerous issues in reporting Core Measure 9.3, which included not appropriately aligning its source code with the Core Measure 9.3 FAQs that were released in December |

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

2021, and incorrectly identifying members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge. HSAG recommends that **AmeriHealth** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **AmeriHealth** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.

- **AmeriHealth** continued to have a low MI2.6 rate in comparison to the other ICOs' reported rates. **AmeriHealth** continued to rely solely on administrative data for reporting MI2.6. **AmeriHealth** indicated that it believed the Continuity of Care Document (CCD) file process was improved since 2020 and that the process was working more consistently, and **AmeriHealth** had begun transmitting transition records directly, its MI2.6 rate remained low. Considering these process improvements and the continued low MI2.6 rate, HSAG recommends that **AmeriHealth** consider reporting MI2.6 following a hybrid methodology in future years.
- The MI5.6 data that **AmeriHealth** had submitted to the FAI DCS contained errors. **AmeriHealth** indicated the root cause of these errors was that it had relied on personnel to complete the FAI DCS submission who did not typically manage the process, as the individuals typically accountable for the submission were dedicated to working on a CMS program audit. HSAG recommends that **AmeriHealth** ensure its regulatory submissions quality assurance process be reevaluated to align with HSAG's previous recommendation for **AmeriHealth** to ensure the process is well documented internally for business continuity. Considering that the **AmeriHealth** personnel who submitted MI5.6 did not readily identify that a sample size of 387 should have been assessed for accuracy (i.e., Michigan-Specific Reporting Requirements indicate the minimum sample size should be 411 unless the eligible population is less than 411), HSAG further recommends that **AmeriHealth** provide adequate Michigan-Specific Reporting Requirements and MMP Core Reporting Requirements training to any personnel who could potentially assist with the FAI DCS and HPMS submissions.
- For 25 of the 45 reported HEDIS measures (56 percent), **AmeriHealth**'s rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization. HSAG recommends that **AmeriHealth** focus on improving performance for measures included in these domains.
- In the Respiratory Conditions domain, **AmeriHealth**'s rates for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* and *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicators decreased by more than 6 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adult members with newly diagnosed or active COPD were not always receiving spirometry testing to confirm the diagnosis, and that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving spirometry testing and appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* and *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicators. **AmeriHealth** should

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

consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).

- In the Medication Management and Care Coordination domain, **AmeriHealth**'s rates for the *TRC—Transitions of Care—Notification of Inpatient Admission and Receipt of Discharge Information* measure indicators decreased by more than 7 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults did not have documentation in the medical record of receipt of notification of inpatient admission or inpatient facility discharge information. HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some adults did not have documentation in the medical record of receipt of notification of inpatient admission or inpatient facility discharge information. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *TRC—Transitions of Care—Notification of Inpatient Admission and Receipt of Discharge Information* measure indicators. **AmeriHealth** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of care coordination or provider education).
- In the Behavioral Health domain, **AmeriHealth**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator decreased by more than 7 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some members were not receiving follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. If it is determined that difficulty reaching and re-engaging members impacted performance, HSAG recommends that **AmeriHealth** consider other methods of outreach along with providing further education to members on the importance of follow-up and engagement in treatment when scheduling follow-up visits. Additionally, if reluctance to use telehealth for follow-up visits is identified as a root cause that impacted the rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator, **AmeriHealth** should consider identifying specific factors behind the reluctance to use telehealth in order to incorporate effective strategies for addressing the member-identified concerns. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator. **AmeriHealth** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider education or staffing shortages).
- In the Access/Availability of Care domain, **AmeriHealth**'s rate for the *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measure indicator decreased by more than 5 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults with a new episode of alcohol or other drug dependence were not always receiving timely treatment. HSAG recommends that **AmeriHealth** conduct a root cause analysis or focused study to determine why some adults with a new episode of alcohol or other drug dependence were not accessing timely treatment. Upon identification of a root cause, **AmeriHealth** should implement appropriate interventions to improve the performance related to the *IET—Engagement of Alcohol and Other Drug Dependence Treatment* measure indicator. **AmeriHealth** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).

2. Prior Year Recommendation From the EQR Technical Report for 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)***:

Core Measure 9.3:

- AmeriHealth Caritas updated the source code for Core Measure 9.3 and resubmitted the reporting period CY2021 to HPMS as directed. Source code updates were made to align with the Core Measure 9.3 frequently asked questions (FAQs) released in December of 2021 and annual core reporting requirements. Technical teams inclusive of Programmers and Business Analysts were trained to review both the core reporting requirements and the provided FAQs. Following data production, the FAQ document is also used to support validation. Subject matter experts were identified and engaged with and are presently involved in the Core 9.3 Performance Improvement Initiative workgroup, whose objective is to improve the regulatory performance of this measure. Information garnered from this workgroup has led to the development of an internal report which when complete, will support early notification and engagement in skilled nursing facility (SNF) admissions and discharges. Secondly, this internal report will be used as a comparative data source in the review of this measure. AmeriHealth has also expanded attendees to the Interdisciplinary Care Team (ICT) meetings to include Utilization Management (UM) in addition to developing early notification reporting to support real-time member engagement. Additional interventions are under review.

MI 2.6:

- AmeriHealth Caritas put additional measures into place to ensure a timely transmission of discharge records. When there is no accessible Continuity of Care Document (CCD) or discharge paperwork in our inpatient (IP) admission episode within our medical record system, Jiva, we utilize our concierge department to assist in reaching out to the IP facilities requesting documents so they can be sent to providers timely. In addition, both the transition nurses and our community liaisons, are reaching out to the facilities as well. We also continue to monitor the daily Admissions, Discharge, Transfer Notifications (ADT) reports alerting us to admissions/discharges and alerts within Jiva, for any possible discharge activity not pulled up in an ADT report.

MI 5.6:

- AmeriHealth Caritas has reviewed and updated our regulatory submissions process. This revision includes stringent timelines for report production, data validation, business analysis of the data, and business owner approval. The Medicare Performance Management team now supports regulatory submissions, and provides oversight, ensuring quality assurance. Team members have been retrained to review technical specifications and core reporting requirements prior to all regulatory submissions. Business Analyst also perform annual gap analysis of all core and State reporting measures to ensure reporting logic aligns with the regulatory requirements.

HEDIS Measures:

- Implemented provider incentive for submission of CPT II codes for the following measures: CBP [Controlling Blood Pressure], COA, HgbA1c [Hemoglobin A1c], MRP [Medication Reconciliation Post-Discharge] to encourage submission of these non-payable codes to close care gaps.
- Expanded the member incentive program 1/1/2023 to include new incentive for colorectal cancer screening.

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

- Developed and mailed new letter to members in 2023 re: importance of annual wellness visit.
- Developed “Quality Welcome Flyer” now included in all 2023 new member welcome packets which addresses preventive care and its importance.
- Continued letter to members with care gaps re: importance of blood pressure control/screening, diabetes management/testing, availability of 90-day medication fill option.
- Continued monthly member texting campaigns active for members with gaps in care specific to measures: BCS [Breast Cancer Screening], CBP, COL [Colorectal Cancer Screening], Diabetes, Medication Adherence.
- Continued member education via articles in quarterly member newsletter.
- Continued completion of annual medication review by ICO pharmacist for all members, mailed to PCP and abstracted for HEDIS reporting.
- Concierge Team continues to call members with ED [emergency department] visit as identified on daily ADT report to remind/assist with follow-up visit.
- PBM and Customer Service teams continue monthly outreach to members and providers re: medication adherence.
- Continue to provide PCPs with monthly “scorecard” identifying their performance on key HEDIS measures and care gaps remaining for members they care for.
- In process of development/approval: new texting campaign re: annual PCP visit/importance of preventive care; voice blast for members unable to receive text messages.
- In the process of finalizing a contract with laboratory services provider to administer in-home testing for members.
- In process of finalizing contract with a wellness company to assist with on-site health screenings during community events.

Respiratory Conditions Domain

- The SPR and PCE measures have small denominators, which increases difficulty of meaningful interpretation of results.
- SPR: 58 in denominator MY2021 and 64 in MY2022.
- PCE: 49 in denominator MY2021 and 60 in MY2022.
- Members were reminded of the importance of PCP care and testing via newsletter articles, and a letter was sent re: the availability of 90-day medication fills.
- Providers were reminded of the clinical practice guidelines available for COPD.
- NOTE: The NCQA will retire the SPR measure beginning MY2024.

TRC-Transitions of Care-Notification of Inpatient Admission and Receipt of Discharge Information measure

- Initiatives launched to improve performance include:
- Added resources to transmit transition record and request transition record, when needed.
- Staff re-educated on workflow to meet this metric.
- Monitoring was enhanced specific to increased frequency, improved process.
- Quality created process of automated fax sent to PCP upon ADT notification of admission and discharge dates to ensure PCP awareness. This was fully implemented in 2022 and continues at this time. Faxes are used for HEDIS measure compliance as approved by HEDIS auditor.

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

FUH-Follow-Up After Hospitalization for Mental Illness-30 Days

- Initiatives launched to improve performance include:
- Added specialized resources to manage transitions.
- Increased staffing to manage transitions.
- Implementing additional communication mode: one-way texting to Members in transitions to remind them to follow with their healthcare provider.
- Improved monitoring specific to frequency, improved reports to track performance.

IET-Engagement of Alcohol and Other Drug Dependence Treatment measure

- Interventions include:
- Educating Enrollees on importance of seeing providers
- Educating on protection from COVID to mitigate fear.
- Offer to find provider as well as make appointments and offer assistance with transportation.
- Offer and encourage Telehealth providers.
- High communication/contact with Enrollees with this condition,
- Engage with PIHP through bi-weekly via our Integrated Care Team meetings and any secure e-mail communication as needed. Transition nurses and Care Coordinators are also reaching as soon as AmeriHealth Caritas is made aware of these admissions. Pending interventions is a 1-way text campaigns for Enrollees transitioning to remind them to contact their Providers as well as prompt them to seek attention.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Core 9.3: Workgroup has recently kicked off; therefore, it is too early to share performance improvements.
- MI 2.6: Integrated Care Management (ICM) has noted improvements and anticipates meeting the goal within the next quarter.
- MI 5.6: None
- HEDIS Measures: Rates for measurement year (MY) 2022 performance compared to MY2021.
- BCS improved 3%
- COA: Medication review improved 9%, functional assessment improved 3%
- CBP improved 1%
- Diabetes: Eye exam improved 4%; HgbA1c control improved 1%
- Medication adherence diabetes meds improved 2%
- SPR improved 3%
- TRC: Notification of Admission improved 23%
- Receipt of DC Info improved 14%
- Respiratory Conditions Domain: None
- TRC-Transitions of Care - Notification of Inpatient Admission and Receipt of Discharge Information measure: Measure has shown improvement. Per NORC reports, performance more than doubled.
- FUH-Follow-Up After Hospitalization for Mental Illness-30 Days: Through integrated care team meetings with our PIHP's and follow up communication via secure e-mail, the care coordinators follow

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

up with the members to confirm follow up appointments are met, transportation is set up and any barriers are addressed.

- IET-Engagement of Alcohol and Other Drug Dependence Treatment measure: Care coordinators through risk touches and transition of care outreaches work with members to encourage and offer to assist in warm transfers to receive needed substance abuse treatment. For those already established with a PIHP provider, the care coordinator works with the PIHP to assist in providing services for members.

c. Identify any barriers to implementing initiatives:

- Core 9.3: None
- MI 2.6: Very often there is no CCD for a discharge or there is a CCD, but the document is unable to be opened. The plan has followed up several times, however, has been told there is no fix in place at this time for the document not opening due to size limitations. Due to timeliness requirements, if we do not receive the CCD or cannot open it the plan is at risk of being out of compliance. We do engage our concierge team, but the team is often unsuccessful because the facility is not responsive or respond to the request after 48 hours.
- MI 5.16: None
- HEDIS Measures: None
- Respiratory Conditions Domain: None
- TRC-Transitions of Care
- Notification of Inpatient Admission and Receipt of Discharge Information measure.
- Continued barrier would be consistent timely notification of discharges.
- FUH-Follow-Up After Hospitalization for Mental Illness-30 Days
- Continued barrier would be consistent timely notification of discharges.
- Continued barrier of receiving notification of discharges.
- IET-Engagement of Alcohol and Other Drug Dependence Treatment measure: Barriers continue to be reluctance to see providers from fear of contracting COVID and while we are being alerted to diagnosis and behavioral health/substance abuse hospitalizations in a timelier manner than previously it is still a barrier as we are alerted weekly and not daily.

HSAG Assessment: HSAG has determined that **AmeriHealth** addressed the prior year's recommendations. **AmeriHealth** addressed the prior year's recommendation for Core Measure 9.3 to review newly released FAQs as well as the annual release of the MMP Core Reporting Requirements and conduct an impact assessment to identify whether source code requires updates, test the output of any revised source code by reviewing the raw data in comparison to the source system, and involve input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements. During the SFY 2023 PMV activity, **AmeriHealth** successfully demonstrated the identification of institutional admissions and discharges to the community. This was noted as a strong improvement over the prior year's reporting, which identified several concerns impacting data element B. **AmeriHealth** demonstrated the integration of the prior year's feedback and Core Measure 9.3 FAQs guidance to ensure that its programming logic was consistent with the measure specifications.

AmeriHealth addressed the prior year's recommendation for MI2.6 to consider reporting MI2.6 following a hybrid methodology. During the SFY 2023 PMV activity, **AmeriHealth** demonstrated significant improvement in its MI2.6 performance measure rate over the prior year related to the timely transmission of the care

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

transmission records to healthcare professionals after discharge. Additionally, **AmeriHealth** increased resources to improve in this area and made improvements in its process for receiving and communicating care transmission records. The timely transmission of this information may help improve the TOC for members between care settings, improve access to follow-up care, and potentially reduce readmissions.

AmeriHealth addressed the prior year's recommendation for MI 5.6 to ensure its regulatory submissions quality assurance process be reevaluated and provide adequate Michigan-Specific Reporting Requirements and MMP Core Reporting Requirements training to any personnel who could potentially assist with the FAI DCS and HPMS submissions. **AmeriHealth** reviewed and updated its regulatory submissions process and provided retraining on the reporting requirements prior to all regulatory submissions. Additionally, during the SFY 2023 PMV activity, no findings were identified by HSAG related to MI5.6, and no MI5.6 resubmission was required.

AmeriHealth has put forth effort to improve performance for measures in the Prevention and Screening, Respiratory Conditions, Diabetes, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization domains. **AmeriHealth** implemented various interventions in MY 2022 including implementing provider incentives for gap closure, expanding the member incentive program to include colorectal cancer screening, mailing of new letters to members regarding the importance of annual wellness visits, distributing welcome packets to help address preventative care importance, continued texting campaigns, providing member education, distributing provider scorecards, administering in-home testing for members, and implementing on-site health screenings. However, some of the measures in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Access/Availability of Care, and Risk-Adjusted Utilization domains were below the statewide average for MY 2022. As such, **AmeriHealth** should continue to monitor and focus its efforts on improving measures in these domains. This should include timely application of interventions when performance continues to be low.

AmeriHealth demonstrated improved performance for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* and *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicators, as its rates increased by over 3 and 4 percentage points, respectively, from MY 2021 to MY 2022. Additionally, **AmeriHealth** has put forth effort to further improve performance for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* and *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicators by reminding members of the importance of primary care and testing via newsletters, sending letters regarding availability of medication refills, and educating providers on guidelines for COPD. However, the rates did not exceed the HEDIS MY 2022 MI Health Link statewide averages. As such, HSAG recommends that **AmeriHealth** continue to focus its efforts on further improving these measures in the Respiratory Conditions domain. Interventions currently in place should be monitored and expanded upon, when necessary (e.g., as barriers are identified).

AmeriHealth demonstrated improved performance for the *TRC—Transitions of Care—Notification of Inpatient Admission* and *Receipt of Discharge Information* measure indicators, as its rates increased by over 23 and 14 percentage points, respectively, from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. Additionally, **AmeriHealth** has put forth effort to further improve performance for the *TRC—Transitions of Care—Notification of Inpatient Admission* and *Receipt of Discharge Information* measure indicators by adding resources to transmit timely transition records, providing staff education on

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

workflow, and automating faxes sent to PCPs upon notification of admission and discharge dates. Therefore, **AmeriHealth** addressed the prior year's recommendation for the measure indicators.

AmeriHealth demonstrated improved performance for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator, as its rate increased by over 17 percentage points from MY 2021 to MY 2022. Additionally, **AmeriHealth** has put forth effort to further improve performance for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator by adding specialized resources to transitions, increasing staffing for management of transitions, and sending texts to members to remind them to follow up with their provider. However, the rate did not exceed the HEDIS MY 2022 MI Health Link statewide average. As such, HSAG recommends that **AmeriHealth** continue to focus its efforts on further improving the measure. Interventions currently in place should be monitored and expanded upon, when necessary (e.g., as barriers are identified).

Data were not available for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator for HEDIS MY 2022, however it should be noted that **AmeriHealth** put forth effort towards improving performance for the *IET—Initiation of Alcohol and Other Drug Dependence Treatment* measure indicator by educating members on the importance of seeing providers, offering transportation assistance, encouraging use of telehealth, and engaging with its subcontracted PIHP.

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

HSAG recommended the following:

- **AmeriHealth** received a score of *Not Met* for nine elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. As **AmeriHealth** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **AmeriHealth** ensure that it consistently uses the most current version of the model member materials.
- **AmeriHealth** received a score of *Not Met* for seven elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. As **AmeriHealth** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members. These efforts should support improved member health outcomes.

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)*:

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

Member Rights and Member Information:

- Year over year Model Document comparisons were completed on current materials and will be applied to all future model releases to ensure all updates were/are applied. Full material reviews were/will be completed by subject matter experts prior to filing with CMS and the state to ensure material accuracy.
- Additional reviews by Business SMEs [subject matter experts], Compliance and Peer audits have been completed to ensure alignment to the current Models distributed and updated by CMS and the state as applicable to the plan. Internal compliance and Marketing complete Model document comparisons to highlight any year over changes are captured and applied to all materials in market.

Coordination and Continuity of Care:

- Multiple initiatives were launched for the seven Not Met elements in the Coordination and Continuity of Care program area including:
 - Caseload limit
 - Assigning initial risk
 - Care plan reformatting
 - Care plan includes members' needs and goals.
 - Care plans are distributed to members reviewed timely.
- The initiatives implemented included hiring more staff to meet caseload limits, additional resources were put into place to identify initial risk within 15 days and distribute care plans. Staff were re-educated on processes related to documenting in the care plan and the required content and monitoring processes were enhanced specifically adding resources, increased frequency.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Member Rights and Member Information: The identified nine Not Met elements were addressed in current year materials and checks were put into place to ensure all required language and mid-year updates to Model materials were applied.
- Coordination and Continuity of Care: The identified seven Not Met elements have shown improved performance.

c. Identify any barriers to implementing initiatives:

- Member Rights and Member Information: No barriers identified.
- Coordination and Continuity of Care: No barriers identified.

HSAG Assessment: HSAG has determined that **AmeriHealth** addressed the prior year's recommendations based on the responses provided by the ICO, and HSAG's review of the ICO's CAP and CAP progress updates. **AmeriHealth** submitted appropriate action plans to address each deficiency, which were approved by HSAG and MDHHS. **AmeriHealth**'s implementation of its action plans to address the requirements under the Member Rights and Member Information and Coordination and Continuity of Care program areas will be reviewed during the SFY 2024 CAP review. **AmeriHealth** should also implement any recommendations made by HSAG through the CAP and CAP progress updates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

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

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):
 - Created indicators to more easily identify certain provider types and the services they provide in order to ensure easier and more accurate reporting.
 - Obtained desktop access to the adequacy reporting tool so we can run reports internally on a more regular basis.
 - Performed a “lessons learned” exercise where the above initiatives were identified, as well as developing clear documentation and guidance on provider data resources and procedures for obtaining the provider data.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Those providers we created indicators for were more easily identified and produced more accurate data. For example, we identified specific durable medical equipment (DME) providers who we were certain offered incontinence supplies versus including all DME suppliers who may or may not offer this product.
 - Obtaining vendor/subcontractor data seemed to go more smoothly and quickly this year.
 - Having the desktop tool made it easier to check the data and re-check if the network changed.
- c. Identify any barriers to implementing initiatives:
 - Obtaining monthly provider lists from vendors/subcontractors to perform ongoing adequacy validations.

HSAG Assessment: HSAG has determined that **AmeriHealth** has addressed the prior year's recommendations since **AmeriHealth** met the requirements for all Medicaid or LTSS NAV standards.

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Of the 44 total survey cases, only 63.6 percent (n=28) of provider locations were able to be contacted. In addition to limitations related to the secret shopper approach, **AmeriHealth**'s dental provider data included invalid telephone contact information or inaccurate information regarding the provider location's acceptance of the ICO or the MI Health Link program. HSAG recommends that **AmeriHealth** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect or disconnected telephone numbers) to address the provider data deficiencies. Additionally, as MDHHS required **AmeriHealth** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Of cases in which the survey respondent reported that the provider location accepted **AmeriHealth**, the MI Health Link program, and new patients, appointment availability was reported for 88.2 percent of cases. However, this results in appointment availability for 34.1 percent of **AmeriHealth**'s total sample. 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. HSAG recommends that **AmeriHealth** work with its contracted providers to ensure that members are able to

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

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

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)*:

- Outreach/research/follow up was conducted to each office to validate provider updates/changes as well as participation status.
- Skygen, our dental subcontractor, added a reminder in their annual training regarding notification requirements.
- AmeriHealth Caritas conducted outreaches to ten offices each month to provide education and validate provider's data.
- Skygen sent out quarterly Provider Data Validation (PDV) Survey forms to every provider to confirm provider data accuracy.
- Skygen increased training by including specifics about AmeriHealth Caritas VIP Care Plus and MI Health Link in Skygen's annual training.
- AmeriHealth Caritas sent out fax blasts each month about AmeriHealth Caritas VIP Care Plus and MI Health Link to supplement the Skygen annual training.
- Skygen contacted each office that had appointment issues via phone and email to remind them of the standards, as well as incorporated this information into their annual training.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- None.

c. Identify any barriers to implementing initiatives:

- Working through a subcontractor can present challenges, as they work for many payers and may not feel the same sense of urgency/commitment that the payer does.
- MI Medicaid appointment availability standards are strict and can be a challenge to meet. Providers probably don't base when they offer appointments based on who the payer is, they just offer the next available. It is not reasonable to expect providers to know all payers' standards and give preferential appointments based on payers.
- Small membership numbers make it challenging for providers to know who we are and be willing to engage with the subcontractor or our plan.
- Subcontractor is not as well known in MI as other subcontractors.

HSAG Assessment: HSAG has determined that **AmeriHealth** partially addressed the prior year's recommendations. **AmeriHealth**'s dental delegate implemented appropriate interventions, and the results of the SFY 2023 activity demonstrated some improvement from the prior year. Specifically, the percentage of provider locations able to be contacted increased. However, the appointment availability rate decreased for survey respondents who reported the provider location accepted **AmeriHealth**, the MI Health Link program, and new patients. As continued opportunities for improvement exist, HSAG further recommends that

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

AmeriHealth continue to monitor for provider-related data concerns and continue any interventions resulting in performance improvement.

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

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)*:

Planning your time and activities:

- To ensure that every member's needs are met we have enhanced the list of questions that our Care Coordinators ask our Waiver Members during every monthly contact. Both our Concierge Department and LTSS Care Coordinators, through contact with the members, are asking questions to ensure that transportation needs and desires for community involvement are addressed.
- The Plan currently has non-medical transportation set up through our Area on Aging partners. The LTSS team will educate members about the benefits offered to them free of charge to promote community inclusion and empowerment. For any member that does not express the want/need for community involvement, the Care Coordinator will elaborate on the benefit giving suggestions or examples of activities our members could benefit from in the community. Our care coordinators conduct at minimum contact with the members monthly where they make sure their needs and desires are being met. The Concierge team is also reaching out to the members to see if they have any unmet needs the plan can assist with through LTSS services.
- Our contract with Detroit Area Agency on Aging also has the supports coordinator making monthly check ins with the members where any needs and desires are discussed so member's satisfaction can and will be monitored.

Transportation to medical appointments:

- The plan meets bi-weekly with our transportation vendor Modivcare. This was done to monitor real-time concerns to avoid any disruption in members' transportation needs.
- Members that report a problem with transportation to their care coordinator are assigned to a Concierge Coordinator. The Concierge Coordinator notifies transportation a day before a reported member trip to ensure that a driver has been scheduled to pick up the member. The Concierge Coordinator will touch

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

base with the member until a successful connection has taken place to ensure the member will make it to the appointment.

Reliable and Helpful Staff:

- LTSS Staff has enhanced the monthly list of questions asked during member risk touch contact to include not only asking if the staff is showing up timely and fulfilling their obligations. New question added includes:
 - Has your assigned worker missed any days in the past month?
 - If yes, when staff could not come to work on the day that they were scheduled, did someone let you know that personal assistance staff could not come that day?
 - If no, members are advised that if this should ever happen to notify their assigned CC (Care Coordinators) right away by contacting them directly or by calling the plan.
 - The LTSS Team maintains an integrated working relationship with Detroit Area on Aging Supports Coordinators to ensure that member is receiving approved support services.

Recommend Homemaker:

- One of the areas care coordinators discuss in their monthly outreaches and any transition of care is members caregiver satisfaction. Are they satisfied with their caregiver/homemaker? If not, they offer to find another caregiver with the assistance of their assigned area agency on aging supports coordinator or work to resolve any ongoing issues with their current caregiver. This is also tied into the reliable and helpful staff section above.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- None.

c. Identify any barriers to implementing initiatives:

- Some members can be difficult to reach telephonically especially during the pandemic. We have seen better contact rates now that home visits have resumed. The plan continues to strategize on member engagement processes.

HSAG Assessment: HSAG has determined that **AmeriHealth** addressed the prior year's recommendations. **AmeriHealth** reported implementing interventions including monthly check-ins with members to discuss gaps in services to help improve member experience with care. The SFY 2023 CAHPS activity also demonstrated a rate increase in top-box scores for the MI Health Link program from the prior year for *Reliable and Helpful Staff*, *Planning Your Time and Activities*, and *Recommend Homemaker*. However, as the 2023 top-box score for *Transportation to Medical Appointments* demonstrated a rate decline from the prior year, HSAG recommends that **AmeriHealth** continue to monitor measures to ensure significant decreases in scores over time do not occur and continue any efforts resulting in performance improvement.

HAP Empowered

Table 4-3—Prior Year Recommendations and Responses for HAP

| 1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects |
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| <p>HSAG recommended the following:</p> <ul style="list-style-type: none"> Although there were no identified weaknesses, HSAG recommends HAP evaluate the effectiveness of the interventions initiated and use the outcomes to guide each intervention's next steps. |
| <p><i>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)</i></p> |
| <p>a. Describe initiatives implemented based on recommendations <i>(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)</i>:</p> <p>HAP Empowered evaluates each intervention by reviewing HEDIS results and comparing baseline to remeasurement periods. All interventions are tracked to determine if the intervention had an impact on the rate. Interventions implemented include the following:</p> <ul style="list-style-type: none"> Primary Care Incentive Program: an incentive program to reward primary care providers for high quality, cost-effective primary care services. CBP is included in the program. Continued the Provider Gaps in Care Report to share members due for services with PO [provider organizations] groups on a monthly basis. Updated the Customer Service Resource (CSR) tool and trained care management and customer service staff members on utilizing the tool to engage members due for services. Continued the medication adherence program through Pharmacy Benefits Manager (PBM). Created targeted analysis and outreach based on geomapping data broken down by member race and food insecurity data. |
| <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <p>Below is a summary of effectiveness of interventions during remeasurement 1:</p> <ul style="list-style-type: none"> A total of 5 provider (PO) groups and 326 total providers met the benchmark for the Controlling High Blood Pressure payout in the 2022 HAP Best Practice Incentive Program and served MMP members in MY2022. 14 PO groups received PCP Detail Gaps in Care Reports. There were 1288 members out of a total of 2031 who were compliant with CBP and had a PCP who was part of a PO group that received monthly provider gap reports, for a rate of 63.42%. Based on MY2022 CSR data, 40 calls addressing CBP gaps in care were conducted in the updated CSR system. Out of the 13 members whose CSR calls addressed CBP gaps, 10 (76.92%) increased their adherence. 957 members were targeted for outreach by ESI, through the medication adherence program. Of those targeted for outreach, 321 members increased their adherence. <p>HAP Empowered analyzes HEDIS results to measure the effectiveness of interventions and to identify additional opportunities for improvement. The MY2022 final hybrid CBP rate for Caucasians was 67.41% compared to the Black/African American rate of 63.83%. The p value was calculated and found to be 0.5052, therefore, a statistically significant disparity did not exist between these two populations. There was a</p> |

1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects

statistically significant improvement in the Black/African American rate between the Baseline to Remeasurement 1 time periods, $p = 0.0141$. Although the Caucasian population CBP HEDIS rate did decline slightly between Baseline (74.24%) to Remeasurement 1 (67.41%), this finding was not statistically significant ($p = 0.2195$).

c. Identify any barriers to implementing initiatives:

HAP Empowered determined that there are continued barriers to members having controlled hypertension.

Barriers on the initial fishbone diagram updated barriers include:

- COVID-19 Pandemic exacerbated pre-existing health inequities, such as access to healthcare services
- SDOH barriers, in part due to history of structural inequities against disparate group

HSAG Assessment: HSAG has determined that **HAP** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. The ICO received a met score for 100 percent of the requirements for implementation of improvement strategies, which include the evaluation of interventions initiated.

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

HSAG recommended the following:

- Although Core Measure 9.1 is a utilization measure and therefore does not have established benchmarks, **HAP's** MY 2021 Core Measure 9.1 rate was an outlier in comparison to the other ICOs. HSAG recommends that **HAP** conduct a root cause analysis to evaluate why its Core Measure 9.1 rate is an outlier. This analysis should include an evaluation of members who are included in Core Measure 9.1 to determine contributing factors to their ED access. **HAP** should consider whether it needs to deploy new strategies to better support earlier identification of behavioral health conditions as well as earlier member engagement in treatment for these conditions. Additionally, **HAP** should assess whether these members are appropriately connected to fully integrated treatment providers if such providers are available in **HAP's** primary care network of providers.
- **HAP** was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. **HAP** did not update its source code to align with the Core Measure 9.3 FAQs that were released in December 2021, and **HAP** incorrectly identified members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge. HSAG recommends that **HAP** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **HAP** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.
- For 25 of the 45 reported HEDIS measures (56 percent), **HAP's** rates indicated worse performance than the statewide average, demonstrating an opportunity for improvement across multiple domains including Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Access/Availability of Care. HSAG recommends that **HAP** focus on improving performance for measures included in these domains.
- In the Respiratory Conditions domain, **HAP's** rates for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators decreased by more than 5 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link

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

statewide average, indicating that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. HSAG recommends that **HAP** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **HAP** should implement appropriate interventions to improve the performance related to the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators. **HAP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).

- In the Cardiovascular Conditions domain, **HAP**'s rate for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator decreased by approximately 5 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults with clinical atherosclerotic cardiovascular disease (ASCVD) were not receiving statin therapy. HSAG recommends that **HAP** conduct a root cause analysis or focused study to determine why some adults with ASCVD were not receiving statin therapy. Upon identification of a root cause, **HAP** should implement appropriate interventions to improve the performance related to the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator. **HAP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).
- In the Behavioral Health domain, **HAP**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measure indicator decreased by more than 8 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some members were not receiving follow-up care for mental illness within seven days of an ED visit. HSAG recommends that **HAP** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness within seven days of an ED visit. Upon identification of a root cause, **HAP** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measure indicator. **HAP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider education or staffing shortages).

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

- a. Describe initiatives implemented based on recommendations (*include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation*):

Core Measure 9.1

- HAP completed an analysis evaluation for MY 2022 Core Measure 9.1 and the results indicate that one member is driving the high ED utilization causing the rate outlier in comparison to the other ICOS. HAP has discussed with Detroit Wayne Integrated Health Network (DWIHN) about this member who continues to use the ED to receive behavioral health medications.

Core Measure 9.3

- HAP updated the Core 9.3 measure source code to identify instances where the patient was readmitted (even for those where the claim really isn't paid). These code updates were approved by HSAG in 2022, and the data for the FY2022 year reflect those changes.

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

HEDIS

- HAP Empowered implemented a number of interventions to improve its lower performing measures. These interventions included:
 - In July of 2021, HAP implemented a Member Rewards Program. This program rewards members who complete the following services: Breast Cancer Screening, Colorectal Cancer Screening, Diabetic Eye Exam, and Annual Medication Review. HAP increased the reward amount for the Annual Medication Review in 2023 from \$15 to \$25. HAP has actively spread the awareness of the Member Rewards program to its members through mailings, the member welcome packet, member-facing staff (Case Management, Pharmacy, Customer Service), and consumer advisory committees. Additionally, HAP shared its Member Rewards Program with its providers, as providers are able to use it as a tool to help get members in for appointments.
 - In MY 2022, HAP partnered with Quest Diagnostics and Henry Ford Health to expand its lab data. It was identified that Henry Ford was only sending lab data to HAP for members that are assigned to a Henry Ford PCP, however there are a number of HAP members that are not assigned to a Henry Ford PCP that go to Henry Ford for lab work. HAP was able to work with Henry Ford to include this data in its lab data that is sent to HAP. This helped improve particular measures such as HbA1c Control and HbA1c Poor Control, and Blood Pressure Control.
 - HAP included MMP in its Osteoporosis Management for Women with a Fracture (OMW) outreach program in 2021. This program includes telephonic outreach, followed up with a letter to the member within 6 weeks of the fracture to remind the member that they need a bone density test. HAP partners with MedXM (now Quest Diagnostics) who then conducts an in-home bone density test if the member prefers an in-home test.
 - HAP has an internally developed tool named the Customer Service Resource (CSR) Tool that member-facing departments such as Case Management and Customer Service are able to use to see which preventive services members may be due for. HAP has also been investigating other areas where these gap reminders can be found, such as having them available directly in CareRadius (HAP's Case Management System) as well as in a developing gap flags in HAP's Member 360 (EDW) where outreach lists can be quickly pulled. Outreach would then be done via the member's documented communication preference (mail, telephonic, texting, email, etc.).
 - HAP has implemented proactive identification of members that will soon run out of antidepressant medications (based on claims review) and helps in outreaching members when they need additional education or to facilitate refills. As such, these proactive outreaches facilitate resolution of any issues around adherence. Telephonic outreach is the cornerstone of the program, and it supports efficacy of member contact, as the member can interact with the Pharmacy Team at any time that works for the member regardless of their location. Additionally, evaluating alternative methods of communication, such as texting, will also be based on membership preference. During these outreach calls, the Pharmacy Team provides support and education on the importance of antidepressant adherence for the best possible outcome for the members with regards to their overall health.
 - HAP has started partnering with MiHIN [Michigan Health Information Network Shared Services] to start obtaining data that they collect from various provider organizations and labs. Access to this data will improve HAP's HEDIS data which will ensure that the programs impact the appropriate members based on their gaps.

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

- (FUM) Follow-up After Emergency Department Visit for Mental Illness:
 - HAP is in the process of enhancing HEDIS reports that Provider Groups receive on a monthly basis. Providers receive a number of reports that relate to HEDIS, all of which currently contain different measures (some missing key measures such as FUH 7 & 30 Days and FUM 7 & 30 Days).
 - HAP's Case Management Team will continue its collaboration with the PIHPs. This collaboration focuses on following up with members after hospitalization for mental illness. It is expected that this collaboration will improve contact rates for these members due to data sharing and resource sharing.
 - HAP is investigating the possibility of developing an Emergency Department Notification report which would be used to conduct outreach to members who recently visited the Emergency Room for mental illness.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Core Measure 9.1

- Member was referred to Complex Case Management at DWIHN as he had not been attending outpatient appointments with his BH provider. HAP has discussed with DWIHN to collaborate to encourage the member to go to his PCP or BH provider for medications, not the ED.

Core Measure 9.3

- There was no notable performance improvement; the update caused a change to Element B of only a few stays.

HEDIS

- HAP had the following notable improvements in the 25 of the 45 reported HEDIS measures:
 - From MY 2021 to MY 2022, HAP improved 21 out of the 25 measures that were below the State Average, with 4 of those measures having statistically significant improvement (HbA1c Control and Poor Control, Adult Access to Care - Total, and Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid). Furthermore, 14 of the measures that were below the State Average in MY 2021, exceeded the State Average in MY 2022.
 - The expansion of HAP's lab data feeds had a direct impact on the lab related measures. HAP implemented the updated lab file in March 2023 for MY 2022 and saw a rate improvement in HbA1c Control of approximately 8 percentage points.
 - In 2022, HAP's Member Rewards Program rewarded 283 members for completing their annual medication review with a HAP Clinical Pharmacist. As of September 11, 2023, HAP has rewarded 336 members for completing this service. This has helped HAP improve its Care for Older Adults Medication Review measure closer to the State Average.
 - HAP has had an improvement from 14.29% in MY 2021 to 20.00% in MY 2022 in Osteoporosis Management for Women with a Fracture. This is a direct result of the outreach efforts done to schedule bone density tests. It should also be noted that HAP has had a small denominator in the measure with a denominator of seven (7) in MY 2021 and 10 in MY 2022.
- (FUM) Follow-Up After Emergency Department Visit for Mental Illness:
 - HAP has had large improvements in both its 7-Day and 30-Day rates from MY 2021 to MY 2022, with the 7-Day rate increasing from 12.9% in MY 2021 to 34.55% in MY 2022 and the 30-Day rate increasing from 38.71% to 50.91%. This improvement is largely attributed to the decrease in the denominator from 62 to 55 accompanied with increases in numerator hits. The MY 2022 7-Day rate exceeds the State Average of 33.87%.

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

- (SPC) Statin Therapy for Patients with Cardiovascular Disease:
 - HAP has had large improvement in Received Statin Therapy measure, improving from a 79.40% in MY 2021 to 82.86% in MY 2022 (exceeding the State Average of 82.00%).

c. Identify any barriers to implementing initiatives:

Core Measure 9.3

- There were no barriers to implementing initiatives; the only change was in code.

HEDIS

- Below are main barriers that HAP has identified for improving the low performing measures:
 - (FUH) Follow-Up After Hospitalization for Mental Illness – 7 & 30 Days: A main barrier for this measure is reaching members after they are discharged due to incorrect contact information. To mitigate this, HAP Case Management has restructured the monthly meetings with PIHPs to discuss members who are admitted/discharged. During the meetings, the teams share contact information or updates as appropriate and collaborate on follow-up with the members. Case Management will also contact the PIHP prior to the monthly meetings when more frequent collaboration is needed with a specific member. This includes helping the members overcome their lack of desire to seek care. Additionally, the HAP data teams identified that the encounters from the PIHPs were being sent to HAP but not reaching the HEDIS data environment correctly due to historical HAP Midwest IDs being used. This has since been corrected which helped improve the FUH rate from 37.5% in MY 2021 to 52.24% in MY 2022.
 - COVID-19 has been a large barrier in 2021. The MMP population is chronically ill and are more hesitant to seek care or put themselves at risk of contracting COVID-19. HAP has seen that this barrier has lessened as the world has opened up in 2022 going into 2023, causing HEDIS rates for preventive services (such as access to care) to improve significantly.
 - Inability to successfully reach members due to incorrect contact information or no contact information. HAP conducts a variety of outreaches to members which include gap in care reminder letters and telephonic outreach. HAP often does not have phone numbers on file for members, incorrect or disconnect phone numbers, as well as incorrect addresses.
 - Medication Reconciliation Post Discharge – HAP has found that a number of provider groups are either not completing medication reconciliation or are not appropriately coding for it in their system. Additionally, when trying to get medical records tied to medication reconciliation, HAP is finding that records to this measure are difficult to obtain from providers, meaning providers are not sending them.
- (FUM) Follow-Up After Emergency Department Visit for Mental Illness:
 - HAP's main barrier to this measure is the lack of timely identification of members who visited the Emergency Department. At this time, HAP does not have a report on Emergency Department visits (including visits for mental health).

HSAG Assessment: HSAG has determined that **HAP** addressed the prior year's recommendations. **HAP** addressed the prior year's recommendation for Core Measure 9.1 to conduct a root cause analysis to evaluate why its Core Measure 9.1 rate is an outlier and assess whether members are appropriately connected to fully integrated treatment providers if such providers are available in **HAP's** primary care network of providers. **HAP** completed an analysis evaluation for Core Measure 9.1 and identified one member was driving the high ED utilization, causing the rate outlier in comparison to the other ICOS. **HAP** also proactively discussed its

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

findings with the PIHP, as the PIHP's member continues to use the ED to receive behavioral health medications.

HAP addressed the prior year's recommendation for Core Measure 9.3 to ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements, conduct an impact assessment to identify whether source code requires updates, test the output of any revised source code by reviewing the raw data in comparison to the source system, and involve input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements. **HAP** updated its Core Measure 9.3 source code to identify instances where the patient was readmitted (even for those where the claim really is not paid). Additionally, during the SFY 2023 PMV activity, HSAG did not have any findings related to Core Measure 9.3, and resubmission of Core Measure 9.3 was not required.

HAP has put forth effort to improve performance for measures in the Prevention and Screening, Respiratory Conditions, Cardiovascular Conditions, Diabetes, Musculoskeletal Conditions, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Access/Availability of Care domains. **HAP** implemented various interventions in MY 2022 including implementing a member rewards program for members completing services, partnering with lab providers, conducting member outreach, in-home bone density testing, and conducting outreach to members who are running out of antidepressant medications. However, some of the measures in the Prevention and Screening, Diabetes, Behavioral Health, Medication Management and Care Coordination, Overuse/Appropriateness, and Access/Availability of Care domains were below the statewide average for MY 2022. As such, **HAP** should continue to monitor and focus its efforts on improving measures in these domains. This should include timely application of interventions when performance continues to be low.

HAP demonstrated improved performance for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator* measure indicators, as its rates increased by over 12 and 5 percentage points, respectively, from MY 2021 to MY 2022 and exceed the HEDIS MY 2022 MI Health Link statewide averages. Therefore, **HAP** addressed the prior year's recommendation for the measure indicators.

HAP demonstrated improved performance for the *SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* measure indicator, as its rate increased by over 3 percentage points from MY 2021 to MY 2022 and exceed the HEDIS MY 2022 MI Health Link statewide average. Therefore, **HAP** addressed the prior year's recommendation for the measure indicator.

HAP demonstrated improved performance for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—7 Days* measure indicator, as its rate increased by over 21 percentage points from MY 2021 to MY 2022 and exceed the HEDIS MY 2022 MI Health Link statewide average. Therefore, **HAP** addressed the prior year's recommendation for the measure indicator.

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

HSAG recommended the following:

- **HAP** received a score of *Not Met* for nine elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. As **HAP** was required to develop a CAP which was approved by

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

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

- **HAP** received a score of *Not Met* for six elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. As **HAP** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.
- **HAP** received a score of *Not Met* for four elements within the Coverage and Authorization of Services program area, indicating members' service requests were not consistently decided timely and adequately. As **HAP** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

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*):

Standard II – Member Rights & Member Information

- As described above, corrective actions plans have been remediated and approved. Processes have been implemented which include updates to policies and procedures, Compliance discussions with business areas to ensure their understanding of the guidance provided, and additional monitoring by the business areas and Compliance.

Standard VII – Coverage and Authorization of Services

- Requirements 4 and 5
 - HAP's Utilization Management Decision Making Policy and Utilization Management Program Document were updated to include the definition of medically necessary services per the 3-Way Contract.
 - All Utilization Management (UM) staff and medical directors received refresher training on the definition of medically necessary services for MI Health Link members.
- Requirement 16
 - All UM staff and medical directors received refresher training on referencing and applying Medicare and Medicaid criteria appropriately when reviewing service authorization requests for MI Health Link members.
 - HAP's UM process was updated to incorporate the requirement that all MMP service authorization requests recommended for denial will be reviewed by the UM Compliance Lead prior to issuing the final denial, to validate appropriate criteria was referenced by UM staff and medical directors.
 - HAP's UM Compliance Lead continues to review 100% of MI Health Link denial recommendations before final denial is issued.

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

- Requirement 26
 - HAP Claims department implemented Integrated Denial Notices (IDNs) in Oct 2022. Since then, the department incorporated the following:
 - Created a policy to adhere to government program guidelines.
 - Implemented monthly IDN letter audits to ensure that the quality meets the regulatory expectations.
 - Further annual reviews are completed to ensure that IDN templates meet the criteria given by State of Michigan.
 - Updated Universe data to measure and validate the mailings and measure timeliness.

Standard VI – Coordination and Continuity of Care

- Requirement 7
 - HAP updated its MI Health Link risk stratification process to incorporate a contact note for documenting and tracking purposes and all care coordinators received training on the updated process.
 - HAP conducts weekly review of all new members to ensure the risk stratification contact note is completed within 15 days of enrollment.
- Requirement 9
 - HAP updated its process to reflect the requirement for the first outreach attempt to be completed within 15 days of new member enrollment and all care coordinators received training on the updated process.
 - HAP conducts weekly review of all new members to ensure they have at least one outreach attempt within 15 days of enrollment.
- Requirement 15
 - HAP updated its process to clarify the requirement to send Waiver, Personal Care Assessment and PIHP referrals within five business days of identification and all care coordinators received training on the updated process.
 - HAP conducts monthly audits to ensure referrals are sent within five business days of identification.
- Requirement 22
 - HAP updated its emergency contingency plan process to incorporate the specific items that must be discussed with the member while planning and all LTSS Care Coordinators were trained on the updated process.
 - HAP conducts a monthly audit to ensure emergency contingency plans contain required documentation.
- Requirement 23
 - HAP implemented an updated care plan within CareRadius. Updates include the addition of intervention due dates, a dedicated place to describe support and services the member is receiving, a list of due dates for reassessments, and the name of those responsible for the reassessment. All Care Coordinators received comprehensive training on documenting within the updated system MMP care plan.
 - HAP conducts a monthly audit to ensure new fields are completed.

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

- Requirement 26
 - HAP updated reporting logic to improve accuracy of due dates for care plan reviews and all care coordinators received refresher training on required timeframes for care plan reviews based on risk level, as well as how to leverage the updated report for tracking coming due reviews.
 - HAP conducts monthly audits to ensure timely care plan reviews.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Standard II – Member Rights & Member Information

- Processes implemented have improved overall compliance with requirements. Completion and timeliness of policies has improved, as well as communication processes amongst business areas.

Standard VII – Coverage and Authorization of Services

- Requirement 16
 - Clinical UM staff and Medical Directors have demonstrated 100% compliance with applying appropriate criteria when reviewing MMP service authorizations.
- Requirement 26
 - The Claims Department has seen a reduction in errors in our universe and required template usage.

Standard VI – Coordination and Continuity of Care

- Requirement 7
 - Care Coordination has demonstrated 98% compliance with documenting risk stratification within 15 days of enrollment.
- Requirement 9
 - Care Coordination has demonstrated 100% compliance with first outreach to members within 15 days of enrollment.
- Requirement 15
 - Care Coordination monitoring began September 2023. Anticipate demonstrated performance improvement Q4 2023.
- Requirement 22
 - LTSS documentation of emergency contingency plans has demonstrated 98% compliance with requirements.
- Requirement 23
 - Care Coordination monitoring began August 2023. Early results demonstrate improvement in capturing appropriate care plan documentation. Anticipate further performance improvement Q4 2023.
- Requirement 26
 - Monitoring began September 2023. Anticipate demonstrated performance improvement Q4 2023.

c. Identify any barriers to implementing initiatives:

Standard II – Member Rights & Member Information

- No barriers.

Standard VII – Coverage and Authorization of Services

- Requirement 4 - No barriers
- Requirement 5 - No barriers

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

- Requirement 16 - No barriers
- Requirement 26 - No barriers

Standard VI – Coordination and Continuity of Care

- Requirement 7 - No barriers
- Requirement 9 - No barriers
- Requirement 15 - Report complexities delayed the start of monitoring for timely referrals.
- Requirement 22 - No barriers
- Requirement 23 - System care plan build complexities delayed the start of documenting missing requirements.
- Requirement 26 - IT resource constraints and report complexity lead to a delay in monitoring.

HSAG Assessment: HSAG has determined that **HAP** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's CAP and CAP progress updates. **HAP** submitted appropriate action plans to address each deficiency, which were approved by HSAG and MDHHS. **HAP**'s implementation of its action plans to address the requirements under the Member Rights and Member Information, Coordination and Continuity of Care, and Coverage and Authorization of Services program areas will be reviewed during the SFY 2024 CAP review. **HAP** should also implement any recommendations made by HSAG through the CAP and CAP progress updates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

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

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)*

- 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 HAP direct contracted providers who are subject to time/distance/geographic requirements, internal network adequacy reports are continuously being run through HAP's Quest network adequacy tool to ensure HAP is continuously meeting network adequacy requirements to at least 2 provider choices within 30 minutes/30 miles. For services that are handled by a delegated entity whose services are subject to time/distance/geographic requirements, network adequacy policies have been received from all delegated entities. These policies demonstrate that all delegated entities are following MI Health Link requirements for time/distance/geographic standards and their networks ensure that at least 2 choices are available within 30 minutes or 30 miles of member's home. Quarterly reporting validating appropriate network adequacy is also being received from the delegates. For both direct contracted providers and providers from a delegated entity that are not subject to time/distance/geographic requirements, HAP is reviewing current networks quarterly to ensure there are at minimum 2 choices for members to choose from.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- HAP continues to meet network adequacy for all LTSS provider types. Reports (either received from delegated entities or from an internal data warehouse) further confirm that HAP is meeting all network adequacy requirements.
- c. Identify any barriers to implementing initiatives:
- None at this time.

HSAG Assessment: HSAG has determined that **HAP** has addressed the prior year's recommendations since **HAP** met the requirements for all Medicaid or LTSS NAV standards.

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Only 52.5 percent of sampled provider locations accepted and/or recognized the ICO, while only 50.0 percent of those cases accepted and/or recognized the MI Health Link program. HSAG recommends that **HAP** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect ICO acceptance) to address the provider data deficiencies and educate provider offices on ICO and MI Health Link acceptance. Additionally, as MDHHS required **HAP** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Of cases in which the survey respondent reported that the provider location accepted **HAP**, the MI Health Link program, and new patients, appointment availability was reported for 38.7 percent of cases. However, this results in appointment availability for 8.9 percent of **HAP**'s total sample. 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. HSAG recommends that **HAP** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **HAP** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

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 has worked with our dental partner (Delta Dental) to create a plan to address the results described above. The plan implemented by HAP (and Delta Dental) includes several aspects:
- Creation of training materials and distribution to network providers – Several items have been created to assist network providers and provider office staff in recognizing MI Health Link and HAP. Materials include a mailer (newsletter format) and a cheat sheet that providers can use during their day-to-day operation of taking calls and making appointments. Additionally, reminders of the information shared in the mailing were regularly included in communication with providers.
 - Reminder of appointment availability requirements – Materials provided to network providers and office staff included reminders of the appointment availability requirements. These reminders were sent

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

separately from the training material reminders mentioned in the above bullet. This ensured that network providers and staff received many reminders regarding the MI Health Link program.

- Evaluation of the effectiveness of the training materials and appointment availability reminders – The effectiveness of the training materials and appointment availability reminders were evaluated regularly as a Secret Shopper survey was performed separately from the Survey performed by HSAG. The format and questions used in the HSAG Survey were replicated to ensure that emphasis was being placed on the proper metrics.
- Feedback from network providers – An annual survey of network providers is conducted to ensure that appointment availability requirements are being met. Additionally, providers are asked for feedback regarding barriers to meeting the requirements.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- As a result of the communication program described above, HAP experienced an improvement in several of the elements in the annual HSAG Secret Shopper Survey.
- Most notably, the results in appointment availability increased from 8.9% of HAP's total sample in 2022 to 84.6% in 2023. Additionally, HAP experienced an increase of provider offices recognizing HAP (52.5% in 2022 and 57.4% in 2023).
- Other metrics mentioned above remained relatively flat from 2022 and 2023 (50.0% in 2022 vs 49.7% in 2023 for the recognition of MI Health Link and 38.7% - 34.5% for appointment availability).

c. Identify any barriers to implementing initiatives:

- The most significant barrier HAP has experienced is the turnover of provider office staff – specifically those answering the phone and making appointments. As staff members change, it is important that all new staff recognize MI Health Link, HAP, and the availability of appointment requirements for MI Health Link members.

HSAG Assessment: HSAG has determined that **HAP** partially addressed the prior year's recommendations. **HAP's** dental delegate implemented appropriate interventions, and the results of the SFY 2023 activity demonstrated some improvement from the prior year. Specifically, the percentage of provider locations accepting and/or recognizing **HAP**, and the appointment availability rate among all surveyed cases and among survey respondents who reported the provider location accepted **HAP**, the MI Health Link program, and new patients increased. However, the rate of sampled provider locations accepting and/or recognizing the MI Health Link program decreased. As continued opportunities for improvement exist, HSAG recommends that **HAP** continue to monitor for provider-related data concerns and continue any interventions resulting in performance improvement.

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

- While no **HAP**-specific results could be presented, the statewide analysis identified four measures that had a mean score below 90 percent, with one of those measures, *Reliable and Helpful Staff*, demonstrating a statistically significant decline from the prior year, indicating opportunities for improvement for the MI Health Link program. Therefore, HSAG recommends that **HAP** develop and implement interventions to improve member experience related to the *Reliable and Helpful Staff*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommend Homemaker* HCBS CAHPS Survey measures. Of note, the lowest performing CAHPS measure was *Planning Your Time and Activities* with a mean score of 73.5 percent, indicating that **HAP** should prioritize its efforts to promote community

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.

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's waiver team regularly communicates with members to help promote health, community inclusion, and empowerment. Our Care Coordinators continually assess members for any waiver needs and member personal goals. This could include assistance with non-medical transportation to help promote community inclusion and empowerment.
 - HAP has a robust Community Outreach Team with dozens of events in Wayne and Macomb County. We are proud to partner with a number of community organizations that work with members on a wide array of issues dealing with Social Determinants of Health (SDoH). HAP uses text messaging, member newsletters and word of mouth from our Care Coordinators to engage members to participate in HAP-sponsored community events. These include health fairs, vision clinics, dental and vaccination clinics and other SDoH style events that help to make sure HAP Empowered MI Health Link members can stay living in their homes and active in the community with family and friends.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - N/A.
- c. Identify any barriers to implementing initiatives:
 - N/A.

HSAG Assessment: HSAG has determined that **HAP** addressed the prior year's recommendations. **HAP** reported implementing interventions including regular communications with members to help improve member experience with care. The SFY 2023 CAHPS activity also demonstrated a rate increase in top-box scores for the MI Health Link program from the prior year for *Reliable and Helpful Staff*, *Planning Your Time and Activities*, and *Recommend Homemaker*. However, as the 2023 top-box score for *Transportation to Medical Appointments* demonstrated a rate decline from the prior year, HSAG recommends that **HAP** continue to monitor measures to ensure significant decreases in scores over time do not occur and continue any efforts resulting in performance improvement.

MeridianComplete

Table 4-4—Prior Year Recommendations and Responses for MER

| 1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects |
|---|
| <p>HSAG recommended the following:</p> <ul style="list-style-type: none"> Although there were no identified weaknesses, HSAG recommends that Meridian evaluate the effectiveness of the interventions initiated and use the outcomes to guide each intervention's next steps. |
| <p><i>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)</i></p> |
| <p>a. Describe initiatives implemented based on recommendations <i>(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)</i>:</p> <ul style="list-style-type: none"> Meridian evaluated the effectiveness of the Quality Improvement Project (QIP) initiated interventions. QIP interventions focused on addressing racial and ethnic health disparities for the HEDIS Statin Therapy for Patients with Diabetes (SPD) by measuring the HEDIS SPD Rate 2 – Statin Adherence 80% performance between African American/Black and White populations. Meridian utilized the evaluation and outcomes to guide the next steps as reported through the QIP Remeasurement One submission. Meridian's Quality Improvement (QI) team worked collaboratively to develop monthly project reports. The report identifies eligible members for the HEDIS Statin Therapy for Patients with Diabetes - Medication Adherence 80% (SPD) measure, which were not seen by their primary care provider (PCP), have not had a cardiovascular test (minimum LDL), and members' statin medication supply or members who have not filled a statin prescription. This intervention proves to be highly effective and will continue for the life cycle of the project. Meridian's provider facing staff engages providers through networking meetings and data abstraction activities to proactively provide education of evidence-based guidelines and to promote Meridian's Pay for Performance (P4P) program to encourage performance improvement and compliance. In addition, Meridian's Quality Provider Associate and Provider Quality Liaison teams distribute member level PCP visit opportunities to low performing providers, through lead lists. The QI team conducts member outreach campaigns to assist with education, reminders, and provide Social Determinants of Health (SDoH) resources to enhance medication adherence and other preventive services. Member facing staff provide appointment and transportation scheduling assistance for members to encourage non-compliant members to visit their assigned PCP. Meridian utilized additional resources such as provider and/or pharmacy outreach to promote 30-day to 90-day supply conversions and use of a mail order prescription program. In efforts to address unable to reach (UTR) members for appointment and testing reminders, Meridian is utilizing a diverse outreach strategy which includes telephone calls, text messages, traditional mail, email, vendor outreach, and in home visiting. The QI team collaborates with the Care Management team to assist with member outreach for medication adherence education, assessment of SDoH, and scheduling of PCP appointments and/or transportation services through Health Risk Assessments, individual care plans, and in-person visits. Meridian will continue all implemented and effective interventions for the project. |

1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The MY2022 African American/Black performance rate of 75.00% increased by 0.79 percentage points when compared to the MY2021 African American/Black rate of 74.21%. In spite of the observed year over year improvement, the African American/Black population did not achieve statistically significant improvement as identified by the Chi Square test results of 0.0368 and a p-value of 0.8478.
 - Furthermore, Meridian observed a promising decrease in health disparities between the African American/Black and White populations validated by the statistical significance of 5.0722 with a p value of 0.0243 when compared to the baseline statistical significance of 12.2289 with a p value of 0.0005. In addition, an overall variant improvement was experienced between the African American/Black and White population with a decrease of 4.16 percentage points when comparing the baseline variance rate of 11.62% to the remeasurement one variance rate of 7.46%. Meridian also experienced a $\leq 1.14\%$ variance between the two populations for the PCP visits and Cardiovascular Disease (LDL) testing metrics.
- c. Identify any barriers to implementing initiatives:
- Meridian experienced delays with material approvals and timing barriers for the implementation of the member reward program in 2022. The My Meridian Rewards member incentive program launched in quarter three of 2023 but was retroactive to 1/1/2023.
 - In addition, Meridian faced design and document approval delays for the member facing culturally appropriate education flyer for 2022 distribution. Meridian distributed a culturally appropriate flyer in quarter one of 2023 and Heart Health Month observation.
 - Meridian was unable to incorporate the Statin Therapy for Patients with Diabetes (SPD) HEDIS measure in the 2022 Provider HEDIS Quick Reference Guide which is an efficient resource for measure specifications, coding options and best practices. Meridian resolved this barrier by including the SPD measure in the 2023 version of the guide.

HSAG Assessment: HSAG has determined that **Meridian** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. The ICO received a met score for 100 percent of the requirements for implementation of improvement strategies, which include the evaluation of interventions initiated.

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

HSAG recommended the following:

- Meridian** was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. **Meridian's** source code did not align with the Core Measure 9.3 FAQs that were released in December 2021, which allowed for the potential to incorrectly identify members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge. Additionally, **Meridian** deviated from the measure specifications and the institutional facility value set codes for Core Measure 9.3 for data element A, as it was identified that **Meridian's** source code was identifying IFA claims for data element A by bill types or bill types and revenue codes, which caused a narrower universe of claims to be reported than was intended. The measure specifications indicate to identify IFA claims by either bill types or revenue codes. HSAG recommends that **Meridian** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **Meridian** should also ensure it conducts an impact assessment to identify

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

whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements. Additionally, HSAG recommends that **Meridian** put quality checks in place to ensure that the programming logic used for future data submissions is in alignment with the reporting requirements, is inclusive of all associated value set codes, and avoids limiting parameters.

- The member-level data provided to HSAG for PMV contained errors that resulted in resubmission of Core Measure 9.3 data to HPMS. It was identified in **Meridian**'s member-level data submitted for Core Measure 9.3 that the file only included discharges from January through June 2021. **Meridian** indicated that its member-level submission was not capturing 2020 data due to the legacy **Meridian** ID number not being populated in its system and having different member AMISYS ID numbers. This caused members enrolled prior to 2020 to not meet the continuous enrollment criteria for data element A. **Meridian** updated its programming logic and submitted a revised Core Measure 9.3 member-level detail file to HSAG. Upon review of the revised member-level detail file, HSAG noted that the file appropriately included IFAs from July 2020 through June 2021, in alignment with the MMP Core Reporting Requirements for data element A. However, the file only included discharges that occurred for members who had admissions between January through June 2021. The member-level file should have reflected discharges that occurred for admissions from July 2020 through June 2021. **Meridian** updated and resubmitted its Core Measure 9.3 member-level detail file once more to include updated programming logic. HSAG recommends that **Meridian** implement more stringent validation checks prior to submission of member-level data. These checks should include reviewing the member-level data to ensure alignment with the reporting requirements, especially in relation to time frame parameters required by the specifications for the performance measure.
- In the Respiratory Conditions domain, **Meridian**'s rate for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator decreased by more than 29 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adult members with COPD were not always receiving appropriate medication therapy to manage an exacerbation. HSAG recommends that **Meridian** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving appropriate medication therapy to manage exacerbations. Upon identification of a root cause, **Meridian** should implement appropriate interventions to improve the performance related to the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator. **Meridian** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).
- In the Musculoskeletal Conditions domain, **Meridian**'s rate for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator decreased by more than 33 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, suggesting that women who suffered a fracture did not receive a bone mineral density test or prescription for a drug to treat osteoporosis within six months of the fracture. HSAG recommends that **Meridian** conduct a root cause analysis or focused study to determine why women were not always receiving timely bone mineral density tests or a prescription to treat osteoporosis within six months of a fracture. Upon identification of a root cause, **Meridian** should implement appropriate interventions to improve the performance related to the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator. **Meridian** should consider the nature and scope of the issue (e.g., whether the issues related to patient and provider education or barriers to accessing care).

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

- In the Behavioral Health domain, **Meridian**'s rate for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator decreased by more than 17 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some members were not receiving follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. HSAG recommends that **Meridian** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care with a mental health provider within 30 days of inpatient discharge for a diagnosis of mental illness or intentional self-harm. Upon identification of a root cause, **Meridian** should implement appropriate interventions to improve the performance related to the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator. **Meridian** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider education or staffing shortages).

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)

- Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):
 - All recommendations provided for the 9.3 source code were implemented and found to be compliant through validation of data elements A, B and C. Additionally, Meridian revised the source code based on recommendations outlined in the latest Core 9.3 FAQs and reporting requirements.
 - Meridian and Michigan Complete Health have fully merged into one database. One unique identifier, the MBI number, is used to identify continuous enrollment for Core 9.3.
 - Meridian's reporting team implemented additional validation checks for Core 9.3 including but not limited to validating that the measure is based on admissions, confirm element B is a subset of A and is less than or equal to element A, ensure no Medicaid-only members are included in data, validate for appropriate admissions and discharge within the report, and confirm data is in alignment with the reporting requirements, and timeframe parameters by specifications.
 - In review of the FY2022 External Quality Review – Organization (EQRO) report, Meridian completed the recommended root cause analysis on HEDIS measure; PCE - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid. This analysis identified that members may not be adherent with prescribed medication and providers may not follow up, timely. As a result of these findings Meridian implemented a Process Improvement Plan (PIP) for PCE - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid. The PIP process allows Meridian to track HEDIS measure rates and review the progress of interventions dedicated to achieving the targeted benchmarks. The Quality Improvement (QI) team shares the PIP results during the quarterly Quality Improvement Committee meeting. In review of the MY2022 performance, Meridian resolved the PIP and will continue to monitor the PCE – Systemic Corticosteroid measure through the collaborative QI and Pharmacy workgroup.
 - In review of the FY2022 EQRO report, Meridian completed the recommended root cause analysis on HEDIS measure; OMW – Osteoporosis Management in Women with a Fracture. This analysis identified a low denominator of eleven members for the measurement year. The measure improved by 6.25 percentage points for MY2022. Meridian identified weaknesses in members adherence to medication, follow up testing and the providers understanding the criteria for closing the gap. As a result of these findings, Meridian implemented an internal PIP for OMW – Osteoporosis Management in Women with a Fracture measure. The PIP process allows Meridian to track HEDIS measure rates

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

and review the progress of interventions dedicated to achieving the targeted benchmarks. The QI team shares the PIP results during the quarterly Quality Improvement Committee meeting. Meridian's QI team annually updates the HEDIS Quick Reference Guide, a one stop HEDIS educational resource and distributes to all Meridian providers. In addition, Meridian's QI and Pharmacy workgroup collaborate on interventions, such as member outreach and provider education on timeliness for testing compliance. In 2023, Meridian offers a member incentive program through the My Meridian Rewards.

- In review of the FY2022 EQRO report, Meridian completed the recommended root cause analysis on the behavioral health HEDIS measure; FUH - Follow Up for Mental Illness 30-days. Meridian identified the decline in this measure for MY2021 may have been attributed to the bifurcation of the benefit as it is an ongoing challenge; Meridian relies on the Prepaid Inpatient Hospital Plan (PIHP) notification of hospitalizations, COVID-19 impacts on ability to obtain in person services, particularly for behavioral health, where the majority moved to telehealth and remained this way for an extended period of time, and/or familiarity with and comfortability using telehealth for this population. For any of Meridian's key measures that are below the state average or withhold benchmark, Meridian places the measures on internal PIP. This process allows Meridian to track HEDIS measure rates and review the progress of interventions dedicated to achieving the targeted benchmarks. The QI team shares the PIP results during the quarterly Quality Improvement Committee meeting. In addition, Meridian's QI team annually updates the HEDIS Quick Reference Guide, which is a one stop HEDIS educational resource that is distributed to all Meridian providers. Meridian also implemented a provider incentive to encourage coordination and continuity of care across care settings. In review of the MY2022 performance. Meridian resolved the PIP and will continue to monitor the FUH – 30-days measure through the collaborative QI, Care Management, and PIHP meetings.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Core 9.3 reporting has improved and is more accurate due to streamlining the data, merging Meridian and Michigan Complete Health into one system, and implementing the validation checks.
- After implementing the revised and updated source code, Core 9.3 data element A: total number of admissions to a facility, increased based on the report being filtered by Bill Types or Revenue Codes from the Facility core value set.
- Meridian observed the MY2022 HEDIS PCE- Systemic Corticosteroid performance rate of 77.51% increased by 34.84 percentage points when compared to the MY2021 rate of 42.67% and exceed the MMP Statewide Average of 68.65%.
- Meridian observed the MY2022 HEDIS OMW rate of 6.66% increased by 6.66 percentage points when compared to the MY2021 rate of 0.00 but remains below the MMP Statewide Average of 16.12%.
- Meridian observed the MY2022 HEDIS FUH – 30 days rate of 58.00% increased by 13.89 percentage points when compared to the MY2021 rate of 42.11% and exceeded the MMP Statewide Average of 50.22% and the MMP withhold benchmark of 56.00%.

c. Identify any barriers to implementing initiatives:

- Meridian identified no barriers.

HSAG Assessment: HSAG has determined that **Meridian** partially addressed the prior year's recommendations. **Meridian** put forth effort to address HSAG's prior recommendation for Core Measure 9.3 to ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements; conduct an impact assessment to identify whether source code requires updates; test the output of any revised source code by reviewing the raw data in comparison to the source system; involve input from a

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

variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements; and put quality checks in place to ensure that the programming logic used for future data submissions is in alignment with the reporting requirements, is inclusive of all associated value set codes, and avoids limiting parameters. **Meridian** implemented HSAG's recommendations and revised its source code based on recommendations outlined in the latest Core Measure 9.3 FAQs and reporting requirements. However, during the SFY 2023 PMV activity, the member-level data provided to HSAG contained errors that resulted in resubmission of Core Measure 9.3 data to HPMS. It was identified in **Meridian**'s member-level data submission to HSAG for Core Measure 9.3 that the file was erroneously populated with members who had admissions to institutional facilities between January 1, 2021, and June 30, 2021. The measure specifications for Core Measure 9.3 define the admission period for the measure as July 1, 2021, through June 30, 2022. This error accounted for an additional 211 members being included into element A of the measure, resulting in inaccurate rate reporting. HSAG continues to recommend that **Meridian** review the annual release of the Core Reporting Requirements in comparison to current source code for Core Measure 9.3.

Meridian put forth effort to address HSAG's prior recommendation for Core Measure 9.3 to implement more stringent validation checks prior to submission of member-level data, including reviewing the member-level data to ensure alignment with the reporting requirements, especially in relation to time frame parameters required by the specifications for the performance measure. **Meridian**'s reporting team implemented additional validation checks for Core Measure 9.3 including but not limited to validating that the measure is based on admissions, confirming element B is a subset of A and is less than or equal to element A, ensuring no Medicaid-only members are included in data, validating for appropriate admissions and discharge within the report, and confirming data are in alignment with the reporting requirements, and time frame parameters by specifications. However, during the SFY 2023 PMV activity, it was identified in **Meridian**'s member-level data submission to HSAG for Core Measure 9.3 that the file was erroneously populated with members who had admissions to institutional facilities between January 1, 2021, and June 30, 2021. The measure specifications for Core Measure 9.3 define the admission period for the measure as July 1, 2021, through June 30, 2022. This error accounted for an additional 211 members being included into element A of the measure, resulting in inaccurate rate reporting. HSAG continues to recommend that **Meridian** review the annual release of the Core Reporting Requirements in comparison to current source code for Core Measure 9.3. HSAG also continues to recommend that **Meridian** implement more stringent quality assurance checks and increased frequency of validation checks prior to submission of member-level data.

Meridian demonstrated improved performance for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator, as its rate increased by over 34 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. Additionally, **Meridian** has put forth effort to further improve performance for the *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator by conducting a root-cause analysis, implementing a PIP to monitor performance, and collaborating during workgroups. Therefore, **Meridian** addressed the prior year's recommendation for the measure indicator.

Meridian demonstrated improved performance for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator, as its rate increased by over 6 percentage points from MY 2021 to MY 2022. Additionally, **Meridian** has put forth effort to further improve performance for the *OMW—Osteoporosis Management in Women Who Had a Fracture* measure indicator by conducting a root-cause analysis, implementing a PIP, providing member incentives, tracking performance, and reviewing interventions during

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

quarterly meetings. However, the rate did not exceed the HEDIS MY 2022 MI Health Link statewide average. As such, HSAG recommends that **Meridian** continue to focus its efforts on further improving the measure. Interventions currently in place should be monitored and expanded upon, when necessary (e.g., as barriers are identified).

Meridian demonstrated improved performance for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator, as its rate increased by over 15 percentage points from MY 2021 to MY 2022. Additionally, **Meridian** has put forth effort to further improve performance for the *FUH—Follow-Up After Hospitalization for Mental Illness—30 Days* measure indicator by conducting a root-cause analysis, implementing a PIP, tracking performance, and reviewing interventions during quarterly meetings. However, the rate did not exceed the HEDIS MY 2022 MI Health Link statewide average. As such, HSAG recommends that **Meridian** continue to focus its efforts on further improving the measure. Interventions currently in place should be monitored and expanded upon, when necessary (e.g., as barriers are identified).

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

HSAG recommended the following:

- **Meridian** received a score of *Not Met* for seven elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. As **Meridian** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **Meridian** ensure that it consistently uses the most current version of the model member materials.
- **Meridian** received a score of *Not Met* for eight elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. As **Meridian** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.
- **Meridian** received a score of *Not Met* for six elements within the Coverage and Authorization of Services program area, indicating members' service requests were not consistently decided timely and adequately. Contributory factors included, but were not limited to, organizational and personnel changes and a lack of established processes. As **Meridian** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

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):

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

- Member Rights and Member Information Standards- Meridian reviews the MMP handbook annually, updating to the new model released by CMS each year. Following this review, Meridian updated the handbook to be compliant and aligned with the mid-year change that was released by CMS. Additionally, Meridian created a handbook check list of all state and federal requirements to use when evaluating the handbook during the annual review process.
- Coordination and Continuity of Care Standards- Meridian has implemented processes to assist with ongoing review, compliance, and oversight of these elements moving forward. As of October 2022, caseload compliance has been maintained at 600 points or less per care manager. Meridian's Care Management team has created job aids and workflows outlining the care management processes. Additionally, staff completed trainings on how to assign initial risk stratification within 15 days. Meridian also implemented additional reporting to help with identification of members with no assigned risk stratification. Additional reporting enhancements have been completed and are ongoing to help identify members who have and have not completed Health Risk Assessments (HRA), who are unable to reach (UTR), or refused to complete an HRA. Care plan job aids and trainings have been created for the requirement of ongoing care plan review related to risk level, and required components of documentation of member specific problems, goals, and interventions. Meridian has worked to schedule ICT meetings around the member's preference and include the member's provider. Lastly, Meridian's internal auditing tool has been updated to align with contractual requirements and auditing process, which includes regular and timely audits on all care managers with a minimum of 2 case audits per month. Leadership has oversight of monthly audit results and staff performance and provides coaching if audits are failed.
- Coverage and Authorization of Services Standards- Meridian has implemented standardized strategies to the prior authorization build and review processes to improve review timeliness and consistency. Meridian is working to update and standardize prior authorization codes and requirements. Additionally, Meridian implemented automation efforts, which dramatically increases intake of authorization requests and increases speed of overall review. This allows for more time to focus on the clinical review component to improve consistency in decision making, allowing for more accurate identification of expedited requests. Lastly, Meridian is working to update the internal review processes. This internal review includes guidelines to evidence of care, prior authorization, and utilization management (UM) trends, medical cost trends to assess potential revisions to prior authorization lists and assess associated trends of codes removed from prior authorization. Additionally, Meridian's UM and Care Management team is working to decrease denials that are due to a lack of information submitted with a prior authorization request.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Coordination and Continuity of Care Standards- Meridian has achieved several consecutive months of caseload compliance. The overall average of audit scores has increased as a result of regular monthly auditing and monitoring.
- Coverage and Authorization of Services Standard- Meridian's turnaround times are performing consistently and above target.

c. Identify any barriers to implementing initiatives:

- Meridian identified no barriers.

HSAG Assessment: HSAG has determined that **Meridian** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's CAP and CAP progress updates.

Meridian submitted appropriate action plans to address each deficiency, which were approved by HSAG and

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

MDHHS. **Meridian**'s implementation of its action plans to address the requirements under the Member Rights and Member Information, Coordination and Continuity of Care, and Coverage and Authorization of Services program areas will be reviewed during the SFY 2024 CAP review. **Meridian** should also implement any recommendations made by HSAG through the CAP and CAP progress updates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- **Meridian** failed to meet the Assistive Technology—Van Lifts and Tie Downs minimum network requirements for Region 4, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. MDHHS did not approve **Meridian**'s exception request for Assistive Technology—Van Lifts and Tie Downs providers in Region 4, as **Meridian** had not contracted with all available providers in the region. HSAG recommends that **Meridian** identify and contract with additional Assistive Technology—Van Lifts and Tie Downs provider types in Region 4 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.
- **Meridian** failed to meet the MIHP Agency minimum network requirements for Region 4, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. MDHHS did not approve **Meridian**'s exception request for the MIHP Agency provider type in Region 4, as **Meridian** had not followed MDHHS' instructions to submit a complete and accurate exception request for MIHP Agency providers in Region 4. HSAG recommends that **Meridian** follow MDHHS' instructions regarding the submission of the exception request form for all applicable provider types during the SFY 2023 NAV.
- **Meridian** failed to meet all Medicaid and LTSS minimum network requirements for Region 9, reflecting opportunities for improvement in maintaining an adequate network for MI Health Link members in this region. MDHHS did not approve **Meridian**'s exception request for the Adult Day Program provider type in Region 9, as **Meridian** had not contracted with all available providers in the region. HSAG recommends that **Meridian** identify and contract with additional Adult Day Program providers in Region 9 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.

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)

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - Area Agency on Aging IV (AAA IV) in region 4 attempted to contract with providers for the Van Lift and Tie Down services. AMIGO, National Seating & Mobility and Superior Van & Mobility declined to contract but did agree to provide services through single case agreements. AAA IV reported the providers are not willing to participate in the contracting and auditing process without guaranteed work.
 - Meridian continues to validate the MIHP network monthly based off the MIHP State Directory to ensure Meridian has contracted all MIHP providers present and servicing region 4. Meridian reached out to multiple MIHP providers in outlying counties of region 4, to contract with MI Health Link and also inquire if they would service members outside of their region. Meridian's attempt with one of these providers was successful and is currently in the process of being fully executed within our

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

system. For the SFY 2023 NAV activity, Meridian has successfully submitted an exception request following the report requirements for region 4.

- Area Agency on Aging 1B attempted to contract with the available Adult Day Program in Macomb County, but the provider is on the Medicare Preclusion list and AAA 1B does not contract with entities excluded from receiving payment from a federal healthcare program. AAA 1B did identify another provider in September of 2023 and is actively working to get the provider contracted for MI Health Link.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- AAA IV was able to identify two additional providers willing to provide Van Lift and Tie Down services under single case agreement.
- For region 4 MIHP providers, Meridian has not seen any improvement yet as we are awaiting contract completion with one provider.
- Area Agency on Aging 1B located an additional Adult Day Center, Catholic Charities of Southeast Michigan, and is actively working to get MI Health Link contracted.

c. Identify any barriers to implementing initiatives:

- AAA IV has shared with Meridian that providers are not willing to contract with their agency due to the auditing required without guaranteed work. AAA IV has not received a request for Van Lift or Tie Down services and is having difficulty bringing on providers who are unwilling to provide estimates without the guarantee of payment.
- Meridian has run into a barrier while fully executing the provider's contract due to a new contracting system that did not have the proper MIHP language needed to generate the updated contract. This change is in the final stages of implementation and Meridian anticipates the contract to be fully executed within the next 30 days.

HSAG Assessment: HSAG has determined that **Meridian** has addressed the prior year's recommendations since **Meridian** met or received an MDHHS exception for all Medicaid or LTSS NAV standards.

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Only 58.4 percent of sampled provider locations accepted and/or recognized the MI Health Link program. HSAG recommends that **Meridian** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **Meridian** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- A limited number of cases were offered an appointment date with **Meridian**. For new members attempting to identify available providers and schedule appointments, procedural barriers represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. HSAG recommends that **Meridian** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Meridian** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
- Of the cases offered an appointment date with **Meridian** in Region 4, the average wait time for a routine dental visit was 95 days and the maximum wait time was 273 days. For new members attempting to

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

identify available providers and schedule appointments, long wait times prevent timely access to care. Survey responses indicated that the location was accepting new patients but booked for the foreseeable future or the office was short staffed. HSAG recommends that **Meridian** work with its contracted providers to ensure members are able to access care and services in a timely manner and the wait times do not exceed the contractually allowable time frames.

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 reviewed all findings from the HSAG secret shopper survey with DentaQuest and required a root cause and remediation plan be developed for each finding. For additional oversight, Meridian implemented a quarterly secret shopper call audit to further investigate the participating network to ensure they are aligned with MI Health Link education, and to monitor access and availability standards. For failed audits, the expectation is for DentaQuest to follow up with the provider offices to have the required changes addressed or inquire as to why they are unable to meet the access and availability requirements. All findings are discussed at the quarterly JOC [joint operations committee] meetings. Additionally, Meridian receives biweekly updates from DentaQuest on their network strategy to ensure all MI Health Link enrollees have adequate access to dental services. Lastly, DentaQuest conducts quarterly Access and Availability monitoring for 25% of their network. Providers who are unable to meet the requirements are instructed to update the directory to show as “Existing Patients Only” until they are able to meet the access requirements for new patient appointments.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - During Meridian's quarterly call audits, there was a noticeable increase in the awareness of the MI Health Link program, as well as better appointment availability. DentaQuest regularly and promptly fulfills all remediation activities and sends provider fax blast reminders with MI Health Link and Meridian information. In addition, the provider fax blasts include reminders to notify DentaQuest of any changes that may impact the provider directory.
- c. Identify any barriers to implementing initiatives:
 - Providers continue to update their provider directory information without notifying DentaQuest. A lack of provider participation is the largest barrier to improving the secret shopper survey score.

HSAG Assessment: HSAG has determined that **Meridian** partially addressed the prior year's recommendations. **Meridian**'s dental delegate implemented appropriate interventions, and the results of the SFY 2023 activity demonstrated some improvement from the prior year. Specifically, the percentage of provider locations able to be contacted increased and the average wait time improved. However, the rate of sampled provider locations accepting and/or recognizing the MI Health Link program, and the appointment availability rate among all surveyed cases and among survey respondents who reported the provider location accepted **Meridian**, the MI Health Link program, and new patients decreased. As continued opportunities for improvement exist, HSAG recommends that **Meridian** continue to monitor for provider-related data concerns and continue any interventions resulting in performance improvement.

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

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)

- 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 partners with Area Agencies on Aging (AAA) to provide Reliable and Helpful Staff. One of Meridian's AAAs received a substantial grant that allowed them to team up with one of their largest providers to design a specific training for direct care workers. Together, they created modules and provided hands-on training. The results of the training have shown an increase in staff retention and improved satisfaction with both participants and staff. The agency is working on extending the training to another provider to see if they produce the same positive results. Additionally, Meridian requested the training and implemented best practices in order to disseminate to the other AAA partners. Additionally, Meridian added member satisfaction and complaints as a standing agenda item to the Quarterly AAA JOC meeting to bring greater visibility to member complaints and identify trends.
 - Meridian provides transportation to medical appointments through a vendor partnership. Meridian's Vendor Management team provides oversight through monthly meetings and the review of barriers and/or member grievances received. Meridian's member facing staff assist with scheduling and identifying transportation barriers and escalate identified trends to the Vendor Management team. In addition, Meridian obtains member feedback on transportation through the Consumer Advisory Committee (CAC) meetings. During the 2023 quarter two meeting, one member expressed concerns with rural area transportation, while another member relayed no issues with the frequently used services. Meridian is exploring opportunities with the partnered vendor to increase available services in rural areas.
 - Meridian prioritized Planning Your Time and Activities through the building of trusted partnerships between members and Care Managers. Meridian assigns a Care Manager to all MMP members upon enrollment. The Care Management team provides a letter/flyer to introduce the care manager and benefits of the program, conducts annual Health Risk Assessments (HRA's), and establishes, reviews, and updates member care plans. Meridian's Care Managers returned to in person visits in 2022 and developed a drop-in visit program for unable to reach members that utilizes door hangers and flyers when the member is unavailable. In addition, as the COVID-19 Public Health Emergency unwound, and restrictions diminished, Meridian returned to attending in person community events. Furthermore, Meridian obtains member feedback on community events through the CAC meetings. In quarter one of 2023, members reported they are comfortable with attending community events, are most active with

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

the Salvation Army, and are interested in attending community events held by Meridian. In addition, members identified mail or telephonic communication of the events is preferred.

- To improve member experience and satisfaction for Recommended Home Maker, Meridian's Care Managers partner with members to utilize natural support systems, when appropriate, to lessen the challenges of the AAA statewide caregiver shortage.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- At this time, the CY2023 HCBS CAHPS survey results are not available. Meridian will assess performance upon receipt of the survey results.

c. Identify any barriers to implementing initiatives:

- Meridian identified the AAA statewide caregiver shortage and lack of available rural transportation providers as barriers to improving member satisfaction.

HSAG Assessment: HSAG has determined that **Meridian** addressed the prior year's recommendations. **Meridian** reported implementing interventions including training and education for staff and partnerships with vendors, care managers, and members to help improve member experience. The SFY 2023 CAHPS activity also demonstrated a rate increase in top-box scores for the MI Health Link program from the prior year for *Reliable and Helpful Staff*, *Planning Your Time and Activities*, and *Recommend Homemaker*. However, as the 2023 top-box score for *Transportation to Medical Appointments* demonstrated a rate decline from the prior year, HSAG recommends that **Meridian** continue to monitor measures to ensure significant decreases in scores over time do not occur and continue any efforts resulting in performance improvement.

Molina Dual Options MI Health Link

Table 4-5—Prior Year Recommendations and Responses for MOL

| 1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects |
|---|
| <p>HSAG recommended the following:</p> <ul style="list-style-type: none"> Although there were no identified weaknesses, HSAG recommends that Molina evaluate the effectiveness of the interventions initiated and use the outcomes to guide each intervention's next steps. |
| <p><i>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)</i></p> |
| <p>a. Describe initiatives implemented based on recommendations <i>(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)</i>:</p> <p>Addressing Disparities in Controlling Blood Pressure (CBP)</p> <ul style="list-style-type: none"> Encourage providers, during in-person and virtual visits, on Tip Sheets within the HEDIS Provider Manual, and Fax Blast reminder, to use CPT II codes to report blood pressure readings. Educate providers, during in-person and virtual visits, on Tips sheets within the HEDIS Provider Manual, and Fax Blast reminders, that they are allowed to collect blood level readings during telehealth/virtual visits. Provide medical sites two blood pressure monitor units to use to teach the patients with hypertension (HTN) the method they should use to take an accurate blood pressure reading at home. Provide digital blood pressure monitors to Black members with a diagnosis of hypertension and who are assigned to the Michigan Community Health Network (MCHN). 74% of these members are Black. Provide Black members with educational materials showing how to sit and position their arm when using a digital blood pressure monitor. Also provide tracking tools and instructions on when to call the provider if the reading is elevated. Finally, provide member outreach education phone calls. Conduct HTN education during Q1 and Q2, followed by a Q3 medication record audit, scoring each site for compliance related to documentation and member blood pressure level compliance. Provide HTN education to Black members electronically, by email. Messages using this method are low cost and easily modified. <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> There was an increase of 1.14 percentage points in administrative rates for CBP measures from December 2021 to December 2022 as a result of more appropriate coding (40.03% in 2021 to 41.17% in 2022). 100% of provider sites (116 of 116) who are participating in the HTN program have received and reported use of provided demo blood pressure monitors. Since conducting education in Q1 and Q2 for HTN to providers, followed by an audit, audit score has increased 20.8 percentage points from 39.2% in 2020 to 60% in 2022. This has also increased blood pressure recheck rates to compliant levels from 65% in 2020 to 93% in 2022. CBP rates for the Black population, reported at 36.43% for HEDIS RY2022, improved to the HEDIS RY2023 rate of 45.06%, which is an 8.36 percentage point increase in one year. |

1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects

c. Identify any barriers to implementing initiatives:

- While education on virtually collecting blood pressure readings has been well received, many providers have returned to a majority of in-person visits rather than a bulk of telehealth visits.
- Provider misunderstanding lead to the impression that the blood pressure monitor distribution program had ended or was time limited resulting in requests for monitors slowing to almost zero.
- Email and mailing information is inconsistent to monitor and measure direct impact on outcomes.

HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's annual QIP submission. Although the ICO evaluated the effectiveness of the intervention strategies initiated, HSAG recommends the ICO develop interventions that target the disparate population for the QIP.

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

HSAG recommended the following:

- **Molina** was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. **Molina**'s source code did not align with the Core Measure 9.3 FAQs that were released in December 2021, which allowed for the potential to incorrectly identify members as discharged to the community who actually had been readmitted to an institutional facility or admitted to a hospital within 60 days of their original IFA discharge. HSAG recommends that **Molina** ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements. **Molina** should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements.
- **Molina** was required to update its MI2.6 data to the FAI DCS due to issues identified in member-level data. Corrected member-level detail file submissions were required for MI2.6 due to HSAG's identification of several cases that were either listed as compliant for data element C that had transition record transmission dates outside of two days after discharge or listed as noncompliant for data element C that had incorrect transition record transmission dates listed. **Molina** indicated that this was due to manual entry issues. Although **Molina** noted future implementation of additional quality checks as a result of HSAG's findings for MI2.6, HSAG recommends that **Molina** ensure these quality checks are implemented in a timely manner and that they include reviewing the member-level data to ensure alignment with the reporting requirements, especially in relation to time frame parameters required by the specifications for the performance measure.
- In the Medication Management and Care Coordination domain, **Molina**'s rate for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator decreased by more than 10 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that there was not always evidence of patient engagement being provided within 30 days after discharge. HSAG recommends that **Molina** conduct a root cause analysis or focused study to determine why there was not always evidence of patient engagement being provided within 30 days after discharge. Upon identification of a root cause, **Molina** should implement appropriate interventions to improve the performance related to the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator. **Molina** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of care coordination or provider education).

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

- In the Behavioral Health domain, **Molina**'s rate for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator decreased by more than 6 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some members were not receiving follow-up care for mental illness within 30 days of an ED visit. HSAG recommends that **Molina** conduct a root cause analysis or focused study to determine why some members were not receiving follow-up care for mental illness within 30 days of an ED visit. Upon identification of a root cause, **Molina** should implement appropriate interventions to improve the performance related to the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator. **Molina** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider education or staffing shortages).

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)

- Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:
 - Core 9.3: Molina follows a “discharge from admission” process where we gather information from members about their desire to return to the community. We explain the benefits and services that the member qualifies for and explain what the process would be for community reintegration.
 - MI 2.6: Molina reviewed the reporting logic with its reporting team to re-validate and ensure that accurate reporting is occurring. Molina re-drafted a process document specific to MI2.6 to ensure all staff participating in this process were accurately and adequately educated on the requirements. From an oversight perspective, Molina identified several subject matter experts (SMEs) to facilitate routine auditing of the requirements to ensure improve compliance. This includes a weekly review of the detailed data using Molina's internal reporting, and a monthly 20% volume audit of the admission volumes from Henry Ford facilities due to their attestation.
 - TRC: Molina implemented a 2 prong approach that involved medication reconciliation being performed by the Molina Transitions of Care (ToC) RN and faxed to the provider along with a more aggressive appointment scheduling process for the member to get early access to their providers. The ToC RN would call the provider office and help facilitate the appointment scheduling and then follow up with the member to make sure the appointment was kept.
 - FUM: Molina began utilizing out Care Connections Nurse Practitioner program more aggressively beginning in 2023 that incorporates telehealth visits and in-person visits for our behavioral health membership. This program works in conjunction with member providers to help fill any gaps in care until the member can be seen by his/her own provider.
- Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Core 9.3: Molina also identified opportunities through a better understanding and interpretation for the FAQs for improved Core 9.3 logic to be utilized when identifying members appropriate for the measure.
 - MI 2.6: Compliance between CY 2021 and CY 2022 doubled (~16% vs ~34%, respectively). We are projecting continued improvement based on the data obtained in 2023 so far.
 - TRC: The TRC measure remained static for MY 2022 but is showing a 4% improvement for 2023.
 - FUM: Molina saw a 3.5% improvement in 2022 for the FUM measure.

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

c. Identify any barriers to implementing initiatives:

- The TRC measure remains difficult due to availability of discharge summaries from facilities and also provider coding errors to be able to close this measure through claims. Otherwise, none at this time

HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations.

Molina addressed the prior year's recommendation for Core Measure 9.3 to ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements, conduct an impact assessment to identify whether source code requires updates, test the output of any revised source code by reviewing the raw data in comparison to the source system, and involve input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements. **Molina** identified opportunities through a better understanding and interpretation for the FAQs for Core Measure 9.3. Additionally, during the SFY 2023 PMV activity, HSAG did not have any findings related to Core Measure 9.3, and resubmission of Core Measure 9.3 was not required.

Molina addressed the prior year's recommendation for MI2.6 to ensure its quality checks are implemented in a timely manner and that they include reviewing the member-level data to ensure alignment with the reporting requirements, especially in relation to time frame parameters required by the specifications for the performance measure. **Molina** reviewed the reporting logic with its reporting team and redrafted a process document specific to MI2.6 to ensure all staff participating in this process were accurately and adequately educated on the requirements. **Molina** also identified subject matter experts to facilitate routine auditing of the requirements to improve compliance. Additionally, during the SFY 2023 PMV activity, HSAG did not have any findings related to MI2.6, and resubmission of MI2.6 was not required.

Molina demonstrated improved performance for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator, as its rate increased by over 12 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. Additionally, **Molina** has put forth effort to further improve performance for the *TRC—Transitions of Care—Patient Engagement After Inpatient Discharge* measure indicator by implementing a process that involved medication reconciliation being performed by the transition nurse and helping facilitate appointment scheduling. Therefore, **Molina** addressed the prior year's recommendation for the measure indicator.

Molina demonstrated improved performance for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator, as its rate increased by over 3 percentage points from MY 2021 to MY 2022. Additionally, **Molina** has put forth effort to further improve performance for the *FUM—Follow-Up After Emergency Department Visit for Mental Illness—30 Days* measure indicator by incorporating more telehealth visits and in-person visits. However, the rate did not exceed the HEDIS MY 2022 MI Health Link statewide average. As such, HSAG recommends that **Molina** continue to focus its efforts on further improving the measure. Interventions currently in place should be monitored and expanded upon, when necessary (e.g., as barriers are identified).

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

HSAG recommended the following:

- Molina** received a score of *Not Met* for seven elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. As **Molina** was required to develop a CAP which was

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

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

- **Molina** received a score of *Not Met* for six elements within the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. As **Molina** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.
- **Molina** received a score of *Not Met* for four elements within the Coverage and Authorization of Services program area, indicating members' service requests were not consistently decided timely and adequately. As **Molina** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

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)

- 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*):
 - Model Member Materials: Molina's dedicated template team continues to maintain and support template updates, training, communication, and the dissemination of new or updated notices to the delegates. The team submits new or updated templates, with the expected implementation due date, to the account managers for each delegated entity.
 - Molina has successfully implemented The MI MMP Member IDN logic expansion to include denials issued to a provider with provider liability. The IDNs for this logic began deployment on 01/03/2023 to Members.
 - Molina has updated the process and workflow titled MI Pega LTSS Process to ensure the notification will be send with the required 10-day notice. Updated process was successfully implemented.
 - Molina has enabled access to its UM dashboard to ensure denied authorizations can be identified on a daily basis and can be distributed to Care Coordinators. Updates to the reporting to allow filtering of denials is complete and in production for distribution to care coordinators.
 - Care Coordinator Caseloads: Molina was able to hire the additional staff required to meet the contractual requirement of care coordinator caseload limit of 600 points.
 - Member Stratification: Molina was able to add a column to our compliance report tracker that identified when the care coordinator performed the pre-call review for each assigned member. This is now tracked on a daily basis by leadership along with assessment and care plan outreaches and completions.
 - Level II Assessments: Molina increased oversight of the referral mailbox so that referrals were getting assigned in a timely manner. This has allowed the care coordinator to work with the member sooner and complete the referral process sooner. We are also in the process of creating a new report that will allow for tracking outside of the mailbox and help improve monitoring efforts.

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

- Individual Integrated Care and Supports Plan: Molina was able to create a member decline letter that includes language explaining that he/she declined to participate in case management and includes the care coordinator name and contact information if the member decides that he/she needs help with anything over the next 12 months. Molina also re-educated staff on the completion of the Residential Status section of the IAS [Individualized Assessment Summary]/IICSP Summary and all sections for engaged members that do not decline to give information for any specific section of all assessments and/or care plans. Molina also re-educated staff on the contractual requirements for outreach based on risk stratification. This included tasking in CCA [Clinical CareAdvance] for the next outreach that is required for the member.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Model Materials: The dedicated template team's efforts have resulted in improved synchronization of template implementation.
- Since implementation of the LTSS corrective action plan, 100% of ABD notices of termination, suspension, or reduction of previously authorized Medicaid-covered services have been mailed to the member within at least 10 days before the date of action.
- Care Coordination: Molina has maintained a compliant caseload for all care coordinators during 2023. Based on internal audits, we can identify a significant improvement in members who decline getting care coordinator contact information through a decline letter and member stratification via pre-call review within 15 days. Based on sampling audits, we do show some improvement in the areas of Residential Status section completeness, risk stratification outreach, and Level II referral completions within 15 days.

c. Identify any barriers to implementing initiatives:

- There have been no identified barriers at this time.

HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's CAP and CAP progress updates. **Molina** submitted appropriate action plans to address each deficiency, which were approved by HSAG and MDHHS. **Molina**'s implementation of its action plans to address the requirements under the Member Rights and Member Information, Coordination and Continuity of Care, and Coverage and Authorization of Services program areas will be reviewed during the SFY 2024 CAP review. **Molina** should also implement any recommendations made by HSAG through the CAP and CAP progress updates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

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

MCE's Response: *(Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

- Molina continues to monitor all lines of business encompassing MI Health Link and conduct ongoing provider outreach to ensure an adequate network is available for its members, included in the process is

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

provider training sessions (Availity, prior authorization, claims), monthly provider publications, and verification of provider data accuracy through the support of external data sources (i.e., CAQH [Council for Affordable Quality Healthcare, Inc.], Zellis, Networks & delegated providers, Secret Shoppers, etc.). Just recently launched, Molina is working with a vendor Hi-Labs to complete verification of provider data accuracy which will support reporting of network adequacy, project is expected to be implemented across all lines of business before the end of 2023.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Through Molina's above-mentioned activities there are no Medicaid gaps within Region 7 and 9, with one barrier in LTSS outlined below.

c. Identify any barriers to implementing initiatives:

- Molina has one noted barrier in LTSS for Region 7 and 9 with Assistive Technology-Van Lifts and Tie Downs currently with only one servicing provider (network adequacy requires two (2) vendors). Molina has offered contracts with other providers, but the providers have declined contracting with Molina.

HSAG Assessment: HSAG has determined that **Molina** did not address the prior year's recommendations as **Molina** did not meet the minimum network requirements for the Assistive Technology—Van Lifts and Tie Downs provider type in regions 7 and 9. MDHHS did not approve **Molina's** requested exception. While **Molina** reported that it has offered contracts with other providers, but the providers have declined contracting with the ICO, **Molina** should continue to make all reasonable attempts to mitigate barriers to why available providers will not contract with the ICO.

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- Only 63.9 percent of sampled provider locations accepted and/or recognized the MI Health Link program. HSAG recommends that **Molina** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **Molina** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.
- Of the 69 cases accepting **Molina**, the MI Health Link program, and new patients, only 39.1 percent (n=27) offered the caller an appointment date. 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. HSAG recommends that **Molina** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **Molina** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations *(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)*:

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

- Providers received education about the MI Health Link Program verbally as well as through documentation. Upon transition to DentaQuest on 3/1/23, provider again received this information. Through DentaQuest, we are receiving weekly updates on providers who have terminated as well as monthly rosters of the DentaQuest Network to update the provider directory.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- The DentaQuest transition occurred on 3/1/23 and Molina and DentaQuest continue to meet weekly in order to ensure network adequacy and standards are being communicated to the dental providers.

c. Identify any barriers to implementing initiatives:

- There have been no identified barriers at this time.

HSAG Assessment: HSAG has determined that **Molina** partially addressed the prior year's recommendations. **Molina**'s dental delegate implemented appropriate interventions, and the results of the SFY 2023 activity demonstrated some improvement from the prior year. Specifically, the appointment availability rate increased for survey respondents who reported the provider location accepted **Molina**, the MI Health Link program, and new patients. However, the rate of sampled provider locations accepting and/or recognizing the MI Health Link program decreased. As continued opportunities for improvement exist, HSAG further recommends that **Molina** continue to monitor for provider-related data concerns and continue any interventions resulting in performance improvement.

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Molina has worked with the contact center in order to drive efficiency with call routing. It was identified that there may be times that a member is routed to the wrong person or department that would be appropriate to handle the issue at hand. This can cause member abrasion and frustration when having to be passed to multiple people during a call.
- Molina has also worked with our transportation vendor, Access to Care (A2C), to help work through identified barriers in getting members timely transportation for medical and non-medical appointments. Molina continues to have monthly meetings with A2C to work through issues and barriers.

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

- Regarding the Recommend Homemaker measure, most of our homemakers are chosen by the member and credentialed through one of our contracted vendors. Molina believes the root cause for this decrease is with our continuity of care members coming to us from another ICO or the State. These members are often not identified until our first contact due to a lack of available information provided at enrollment. Molina has added a question in our assessment tool, asking if the member is coming to us with a paid caregiver to help facilitate the information collection needed for the caregiver to remain with the member and setting up an onboarding connection with a contracted vendor so the homemaker can be paid in a timely manner.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Molina is showing a significant decrease in overall grievances from 2022 to 2023, and a noted decrease for Admin (reliable and helpful staff falls in this category) and transportation.

c. Identify any barriers to implementing initiatives:

- Readily available data coming in for new members that have a paid caregiver will continue to be a barrier.

HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations. **Molina** reported implementing interventions, including working with vendors to identify efficiencies and address any barriers in processes to improve member experience with care. The SFY 2023 CAHPS activity also demonstrated a rate increase in top-box scores for the MI Health Link program from the prior year for *Reliable and Helpful Staff*, *Planning Your Time and Activities*, and *Recommend Homemaker*. However, as the 2023 top-box score for *Transportation to Medical Appointments* demonstrated a rate decline from the prior year, HSAG recommends that **Molina** continue to monitor measures to ensure significant decreases in scores over time do not occur and continue any efforts resulting in performance improvement.

Upper Peninsula Health Plan MI Health Link

Table 4-6—Prior Year Recommendations and Responses for UPHP

| 1. Prior Year Recommendation From the EQR Technical Report for Validation of Quality Improvement Projects |
|---|
| <p>HSAG recommended the following:</p> <ul style="list-style-type: none"> Although there were no identified weaknesses, HSAG recommends that UPHP evaluate the effectiveness of the interventions initiated and use the outcomes to guide each intervention’s next steps. |
| <p>MCE’s Response: <i>(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)</i></p> |
| <p>a. Describe initiatives implemented based on recommendations <i>(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)</i>:</p> <ul style="list-style-type: none"> UPHP evaluated effectiveness of interventions completed in CY22 to impact the target population identified in the Annual Dental Care Disparity QIP as part of the 2022-23 ICO QIP Validation Submission and used the results to inform next steps. These findings were documented in Step 8 of the Validation Submission form; UPHP met for all elements. |
| <p>b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):</p> <ul style="list-style-type: none"> No opportunity for improvement was identified related to evaluation of effectiveness, as evidenced by meeting all elements of Step 8 for the 2022-2023 ICO QIP Validation Submission. |
| <p>c. Identify any barriers to implementing initiatives:</p> <ul style="list-style-type: none"> N/A. |
| <p>HSAG Assessment: HSAG has determined that UPHP addressed the prior year’s recommendations based on the responses provided by the ICO and HSAG’s review of the ICO’s annual QIP submission. The ICO received a met score for 100 percent of the requirements for implementation of improvement strategies, which include the evaluation of interventions initiated.</p> |
| 2. Prior Year Recommendation From the EQR Technical Report for Performance Measures |
| <p>HSAG recommended the following:</p> <ul style="list-style-type: none"> UPHP was required to update its Core Measure 9.3 source code and resubmit its Core Measure 9.3 data to HPMS. UPHP’s source code did not align with the Core Measure 9.3 Core Reporting Requirements, as it was not limiting identification of data element A to only paid claims. HSAG recommends that UPHP ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements to confirm that its programming logic fully aligns with the reporting requirements and guidance. UPHP should also ensure it conducts an impact assessment to identify whether source code requires updates, testing the output of any revised source code by reviewing the raw data in comparison to the source system, and involving input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements. UPHP was required to update its MI5.6 source code and to resubmit MI5.6 data to the FAI DCS. During the virtual review, it was discussed that as a result of source code review, UPHP had updated its logic for MI5.6 to exclude hospice members, in alignment with the Michigan-Specific Reporting Requirements. This update resulted in 17 members who needed to be removed from inclusion in data element A due to hospice encounter/intervention claims, and one member who was erroneously included in data element B due to the |

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

hospice encounter/intervention logic omission. **UPHP** indicated that removal of the one member from data element B would reduce the data element B sample size to 410. HSAG advised **UPHP** to reach out to the National Opinion Research Center (NORC) help desk to request next steps, as a sample size of 410 did not align with the Michigan-Specific Reporting Requirements hybrid sampling methodology. HSAG recommends that **UPHP** ensure it carefully reviews the annual release of the Michigan-Specific Reporting Requirements to confirm its programming logic fully aligns with the reporting requirements. Additionally, for future reporting of MI5.6, **UPHP** should also ensure that it follows the hybrid sampling methodology outlined in the Michigan-Specific Reporting Requirements and should determine an appropriate oversample to guarantee that the targeted sample size of 411 is always met.

- In the Respiratory Conditions domain, **UPHP**'s rate for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator decreased by more than 11 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adult members with newly diagnosed or active COPD were not always receiving spirometry testing to confirm the diagnosis. HSAG recommends that **UPHP** conduct a root cause analysis or focused study to determine why some adults with COPD are not receiving spirometry testing. Upon identification of a root cause, **UPHP** should implement appropriate interventions to improve the performance related to the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator. **UPHP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).
- In the Cardiovascular Conditions domain, **UPHP**'s rate for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator decreased by more than 11 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adult members were not using a beta-blocker as treatment after a heart attack. HSAG recommends that **UPHP** conduct a root cause analysis or focused study to determine why some adults were not using a beta-blocker after a heart attack. Upon identification of a root cause, **UPHP** should implement appropriate interventions to improve the performance related to the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator. **UPHP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or provider education).
- In the Behavioral Health domain, **UPHP**'s rates for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators decreased by more than 5 percentage points from MY 2020 to MY 2021 and fell below the HEDIS MY 2021 MI Health Link statewide average, indicating that some adults with a diagnosis of major depression, who were newly treated with antidepressant medication, did not remain on antidepressant medication for at least 84 and 180 days. HSAG recommends that **UPHP** conduct a root cause analysis or focused study to determine why some adults with a diagnosis of major depression did not remain on antidepressant medication. Upon identification of a root cause, **UPHP** should implement appropriate interventions to improve the performance related to the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. **UPHP** should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or patient education).

2. Prior Year Recommendation From the EQR Technical Report for 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)*:
- Source Code 9.3 & 5.6: The team that extracts Core and MI Specific measure data have integrated into their workflow a review of the reporting requirements, FAQs, and code sets each time a measure is extracted. When a change is identified the team will meet with subject matter experts on an as needed basis. The subject matter expert will perform primary source verification on the extracted data to ensure accuracy.
 - SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD: UPHP did not implement any additional interventions based on recommendations, as programming to impact these measures was already in place. Activities included:
 - A total of 173 care gap faxes were shared with primary and behavioral health providers over the course of the measurement period. A total of 198 members received the COPD educational mailing during 2022.
 - Better/COPD Awareness Month & Great American Smoke Out health promotion campaign in November 2022. A total of eighteen primary care practice locations received a share of 340 tobacco quit kits to assist with providing member smoking cessation education and support: new in 2022 was the addition of a signs and symptoms of COPD flyer created by the National Heart Lung and Blood Institute and COPD Foundation.
 - A total of 128 clinic locations received electronic COPD Awareness month materials.
 - An annual performance report card, stratified by community mental health agency is shared and reviewed with NorthCare Network partners.
 - Two health systems took part in the Asthma and COPD shared savings program, which encourages guideline recommended COPD care and includes minimum quality scores in the HEDIS SPR measure to qualify for payout. The 2022 shared savings program contract runs from July 1, 2022, through June 30, 2023.
 - PBH—Persistence of Beta-Blocker Treatment After a Heart Attack measure indicator decreased by more than 11 percentage points from MY 2020 (100%) to MY 2021 (88.9%). Based on the denominator of ten or less for both years, this rate equates to only one member not being treated with a beta blocker annually. NCQA does not consider this denominator large enough to report and does not provide reliable trending data comparable to the state MMP average. Analysis of the one member who did not meet from MY22 was completed and based on the complex medical and behavioral health history of the member, no barrier to act on was identified.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Source Code 9.3 & 5.6: No additional audited measures have been identified as inaccurate.
 - SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD: SPR rate for UPHP members mutually served with the regional PIHP increased from 18.9% in MY21 to 20.37% in MY22.
 - PBH—Persistence of Beta-Blocker Treatment After a Heart Attack measure: N/A

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

c. Identify any barriers to implementing initiatives:

- Source Code 9.3 & 5.6: None. Initiatives have been implemented by adding them to the acceptance criteria of each task.
- SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD: Barriers to implementing initiative to impact spirometry.
- PBH—Persistence of Beta-Blocker Treatment After a Heart Attack: N/A

HSAG Assessment: HSAG has determined that **UPHP** partially addressed the prior year's recommendations. **UPHP** put forth effort to address HSAG's prior year recommendation for Core Measure 9.3 to ensure it carefully reviews newly released FAQs as well as the annual release of the MMP Core Reporting Requirements to confirm that its programming logic fully aligns with the reporting requirements and guidance, conducts an impact assessment to identify whether source code requires updates, tests the output of any revised source code by reviewing the raw data in comparison to the source system, and involves input from a variety of ICO subject matter experts who can correctly interpret the FAQs and MMP Core Reporting Requirements. The team that extracted measure data integrated into their workflow a review of the reporting requirements, FAQs, and code sets each time a measure was extracted. When a change was identified, the team met with subject matter experts as needed. The subject matter expert performed PSV on the extracted data to ensure accuracy. However, **UPHP** was required to update its Core Measure 9.3 source code and to resubmit its Core Measure 9.3 data to HPMS. **UPHP**'s source code was incorrectly removing members with diagnoses that did not map to the risk adjustment weights value set. As such, HSAG recommends that **UPHP** continue to review its member-level detail file for any potential errors, including the review of any blank data to determine if this is valid for a given field. **UPHP** should also review its results against the prior year's data results and review any significant changes, and explore factors impacting the change to determine if there was a coding error or if the performance is consistent with its expectations.

UPHP put forth effort to address HSAG's prior year recommendation for MI5.6 to ensure it carefully reviews the annual release of the Michigan-Specific Reporting Requirements to confirm its programming logic fully aligns with the reporting requirements and follows the hybrid sampling methodology outlined in the Michigan-Specific Reporting Requirements to determine an appropriate oversample to guarantee that the targeted sample size of 411 is always met. The team that extracted measure data integrated into their workflow a review of the reporting requirements, FAQs, and code sets each time a measure was extracted. When a change was identified, the team met with subject matter experts as needed. The subject matter expert performed PSV DCS on the extracted data to ensure accuracy. However, HSAG identified a similar finding for MI2.6 during the SFY 2023 PMV activity. **UPHP** was required to update its MI2.6 sampling methodology and resubmit its data to HPMS due to the hybrid sampling methodology not adhering to oversample substitution to keep the sample at 411 members. **UPHP** did not fully understand how to implement the hybrid oversample related to substitution. As such, HSAG recommends that **UPHP** implement its processes to incorporate the guidance related to hybrid sampling and use of the oversample in future years for all measures that use hybrid reporting.

UPHP demonstrated improved performance for the *SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure indicator, as its rate increased by over 4 percentage points from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide average. Therefore, **UPHP** addressed the prior year's recommendation for the measure indicator.

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

UPHP demonstrated improved performance for the *PBH—Persistence of Beta-Blocker Treatment After a Heart Attack* measure indicator, as its rate increased by over 1 percentage point from MY 2021 to MY 2022. However, the rate did not exceed the HEDIS MY 2022 MI Health Link statewide average. As such, HSAG recommends that **UPHP** continue to focus its efforts on further improving the measure. Interventions currently in place should be monitored and expanded upon, when necessary (e.g., as barriers are identified).

UPHP demonstrated improved performance for the *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment* measure indicators, as its rates increased by over 15 and 17 percentage points, respectively, from MY 2021 to MY 2022 and exceeded the HEDIS MY 2022 MI Health Link statewide averages. Therefore, **UPHP** addressed the prior year’s recommendation for the measure indicators.

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

HSAG recommended the following:

- **UPHP** received a score of *Not Met* for six elements within the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. As **UPHP** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information. Additionally, MDHHS and HSAG collaborated to update the model member materials to ensure alignment with federal requirements. These model member materials were provided to the ICOs and, as such, HSAG further recommends that **UPHP** ensure that it consistently uses the most current version of the model member materials.
- **UPHP** received a score of *Not Met* for seven elements within the Coordination and Continuity of Care program area, indicating members’ care may not be effectively coordinated through the care management program. As **UPHP** was required to develop a CAP which was approved by HSAG and MDHHS, HSAG recommends that the ICO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and information.

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)

- 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 has taken significant steps to improve member rights and information access in response to HSAG and MDHHS recommendations. We have revised policies, committed to an annual review of model language, enhanced marketing compliance, added contact information for reporting fraud and abuse, and updated procedures for ongoing compliance checks. Additionally, UPHP now notifies members of significant handbook changes, and their directories now include Care Team descriptions. These changes reflect UPHP’s dedication to member satisfaction and regulatory compliance.
 - Coordination and Continuity of Care – Care Coordinator Case Loads: Based on current risk points the number of care coordinators needed to be compliant with care coordinator caseloads is 30. UPHP currently has 31 full time care coordinators. UPHP continues recruitment efforts and advertising to fill 3 additional care coordinator positions to create a “buffer” to compensate for staff turnover and extended leave to maintain compliance.

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

- Coordination and Continuity of Care – Member Stratification: UPHP updated processes for setting risk scores within 15 days of enrollment including assignment of “low” for those members who are unable to be reached in addition to management staff running dashboard by the 15th of each month to identify any member without a risk score assignment. Regular auditing of new member charting indicates ongoing compliance with this requirement.
- Coordination and Continuity of Care – Initial Outreach/Screening: UPHP process documents including the chart review tool reflect that outreach must occur for all members regardless of future disenrollment dates. Compliance with this requirement is conducted monthly for new staff, and during quarterly data validation. Training for staff occurs upon hire (within the orientation period) and ad hoc as needed.
- Coordination and Continuity of Care – Level I Assessment: UPHP created a process indicating at least one of the five initial outreach attempts will be a telephonic attempt outside of UPHPs standard working hours, to occur after 5pm within the first 60 days of enrollment. All members who have been unable to be reached after 4 unsuccessful attempts are scheduled for outreach outside of UPHPs standard business hours and after 5pm. All outreach is date and timestamped within the care management system.
- Coordination and Continuity of care – Level II Assessments: Oversight of Level II timeliness has been incorporated into the quarterly meetings/monitoring plan with the PIHP.
- Coordination and Continuity of Care – Individual Integrated Care and Supports Plan: An updated IICSP template was implemented on 11/18/2022 which addresses all required elements of the IICSP and combines the team care plan with the member task plan creating one single care plan for the member. All clinical coordinators were updated related to this change and migrated existing member plans into this template.
- Coordination and Continuity of Care – 30 day care plan review: Staff training occurred and process documents were updated to ensure that all members with a high-risk stratification are to have a IICSP review every 30 calendar days and that outreach should start well before the 30th day to ensure compliance.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Coordination and Continuity of Care – Care Coordinator Case Loads: Resulting reduction in caseloads and case acuity for care coordinator staff to allow effective management of workload as it relates to travel, documentation, and meeting deadline requirements and meeting member needs effectively.
- Coordination and Continuity of Care – Member Stratification: Bi-annual internal chart audit (April 2023 – August 2023) indicates a score of 100% compliance rate.
- Coordination and Continuity of Care-Initial Outreach/Screening: Bi-annual internal chart audit (April 2023 – August 2023) indicates a score of 93% compliance rate.
- Coordination and Continuity of Care – Level I Assessments: Bi-annual internal chart audit (April 2023 – August 2023) indicates a score of 100% compliance rate.
- Coordination and Continuity of Care – Level II Assessments: No deficiencies were noted for the following delegation oversight committee meetings for Q1 2023 which occurred on 3/20/2023, Q2 2023 which occurred on 7/19/2023. The next delegation oversight committee meeting for Q3 2023 is scheduled for 9/27/2023.
- Coordination and Continuity of Care – Individual Integrated Care and Supports Plan: Bi-annual internal chart audit (April 2023 – August 2023) indicates a score of 85% compliance rate.

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

- Coordination and Continuity of Care – 30 day care plan review: Bi-annual internal chart audit (April 2023 – August 2023) indicates a score of 94% compliance rate.

c. Identify any barriers to implementing initiatives:

- Coordination and Continuity of Care – Care Coordinator Case Loads: Limited number of qualified applicants submitting applications.
- Coordination and Continuity of Care – Individual Integrated Care and Supports Plan: A number of new staff are within their first 6 months of hire and fall within the bi-annual chart audit. All staff continue to receive education and training on requirements related to care plan development and expectations are that UPHP will be within compliance at 86% or above for next internal reviews.

HSAG Assessment: HSAG has determined that **UPHP** addressed the prior year's recommendations based on the responses provided by the ICO and HSAG's review of the ICO's CAP and CAP progress updates. **UPHP** submitted appropriate action plans to address each deficiency, which were approved by HSAG and MDHHS. **UPHP's** implementation of its action plans to address the requirements under the Member Rights and Member Information and Coordination and Continuity of Care program areas will be reviewed during the SFY 2024 CAP review. **UPHP** should also implement any recommendations made by HSAG through the CAP and CAP progress updates.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- **UPHP** should maintain an internal data verification process to continually identify and contract with Adult Day Program, Dental, Hearing Aids, Hearing Examinations, MIHP Agency, and NEMT provider types as they become available in Region 1 to improve compliance with Medicaid and LTSS minimum network standards for time/distance and capacity for MI Health Link members in the region.

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 implemented SOP 510-1051 – Network Testing Validation, to review the current network to assess network gaps. The UPHP Provider Relations Department will work with the Utilization Management Department to verify provider offices/specialties that submit Prior Authorization to assess if there are providers that are interested in contracting with UPHP. UPHP will also work with UPCAP for the LTSS provider network and Delta Dental for the dental network to assess potential providers to contract.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- If any providers/organizations are identified during the testing process, UPHP Provider Relations Department will provide the information to UPCAP and Delta Dental regarding potential contracting opportunities. Some providers/organizations have contracted through this process.

c. Identify any barriers to implementing initiatives:

- The Upper Peninsula service area and rural nature do continue to be barriers to contracting/credential with provider types. Any new providers/organizations that do come within the service area, outreach is conducted.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation

HSAG Assessment: HSAG has determined that **UPHP** has addressed the prior year's recommendations since **UPHP** met or received an MDHHS exception for all Medicaid or LTSS NAV standards.

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

HSAG recommended the following:

- A limited number of callers were offered appointment dates and times. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of cases offered an appointment. HSAG recommends that **UPHP** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **UPHP** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
- Of the 33.3 percent of cases offered an appointment, the average wait time was 99 days, and the longest wait time for a routine dental appointment was 236 days. For new members attempting to identify available providers and schedule appointments, long wait times prevent timely access to care. Survey responses indicated that the location was accepting new patients but booked for the foreseeable future or the office was short staffed. HSAG recommends that **UPHP** work with its contracted providers to ensure that members are able to access care and services in a timely manner and the wait times do not exceed the contractually allowable time frames.
- Only 61.1 percent of sampled provider locations accepted and/or recognized the MI Health Link program. In addition to limitations related to the secret shopper approach, **UPHP**'s data included inaccurate information regarding the provider location's acceptance of the MI Health Link program. HSAG recommends that **UPHP** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect MI Health Link acceptance) to address the provider data deficiencies and educate provider offices on the MI Health Link program. Additionally, as MDHHS required **UPHP** to submit a CAP, HSAG further recommends that the ICO fully implement its remediation plans and continue to monitor for provider-related data concerns.

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 implemented an annual secret shopper survey process to verify information on file for provider offices, as well as dental providers, was correct in the system. Any deficiencies noted for the dental network were provided to Delta Dental to update their provider network information.
- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 - Through the secret shopper survey process, any deficiencies noted were corrected immediately. UPHP provided information to the provider network regarding provider wait time education.
- c. Identify any barriers to implementing initiatives:
 - Through the secret shopper survey calls, it was noted from provider offices that they continue to be short staffed, especially the dental network. This is resulting in the longer wait times for members to receive care.

5. Prior Year Recommendation From the EQR Technical Report for Secret Shopper Survey

HSAG Assessment: HSAG has determined that **UPHP** partially addressed the prior year's recommendations. **UPHP**'s dental delegate implemented appropriate interventions, and the results of the SFY 2023 activity demonstrated some improvement from the prior year. Specifically, the percentage of provider locations able to be contacted and the rate of sampled provider locations accepting and/or recognizing the MI Health Link program increased. However, the appointment availability rate among all surveyed cases and among survey respondents who reported the provider location accepted **UPHP**, the MI Health Link program, and new patients decreased with an average wait time of 147 days. As continued opportunities for improvement exist, HSAG recommends that **UPHP** continue to monitor for provider-related data concerns and continue any interventions resulting in performance improvement.

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

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

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)

- 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 implemented an internal annual HCBS Waiver Member Satisfaction Survey to measure members experience with case management and the provision of their home-based services including satisfaction with timeliness and quality of service. Additionally, a new Universal Level I assessment implemented April 1, 2023 includes questions related to member preferences in the areas of religious beliefs, culture, background, and strengths or things the member takes pride in about themselves to tailor a robust person-centered plan of care that considers how a member prefers to spend their time.
 - UPHP also receives updates from the LTSS vendor of regular quarterly meetings the AAA has with agency providers to address issues related to scheduling/hiring/member concerns, etc. Efforts continue across the Upper Peninsula and across agencies to hire staff to ensure adequate coverage of services. UPHP will continue with an annual member experience survey related to HCBS waiver membership.
 - UPHP implemented an online transportation tool in which members can upload their mileage reimbursement requests and proof of appointments making it easier for some members. Members are also able to submit requests to set up transportation for medical appointments with this tool if they find this easier than calling in the request. UPHP also updated the NEMT rules which are easier to read and more transparent for members.

6. Prior Year Recommendation From the EQR Technical Report for CAHPS Analysis

- b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Analysis of the 63 survey responses for 2023 reveal that UPHP was able to achieve a satisfaction rate of 98% (62/63), meeting the UPHP goal of 96%, for overall satisfaction with the program. Additionally, program grievances were reviewed for the time period and there were two grievances related to HCBS care management or services during the reporting period. Both of these instances were filed by the same member. The grievances pertained to the quality of the services provided under the HCBS C waiver home modifications program as well as the member's preference for a new care coordinator. The grievances were resolved and member satisfaction was achieved as a result and they remain enrolled in the HCBS C waiver program.
 - In total, 87% (54/62) of members surveyed felt that by being in the UPHP HCBS C-waiver program they had an improved quality of life. This is an increase in the perceived quality of life from the previous year in which 78% of members felt their quality of life had improved. The survey results reflect UPHP's values of ensuring a member lives in the setting of their choice with all necessary supports in place to ensure their needs are met. No overarching program issues were identified and UPHP will continue to survey members and assess results annually.
- c. Identify any barriers to implementing initiatives:
- UPHP continues to experience worker shortages in areas across the U.P. which appears to have impacted member satisfaction rates related to Reliable and Helpful Staff. UPHP continues to work closely with the delegated LTSS service provider to ensure member needs are being met related to staffing concerns.
 - As indicated, some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day, however the HCBS CAHPS survey encompassed the time period of heightened COVID-19 restrictions. UPHP is hopeful this specific CAHPS measure will improve as quarantine restrictions have now been relaxed.

HSAG Assessment: HSAG has determined that **UPHP** addressed the prior year's recommendations. **UPHP** reported implementing interventions, which included conducting an internal annual HCBS Waiver Member Satisfaction Survey, conducting quarterly meetings to discuss any issues or barriers to care, and introducing an online transportation scheduling tool. The SFY 2023 CAHPS activity also demonstrated a rate increase in top-box scores for the MI Health Link program from the prior year for *Reliable and Helpful Staff*, *Planning Your Time and Activities*, and *Recommend Homemaker*. However, as the 2023 top-box score for *Transportation to Medical Appointments* demonstrated a rate decline from the prior year, HSAG recommends that **UPHP** continue to monitor measures to ensure significant decreases in scores over time do not occur and continue any efforts resulting in performance improvement.

5. Integrated Care Organization Comparative Information

In addition to performing a comprehensive assessment of each ICO's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each ICO to assess the MI Health Link program. Specifically, HSAG identifies any patterns and commonalities that exist across the six ICOs and the MI Health Link program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which MDHHS could leverage or modify MDHHS' CQS to promote improvement.

Integrated Care Organization External Quality Review Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the ICOs.

Validation of Quality Improvement Projects

For the SFY 2023 validation, the ICOs submitted Remeasurement 1 data for their ICO-specific QIP topic. HSAG's validation evaluated the technical methods of the ICO's QIPs (i.e., the QIP Implementation and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of each ICO's QIP and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 5-1 provides a comparison of the overall QIP validation ratings and the scores for the QIP Design (Steps 1 through 6), Implementation (Steps 7 and 8), and Outcomes (Step 9) stages, by ICO.

Table 5-1—Comparison of Validation Ratings and Scores by ICO

| Overall QIP Validation Rating, by ICO | | | Design, Implementation, and Outcomes Scores | | |
|---------------------------------------|--|------------|---|----------------------|----------------|
| | | | <i>Met</i> | <i>Partially Met</i> | <i>Not Met</i> |
| AET | <i>Comprehensive Diabetes Care—HbA1c Test: Decreasing the Disparity Between White and African American Members</i> | <i>Met</i> | 90% | 0% | 10% |
| AMI | <i>Transitions of Care, Medication Reconciliation Post-Discharge</i> | <i>Met</i> | 90% | 3% | 7% |
| HAP | <i>Reducing Controlling Blood Pressure Disparity Between Black/African American and White/Caucasian Members</i> | <i>Met</i> | 97% | 3% | 0% |
| MER | <i>Addressing Race and Ethnic Health Disparities: Statin Therapy for Patients With Diabetes</i> | <i>Met</i> | 95% | 0% | 5% |

| Overall QIP Validation Rating, by ICO | | | Design, Implementation, and Outcomes Scores | | |
|---------------------------------------|--|-----|---|---------------|---------|
| | | | Met | Partially Met | Not Met |
| MOL | Addressing Disparities in Controlling Blood Pressure | Met | 90% | 5% | 5% |
| UPHP | Annual Dental Care | Met | 95% | 0% | 5% |

Table 5-2 provides a comparison of the ICOs' QIPs by target populations and results, including a summary of each ICO's progress on meeting the goals of the QIP.

Table 5-2—Comparison of QIP Target Populations and Results by ICO

| ICO | Target Population(s) | Results | | Progress on Meeting Goals |
|-----|--|----------|---------|--|
| | | Baseline | R1 | |
| AET | Disparate: Black or African-American members | 73.6% | 76.6% ↔ | ✓ rate for disparate population increased ✓ rate for comparison population increased ✗ existing disparity not eliminated |
| | Comparison: White members | 87.8% | 89.6% ↔ | |
| AMI | Disparate: Black/African-American members | 66.2% | 61.4% ↔ | ✗ rate for disparate population declined ✗ rate for comparison population declined ✗ existing disparity not eliminated |
| | Comparison: White members | 80.0% | 59.1% ↓ | |
| HAP | Disparate: African-American members | 51.1% | 63.8% ↑ | ✓ rate for disparate population increased significantly ✓ disparity eliminated ✗ rate for comparison population declined |
| | Comparison: Caucasian members | 74.2% | 67.4% ↔ | |
| MER | Disparate: African-American/Black members | 74.2% | 75.0% ↔ | ✓ programmatically significant improvement achieved ✓ rate for disparate population increased ✗ rate for comparison population declined ✗ existing disparity not eliminated |
| | Comparison: White members | 85.8% | 82.5% ↔ | |
| MOL | Disparate: Black members | 36.4% | 45.1% ↑ | ✓ rate for disparate population increased significantly ✓ rate for comparison population increased significantly ✗ existing disparity not eliminated |
| | Comparison: White members | 47.3% | 53.3% ↑ | |

| ICO | Target Population(s) | Results | | Progress on Meeting Goals |
|------|---|----------|---------|---|
| | | Baseline | R1 | |
| UPHP | Disparate: American Indian/Alaskan Native members | 22.7% | 21.2% ⇄ | ✓ rate for comparison population increased ✓ programmatically significant improvement achieved |
| | Comparison: White members | 34.6% | 35.1% ⇄ | ✗ rate for disparate population declined ✗ existing disparity not eliminated |

R1 = Remeasurement 1

↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).

⇄ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).

↓ = Statistically significant decline over the baseline measurement period (p value < 0.05).

✓ = Positive progress made toward achieving the goals of the QIP.

✗ = Minimal to no progress made toward achieving the goals of the QIP.

Performance Measure Validation

The SFY 2023 PMV of Core Measure 9.3—*Minimizing Institutional Length of Stay*, MI2.6—*Timely Transmission of Care Transition Record to Health Care Professional*, MI5.6—*Care for Adults—Medication Review*, and MI7.3—*Annual Dental Visit* resulted in all six ICOs receiving validation designations of *Reportable (R)* for all measures, indicating the measure data were compliant with the MMP Core Reporting Requirements and Michigan-Specific Reporting Requirements.

Table 5-3 provides the validation designations for the MI Health Link program PMV of Core Measure 9.3, MI2.6, MI5.6, and MI7.3.

Table 5-3—Comparison of Overall Validation Designations

| ICO | Core Measure 9.3 | MI2.6 | MI5.6 | MI7.3 |
|------|------------------|----------------|----------------|----------------|
| AET | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) |
| AMI | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) |
| HAP | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) |
| MER | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) |
| MOL | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) |
| UPHP | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) | REPORTABLE (R) |

Table 5-4 provides the validated performance measure rates for the MI Health Link program PMV of Core Measure 9.3, MI2.6, MI5.6, and MI7.3 and provides an ICO-to-ICO comparison.

Table 5-4—Comparison of SFY 2023 Performance Measure Results and Quality Withhold Status

| Performance Measure | AET | AMI | HAP | MER | MOL | UPHP |
|---------------------|--------|--------|--------|--------|--------|--------|
| Core 9.3 | 1.07 | 0.62 | 1.35 | 1.51 | 1.07 | 1.35 |
| MI2.6 | 20.70% | 22.60% | 34.50% | 23.10% | 34.50% | 69.10% |
| MI5.6 | 87.80% | 96.80% | 68.60% | 68.40% | 80.50% | 93.20% |
| MI7.3 | 25.10% | 16.10% | 29.10% | 25.40% | 24.70% | 34.30% |

Best-performing ICOs' rates are denoted in green font.

Worst-performing ICOs' rates are denoted in red font.

Table 5-5 and Table 5-6 include the quality withhold analysis results for ICOs in the MI Health Link demonstration for Demonstration Year (DY) 7, which covers CY 2022. Table 5-5 provides the results for each CMS Core measure, and Table 5-6 provides the results for each state-specific measure. For each measure, the ICOs earn a “met” or “not met” designation depending on their achieved rate relative to the benchmark level or, where applicable, the gap closure target. Based on the percentage of measures with a “met” designation, the ICOs receive a quality withhold payment. Of note, measures that also utilize the gap closure target methodology are marked with an asterisk. For these measures, the ICOs can earn a “met” designation by meeting the benchmark or the gap closure target. For more information about the quality withhold methodology, measures, and benchmarks, refer to the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DYs 2 through 10 and the Michigan Quality Withhold Technical Notes for DYs 2 through 8. These documents are available on the [MMP Quality Withhold Methodology & Technical Notes](#) webpage.

Table 5-5—CMS Core Measure Quality Withhold Results

| ICO | CW6—Plan All-Cause Readmissions | CW7—Annual Flu Vaccine* | CW8—Follow-Up After Hospitalization for Mental Illness* | CW11—Controlling Blood Pressure* |
|------|---------------------------------|-------------------------|---|----------------------------------|
| | Benchmark: 1.00 | Benchmark: 69% | Benchmark: 56% | Benchmark: 71% |
| AET | Not Met | Not Met | Met | Met |
| AMI | Not Met | Met | Met | Met |
| HAP | Met | Met | Met | Met |
| MER | Not Met | Met | Met | Not Met |
| MOL | Not Met | Met | Met | Met |
| UPHP | Met | Met | Met | Met |

* Indicates measures that also utilize the gap closure target methodology.

Table 5-6—Michigan State-Specific Measure Quality Withhold Results

| ICO | MIW4—Care Transition Record Transmitted to Health Care Professional* | MIW5—Medication Review—All Populations* | MIW8—Annual Dental Visit* | MIW9—Minimizing Institutional Length of Stay | MIW10—Antidepressant Medication Management—Effective Acute Phase Treatment | MIW11—Colorectal Cancer Screening* | MIW12—Medication Reconciliation Post-Discharge* |
|------|--|---|---------------------------|--|--|------------------------------------|---|
| | Benchmark: 65% | Benchmark: 90% | Benchmark: 60% | Benchmark: 1.25 | Benchmark: 68% | Benchmark: 66% | Benchmark: 62% |
| AET | Met | Met | Not Met | Not Met | Met | Not Met | Met |
| AMI | Met | Met | Met | Not Met | Met | Not Met | Not Met |
| HAP | Met | Met | Not Met | Met | Met | Not Met | Met |
| MER | Not Met | Not Met | Not Met | Met | Met | Met | Not Met |
| MOL | Met | Not Met | Not Met | Not Met | Met | Met | Not Met |
| UPHP | Met | Met | Not Met | Met | Met | Not Met | Met |

* Indicates measures that also utilize the gap closure target methodology.

Performance Measure Rates

Table 5-7 provides an ICO-to-ICO comparison with the statewide average for HEDIS MY 2022 performance data in 10 HEDIS measure domains. **Green** represents best ICO performance in comparison to the statewide average. **Red** represents worst ICO performance in comparison to the statewide average. Table 5-7 also provides a comparison of HEDIS MY 2021 and HEDIS MY 2022 statewide averages. Statewide averages in **bold** font and shaded in **orange** indicate the HEDIS MY 2022 statewide average demonstrated better performance than the HEDIS MY 2021 statewide average.

Table 5-7—ICO-to-ICO Comparison and Statewide Average

| HEDIS Measure | HEDIS MY 2021 Statewide Average (%) | HEDIS MY 2022 | | | | | | |
|--|-------------------------------------|-----------------------|---------|---------|---------|---------|---------|----------|
| | | Statewide Average (%) | AET (%) | AMI (%) | HAP (%) | MER (%) | MOL (%) | UPHP (%) |
| Prevention and Screening | | | | | | | | |
| BCS—Breast Cancer Screening | 52.74 | 56.70 | 50.40 | 50.11 | 59.61 | 55.86 | 59.22 | 65.49 |
| COL—Colorectal Cancer Screening | 56.03 | 57.59 | 50.26 | 45.45 | 57.63 | 58.05 | 63.19 | 64.12 |
| COA—Care for Older Adults—Medication Review | 74.85 | 80.41 | 93.67 | 95.13 | 61.67 | 66.18 | 79.08 | 94.16 |
| COA—Care for Older Adults—Functional Status Assessment | 58.42 | 62.71 | 71.53 | 64.48 | 68.55 | 35.04 | 65.69 | 83.94 |

| HEDIS Measure | HEDIS MY 2021 Statewide Average (%) | HEDIS MY 2022 | | | | | | |
|---|-------------------------------------|-----------------------|---------|---------|---------|---------|---------|----------|
| | | Statewide Average (%) | AET (%) | AMI (%) | HAP (%) | MER (%) | MOL (%) | UPHP (%) |
| COA—Care for Older Adults—Pain Assessment | 75.25 | 78.04 | 79.32 | 72.51 | 78.62 | 64.96 | 82.24 | 92.70 |
| Respiratory Conditions | | | | | | | | |
| SPR—Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 22.93 | 22.01 | 19.88 | 20.31 | 29.81 | 20.11 | 21.73 | 24.07 |
| PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid | 68.65 | 74.10 | 82.02 | 60.00 | 74.42 | 77.51 | 63.77 | 89.76 |
| PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator | 89.67 | 88.82 | 93.26 | 86.67 | 94.19 | 89.00 | 83.48 | 90.55 |
| Cardiovascular Conditions | | | | | | | | |
| CBP—Controlling High Blood Pressure | 60.52 | 66.14 | 61.56 | 62.03 | 68.11 | 66.42 | 64.48 | 80.05 |
| PBH—Persistence of Beta-Blocker Treatment After a Heart Attack | 95.25 | 90.85 | 86.67 | 90.00 | 100 | 90.63 | 91.18 | 90.00 |
| SPC—Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy | 82.00 | 80.90 | 76.71 | 84.87 | 82.86 | 79.01 | 83.81 | 80.12 |
| SPC—Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80% | 84.22 | 79.55 | 78.13 | 81.19 | 87.36 | 81.82 | 75.36 | 80.45 |
| Diabetes | | | | | | | | |
| HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* | 43.53 | 34.07 | 32.36 | 37.32 | 29.20 | 33.09 | 41.36 | 21.90 |
| HBD—Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) | 49.06 | 58.51 | 58.64 | 53.66 | 64.23 | 58.88 | 53.53 | 68.86 |
| EED—Eye Exam for Patients With Diabetes | 57.33 | 62.89 | 59.37 | 56.83 | 66.67 | 62.04 | 64.72 | 66.91 |
| BPD—Blood Pressure Control for Patients With Diabetes | 60.82 | 68.13 | 64.96 | 59.51 | 66.91 | 69.83 | 65.45 | 85.64 |
| SPD—Statin Therapy for Patients With Diabetes—Received Statin Therapy | 76.83 | 76.44 | 73.88 | 77.82 | 78.56 | 78.10 | 77.87 | 71.22 |

| HEDIS Measure | HEDIS MY 2021 Statewide Average (%) | HEDIS MY 2022 | | | | | | |
|---|-------------------------------------|-----------------------|---------|---------|---------|---------|---------|----------|
| | | Statewide Average (%) | AET (%) | AMI (%) | HAP (%) | MER (%) | MOL (%) | UPHP (%) |
| <i>SPD—Statin Therapy for Patients With Diabetes—Statin Adherence 80%</i> | 82.46 | 78.95 | 74.48 | 77.50 | 80.00 | 79.97 | 78.65 | 86.53 |
| Musculoskeletal Conditions | | | | | | | | |
| <i>OMW—Osteoporosis Management in Women Who Had a Fracture</i> | 16.12 | 11.18 | 12.50 | 0.00 | 20.00 | 6.25 | 13.79 | 10.00 |
| Behavioral Health | | | | | | | | |
| <i>AMM—Antidepressant Medication Management—Effective Acute Phase Treatment</i> | 75.06 | 73.66 | 71.18 | 78.13 | 74.16 | 72.89 | 71.35 | 82.79 |
| <i>AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment</i> | 60.75 | 57.94 | 54.15 | 59.38 | 60.67 | 59.34 | 53.44 | 71.31 |
| <i>FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i> | 26.13 | 32.79 | 29.61 | 24.56 | 20.90 | 34.00 | 37.43 | 41.54 |
| <i>FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up</i> | 50.22 | 58.91 | 53.95 | 49.12 | 52.24 | 58.00 | 62.57 | 73.85 |
| <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up</i> | 33.87 | 32.06 | 48.60 | 11.43 | 34.55 | 35.71 | 22.88 | 29.55 |
| <i>FUM—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up</i> | 51.71 | 54.39 | 68.16 | 34.29 | 50.91 | 56.25 | 47.03 | 61.36 |
| Medication Management and Care Coordination | | | | | | | | |
| <i>TRC—Transitions of Care—Medication Reconciliation Post-Discharge</i> | 43.96 | 47.59 | 67.88 | 58.15 | 42.09 | 38.69 | 28.71 | 74.94 |
| <i>TRC—Transitions of Care—Notification of Inpatient Admission</i> | 13.11 | 16.53 | 1.22 | 25.30 | 15.57 | 25.79 | 2.92 | 60.83 |
| <i>TRC—Transitions of Care—Receipt of Discharge Information</i> | 12.77 | 15.38 | 2.19 | 16.79 | 16.55 | 27.74 | 4.14 | 45.99 |
| <i>TRC—Transitions of Care—Patient Engagement After Inpatient Discharge</i> | 74.60 | 77.74 | 71.53 | 71.68 | 79.32 | 77.62 | 78.83 | 89.78 |
| Overuse/Appropriateness | | | | | | | | |
| <i>PSA—Non-Recommended PSA-Based Screening in Older Men*</i> | 24.68 | 26.71 | 22.95 | 22.18 | 28.02 | 21.84 | 35.52 | 21.19 |

| HEDIS Measure | HEDIS MY 2021 Statewide Average (%) | HEDIS MY 2022 | | | | | | |
|--|-------------------------------------|-----------------------|---------|---------|---------|---------|---------|----------|
| | | Statewide Average (%) | AET (%) | AMI (%) | HAP (%) | MER (%) | MOL (%) | UPHP (%) |
| <i>DDE—Potentially Harmful Drug-Disease Interactions in Older Adults*</i> | 31.94 | 33.45 | 36.83 | 26.23 | 35.26 | 30.61 | 31.38 | 41.20 |
| <i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid*</i> | 17.81 | 18.16 | 17.64 | 10.69 | 23.18 | 15.23 | 19.57 | 21.18 |
| <i>DAE—Use of High-Risk Medications in Older Adults—High-Risk Medications to Avoid Except for Appropriate Diagnosis*</i> | 5.50 | 5.23 | 5.36 | 4.21 | 4.62 | 4.97 | 4.23 | 9.54 |
| <i>DAE—Use of High-Risk Medications in Older Adults—Total*</i> | 21.56 | 21.78 | 21.53 | 14.18 | 25.78 | 18.79 | 22.21 | 28.19 |
| Access/Availability of Care | | | | | | | | |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—20–44 Years</i> | 84.27 | 84.90 | 81.31 | 82.30 | 84.08 | 81.80 | 88.36 | 91.09 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—45–64 Years</i> | 93.49 | 93.83 | 92.66 | 90.13 | 94.49 | 91.87 | 96.14 | 95.55 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—65 and Older</i> | 91.45 | 91.69 | 90.16 | 86.31 | 91.42 | 90.42 | 93.97 | 94.93 |
| <i>AAP—Adults’ Access to Preventive/Ambulatory Health Services—Total</i> | 90.77 | 91.08 | 89.08 | 86.71 | 91.13 | 89.12 | 93.76 | 94.48 |
| Risk-Adjusted Utilization | | | | | | | | |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 18–64)*</i> | 1.17 | 1.07 | 1.40 | 0.95 | 1.00 | 1.03 | 1.11 | 0.51 |
| <i>PCR—Plan All-Cause Readmissions—Observed to Expected Ratio (Ages 65+)*</i> | 1.20 | 1.21 | 1.51 | 1.66 | 0.99 | 1.02 | 1.17 | 0.97 |

* Measures for which lower rates indicate better performance.

Green represents best ICO performance in comparison to the statewide average. Red represents worst ICO performance in comparison to the statewide average.

When HEDIS MY 2021 and HEDIS MY 2022 are comparable, statewide averages in bold font and shaded in orange indicate the HEDIS MY 2022 statewide average demonstrated better performance than the HEDIS MY 2021 statewide average.

Compliance Review

Table 5-8 presents the current three-year cycle of reviews (SFY 2022–SFY 2024) and the division of standards reviewed over each year. Table 5-8 also compares the MI Health Link program average compliance score in each of the 14 standards with the compliance score achieved by each ICO. In SFY 2024, HSAG will conduct a review of each ICO’s implementation of corrective actions taken to remediate any elements that received a *Not Met* score during SFY 2022 and SFY 2023.

Table 5-8—Summary of Combined SFY 2022 and SFY 2023 Compliance Review Results

| Standard ¹ | AET | AMI | HAP | MER | MOL | UPHP | MI Health Link Program |
|---|------------|------------|------------|------------|------------|------------|------------------------|
| SFY 2022 (Year One) | | | | | | | |
| Standard I—Disenrollment: Requirements and Limitations ² | 100% | 100% | 100% | 100% | 100% | 89% | 97% |
| Standard II—Member Rights and Member Information | 65% | 59% | 61% | 70% | 70% | 73% | 66% |
| Standard III—Emergency and Poststabilization Services ² | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Standard IV—Availability of Services | 92% | 85% | 100% | 100% | 100% | 85% | 94% |
| Standard V—Assurances of Adequate Capacity and Services | 100% | 100% | 75% | 75% | 100% | 75% | 88% |
| Standard VI—Coordination and Continuity of Care | 73% | 77% | 80% | 73% | 80% | 77% | 77% |
| Standard VII—Coverage and Authorization of Services | 89% | 89% | 86% | 78% | 85% | 100% | 88% |
| SFY 2022 Total Compliance Score | 83% | 82% | 83% | 81% | 85% | 86% | 83% |
| SFY 2023 (Year Two) | | | | | | | |
| Standard VIII—Provider Selection | 91% | 91% | 87% | 87% | 87% | 87% | 88% |
| Standard IX—Confidentiality | 100% | 73% | 91% | 91% | 100% | 64% | 86% |
| Standard X—Grievance and Appeal Systems | 78% | 71% | 78% | 78% | 71% | 80% | 76% |
| Standard XI—Subcontractual Relationships and Delegation | 80% | 80% | 80% | 80% | 80% | 60% | 77% |
| Standard XII—Practice Guidelines | 100% | 100% | 100% | 83% | 100% | 83% | 94% |
| Standard XIII—Health Information Systems ³ | 89% | 100% | 100% | 100% | 100% | 100% | 98% |
| Standard XIV—Quality Assessment and Performance Improvement Program | 90% | 90% | 90% | 95% | 81% | 90% | 90% |
| SFY 2023 Total Compliance Score | 87% | 83% | 86% | 86% | 83% | 83% | 84% |

| Standard ¹ | AET | AMI | HAP | MER | MOL | UPHP | MI Health Link Program |
|---|------------|------------|------------|------------|------------|------------|------------------------|
| Combined Compliance Score (SFY 2022 and SFY 2023) | 85% | 82% | 84% | 83% | 84% | 84% | 84% |
| SFY 2024 (Year Three) | | | | | | | |
| HSAG will perform a comprehensive review of the ICOs' implementation of corrective actions taken to remediate any elements that received a <i>Not Met</i> score during SFY 2022 and SFY 2023. | | | | | | | |

Total Compliance Score: Elements scored *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each ICO's standards and for the MI Health Link program.

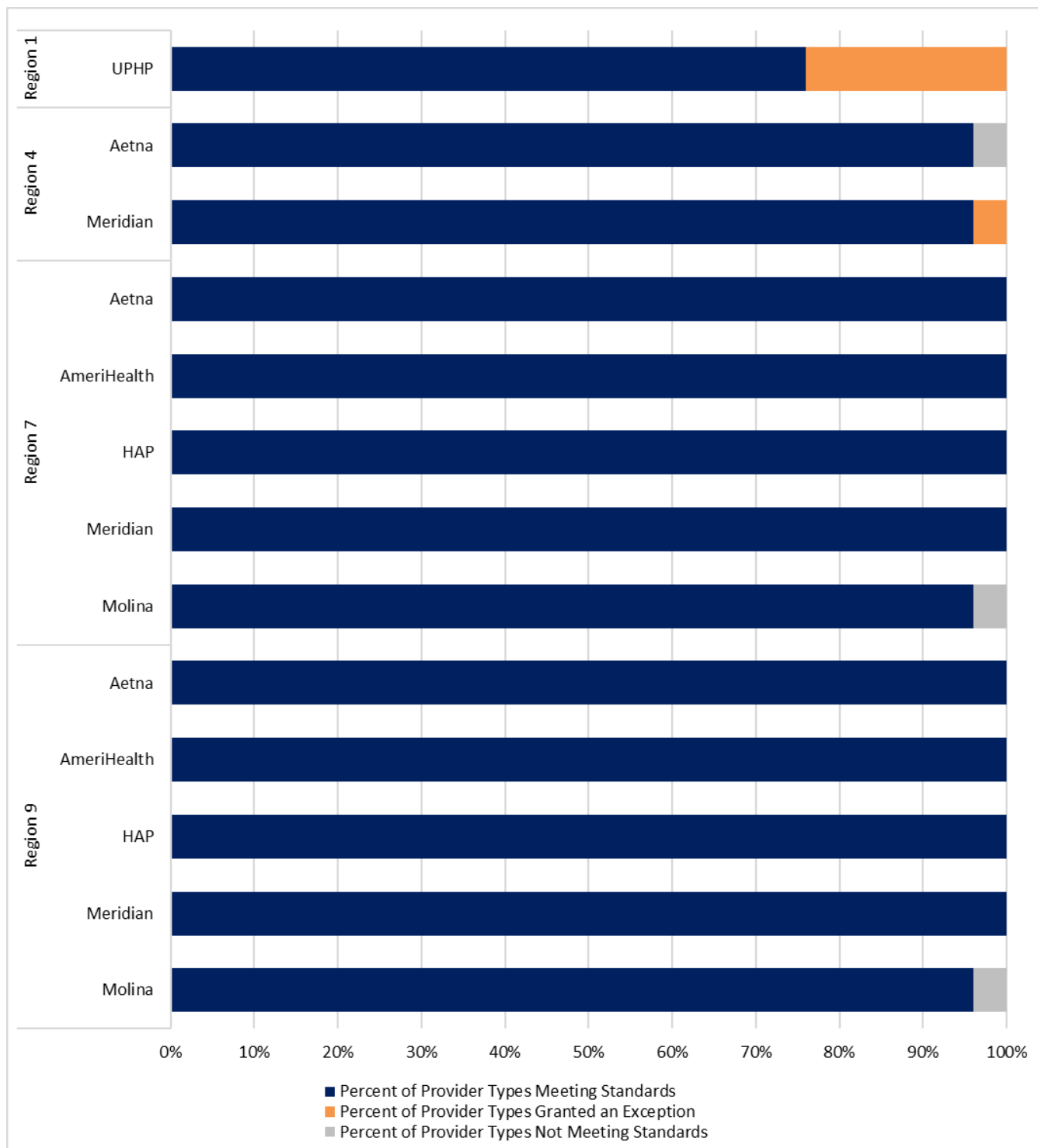
- ¹ The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).
- ² Performance in this standard should be interpreted with caution as there were noted opportunities for the ICO to enhance written documentation supporting the federal and/or State requirements; therefore, full compliance in this program area is not considered a strength within this compliance review. The ICO's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.
- ³ The Health Information Systems standard includes an assessment of each ICO's IS capabilities.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

HSAG validated the adequacy of each ICO's provider network according to MI Health Link's minimum network requirements for 25 Medicaid and LTSS provider types. Figure 5-1 presents the ICOs' final region-specific NAV results (i.e., the percentage of the 25 Medicaid and LTSS provider types for which each ICO met the minimum network requirements, received an exception, or did not meet the minimum network requirements) using the most recent data submission and MDHHS' exception determinations.

Figure 5-1—SFY 2023 Final NAV Results by Region and ICO



Secret Shopper Survey

During March and April 2023, HSAG completed a secret shopper telephone survey of dental provider offices contracted with one or more ICOs under the MI Health Link program to collect information on the MI Health Link members’ access to preventive dental care visits. Therefore, survey respondents may have given different information for each ICO-specific sampled provider location (i.e., “case”). Table 5-9 summarizes the number of survey cases and outcomes by region and ICO.

Table 5-9—Summary of Secret Shopper Survey Case Outcomes, by Region and ICO^{5-1,5-2}

| ICO | Total Survey Cases | Cases Accepting ICO | Cases Accepting MI Health Link | Cases Accepting New Patients | Cases Offered Appointment | Median Appointment Wait Time (Calendar Days) |
|-----------------------|--------------------|---------------------|--------------------------------|------------------------------|---------------------------|--|
| Region 1 | | | | | | |
| UPHP | 21 | 12 | 12 | 9 | 6 | 177 |
| Region 1 Total | 21 | 12 | 12 | 9 | 6 | 177 |
| Region 4 | | | | | | |
| Aetna | 15 | 11 | 6 | 5 | 3 | 49 |
| Meridian | 11 | 5 | 1 | 1 | 1 | 25 |
| Region 4 Total | 26 | 16 | 7 | 6 | 4 | 37 |
| Region 7 | | | | | | |
| Aetna | 51 | 41 | 34 | 32 | 28 | 13 |
| AmeriHealth | 17 | 11 | 5 | 5 | 2 | 30 |
| HAP | 182 | 97 | 79 | 74 | 68 | 14 |
| Meridian | 101 | 60 | 50 | 47 | 36 | 22 |
| Molina | 98 | 54 | 54 | 51 | 42 | 11 |
| Region 7 Total | 449 | 263 | 222 | 209 | 176 | 17 |
| Region 9 | | | | | | |
| Aetna | 44 | 34 | 22 | 21 | 19 | 14 |
| AmeriHealth | 17 | 9 | 5 | 5 | 4 | 49 |

⁵⁻¹ Molina transitioned to a new dental benefits administrator (DBA) on March 1, 2023. During survey administration, four sampled providers opted out of Molina’s network and were removed from the final survey results.

⁵⁻² Aetna reported an issue with its provider data files after survey administration was completed. Aetna did not provide a full network sample frame for Region 7 (i.e., contracted providers were unintentionally dropped from the file during formatting); however, a valid sample was selected for Aetna in Region 7 using the original data file.

| ICO | Total Survey Cases | Cases Accepting ICO | Cases Accepting MI Health Link | Cases Accepting New Patients | Cases Offered Appointment | Median Appointment Wait Time (Calendar Days) |
|-----------------------|--------------------|---------------------|--------------------------------|------------------------------|---------------------------|--|
| HAP | 183 | 82 | 76 | 75 | 58 | 9 |
| Meridian | 49 | 17 | 14 | 14 | 13 | 13 |
| Molina | 46 | 21 | 20 | 18 | 15 | 12 |
| Region 9 Total | 339 | 163 | 137 | 133 | 109 | 12 |
| ICO Total | 835 | 454 | 378 | 357 | 295 | 14 |

Table 5-10 displays the number and percentage of cases in which the survey respondent reported that the provider location offered an appointment date to new MI Health Link patients with the specified ICO for a routine dental visit. Appointments may have been offered with any practitioner at the sampled location.

Table 5-10—New Patient Appointment Wait Time in Calendar Days for Routine Dental Services, by ICO and Region

| | | | Cases Offered an Appointment | | | Appointment Wait Time (Days) | | | |
|-----------------------|--------------------|--|------------------------------|--|--|------------------------------|------------|------------|------------|
| ICO | Total Survey Cases | Cases Contacted and Accepting New Patients | Number | Rate Among All Surveyed Cases ¹ (%) | Rate Among Cases Accepting New Patients ² (%) | Min | Max | Average | Median |
| Region 1 | | | | | | | | | |
| UPHP | 21 | 9 | 6 | 28.6% | 66.7% | 1 | 228 | 147 | 177 |
| Region 1 Total | 21 | 9 | 6 | 28.6% | 66.7% | 1 | 228 | 147 | 177 |
| Region 4 | | | | | | | | | |
| Aetna | 15 | 5 | 3 | 20.0% | 60.0% | 1 | 56 | 35 | 49 |
| Meridian | 11 | 1 | 1 | 9.1% | 100% | 25 | 25 | 25 | 25 |
| Region 4 Total | 26 | 6 | 4 | 15.4% | 66.7% | 1 | 56 | 33 | 37 |
| Region 7 | | | | | | | | | |
| Aetna | 51 | 32 | 28 | 54.9% | 87.5% | 0 | 79 | 18 | 13 |
| AmeriHealth | 17 | 5 | 2 | 11.8% | 40.0% | 24 | 35 | 30 | 30 |
| HAP | 182 | 74 | 68 | 37.4% | 91.9% | 1 | 245 | 25 | 14 |
| Meridian | 101 | 47 | 36 | 35.6% | 76.6% | 0 | 69 | 25 | 22 |

| | | | Cases Offered an Appointment | | | Appointment Wait Time (Days) | | | |
|-----------------------|--------------------|--|------------------------------|--|--|------------------------------|------------|-----------|-----------|
| ICO | Total Survey Cases | Cases Contacted and Accepting New Patients | Number | Rate Among All Surveyed Cases ¹ (%) | Rate Among Cases Accepting New Patients ² (%) | Min | Max | Average | Median |
| Molina | 98 | 51 | 42 | 42.9% | 82.4% | 1 | 96 | 21 | 11 |
| Region 7 Total | 449 | 209 | 176 | 39.2% | 84.2% | 0 | 245 | 23 | 17 |
| Region 9 | | | | | | | | | |
| Aetna | 44 | 21 | 19 | 43.2% | 90.5% | 1 | 35 | 15 | 14 |
| AmeriHealth | 17 | 5 | 4 | 23.5% | 80.0% | 28 | 124 | 62 | 49 |
| HAP | 183 | 75 | 58 | 31.7% | 77.3% | 0 | 205 | 21 | 9 |
| Meridian | 49 | 14 | 13 | 26.5% | 92.9% | 0 | 77 | 18 | 13 |
| Molina | 46 | 18 | 15 | 32.6% | 83.3% | 1 | 53 | 17 | 12 |
| Region 9 Total | 339 | 133 | 109 | 32.2% | 82.0% | 0 | 205 | 20 | 12 |
| ICO Total | 835 | 357 | 295 | 35.3% | 82.6% | 0 | 245 | 25 | 14 |

¹ The denominator includes all cases included in the sample.

² The denominator includes cases reached that accept the ICO, MI Health Link, and new patients.

Among all surveyed cases, the overall appointment rate was 35.3 percent. Appointment availability was reported for 82.6 percent of all cases in which the survey respondent reported that the provider location accepted the ICO, the MI Health Link program, and new patients.

Encounter Data Validation

Table 5-11 presents the EDV results for all ICOs. Results for the administrative profile are stratified by category of service. For both analyses, cells with a “✓” indicate no or minor concerns noted, cells with a “–” indicate moderate concerns noted, and cells with an “x” indicate major concerns noted. For ICO-specific results, refer to Section 3.

Table 5-11—EDV ICO Comparison

| Analysis | | Aetna | AmeriHealth | HAP | Meridian | Molina | UPHP |
|---------------------------------------|---------------|-------|-------------|-----|----------|--------|------|
| IS Review | | | | | | | |
| Encounter Data Sources and Systems | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Payment Structures | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Encounter Data Quality Monitoring | | – | ✓ | – | – | – | – |
| Administrative Profile | | | | | | | |
| Encounter Data Completeness | Professional | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Institutional | ✓ | ✓ | ✓ | ✓ | – | ✓ |
| | Dental | ✓ | ✓ | ✓ | NA | ✓ | ✓ |
| | Pharmacy | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Encounter Data Timeliness | Professional | ✓ | ✓ | ✓ | x | x | ✓ |
| | Institutional | ✓ | – | ✓ | – | x | ✓ |
| | Dental | ✓ | ✓ | ✓ | NA | x | x |
| | Pharmacy | ✓ | ✓ | – | x | ✓ | ✓ |
| Field-Level Completeness and Accuracy | Professional | – | ✓ | – | – | – | – |
| | Institutional | ✓ | – | ✓ | ✓ | ✓ | ✓ |
| | Dental | ✓ | ✓ | ✓ | NA | ✓ | ✓ |
| | Pharmacy | ✓ | ✓ | – | ✓ | ✓ | ✓ |
| Encounter Referential Integrity | Professional | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Institutional | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Dental | ✓ | ✓ | ✓ | NA | ✓ | ✓ |
| | Pharmacy | – | ✓ | – | ✓ | – | – |

| Analysis | Aetna | AmeriHealth | HAP | Meridian | Molina | UPHP |
|----------------------|---------------|-------------|-----|----------|--------|------|
| Encounter Data Logic | Professional | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Institutional | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Dental | ✓ | ✓ | ✓ | NA | ✓ |
| | Pharmacy | ✓ | ✓ | ✓ | ✓ | ✓ |

NA: Not applicable.

| | |
|---|-----------------------------|
| ✓ | No or minor concerns noted. |
| – | Moderate concerns noted. |
| ✗ | Major concerns noted. |

Consumer Assessment of Healthcare Providers and Systems Analysis

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in all six ICOs; however, due to the low number of respondents to the survey, individual plan results are unable to be presented or compared across the ICOs. Table 5-12 presents the 2021, 2022, and 2023 HCBS CAHPS top-box scores for the MI Health Link program. Top-box scores represent the percentage of eligible respondents who answered with the most positive response. For more detailed information regarding top-box scores, please refer to Appendix A.

Table 5-12—Summary of HCBS CAHPS Survey Mean Top-Box Scores for the MI Health Link Program^{5-3, 5-4}

| | 2021 Top-Box Score | 2022 Top-Box Score | 2023 Top-Box Score |
|--|--------------------|--------------------|--------------------|
| Global Ratings | | | |
| <i>Rating of Personal Assistance and Behavioral Health Staff</i> | 86.32% | 86.58% | 89.96%↑ |
| <i>Rating of Homemaker</i> | 89.44% | 82.50%* | 88.89%↑ |
| <i>Rating of Case Manager</i> | 87.25% | 87.18% | 89.24%↑ |
| Composite Measures | | | |
| <i>Planning Your Time and Activities</i> | 63.60% | 62.11% | 63.70%↑ |
| <i>Reliable and Helpful Staff</i> | 88.81% | 81.40%▼ | 87.07% |
| <i>Staff Listen and Communicate Well</i> | 89.80% | 86.80%* | 89.43% |
| <i>Helpful Case Manager</i> | 94.41% | 92.48%* | 96.51%↑ |

⁵⁻³ The HCBS CAHPS Database benchmark (i.e., AHRQ Top-Box Aggregate) was not available for 2023 at the time this report was prepared; therefore, 2021 data were used for this comparative analysis. Caution should be exercised when comparing the 2021 HCBS CAHPS Database benchmarks to the 2023 results.

⁵⁻⁴ HSAG updated its analysis of 2023 results from mean scores to top-box scores and recalculated the 2022 and 2021 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability.

| | 2021 Top-Box Score | 2022 Top-Box Score | 2023 Top-Box Score |
|--|--------------------|--------------------|--------------------|
| <i>Choosing the Services that Matter to You</i> | 83.93% | 81.37% | 82.87% |
| <i>Transportation to Medical Appointments</i> | 82.24% | 80.12% | 77.82%↑ |
| <i>Personal Safety and Respect</i> | 96.57% | 94.60% | 95.83%↑ |
| Recommendation Measures | | | |
| <i>Recommend Personal Assistance/Behavioral Health Staff</i> | 91.94%▲ | 86.75% | 85.11%↑ |
| <i>Recommend Homemaker</i> | 88.81% | 74.36%* | 86.09%↑ |
| <i>Recommend Case Manager</i> | 86.21% | 83.12% | 83.18%↑ |
| Unmet Need Measures | | | |
| <i>No Unmet Need in Dressing/Bathing</i> | S | S | 75.00%* |
| <i>No Unmet Need in Meal Preparation/Eating</i> | S | S | S |
| <i>No Unmet Need in Medication Administration</i> | 84.21%* | S | 71.43%* |
| <i>No Unmet Need in Toileting</i> | 100.0% | 93.65%* | 98.04%* |
| <i>No Unmet Need with Household Tasks</i> | S | S | S |
| Physical Safety Measure | | | |
| <i>Not Hit or Hurt by Staff</i> | 100.0% | 98.97% | 100.0%* |

* Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

“S” Indicates that there were fewer than 11 respondents for a measure; therefore, results were suppressed.

▲ Indicates the score is statistically significantly higher than the 2023 score.

▼ Indicates the score is statistically significantly lower than the 2023 score.

↑ Indicates the 2023 score is statistically significantly higher than the 2021 AHRQ Top-Box Aggregate.

↓ Indicates the 2023 score is statistically significantly lower than the 2021 AHRQ Top-Box Aggregate.

If no statistically significant differences were found, no triangle or arrow indicator is shown.

6. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the ICOs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the MI Health Link program to identify programwide conclusions. The programwide conclusions are not intended to be inclusive of all EQR activity results; rather, only those results that had a substantial impact on a CQS goal. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the Michigan CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members.

Table 6-1—Programwide Conclusions and Recommendations

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|---|---|---|
| Goal #1 —Ensure high quality and high levels of access to care | <p>Conclusions: The results of the SFY 2023 NAV and secret shopper activities identified mixed results related to the assessment of adequate access to providers. As demonstrated through the NAV activity, the ICOs met minimum network requirements for each region, or were granted an exception(s), for most provider types. Overall, MI Health Link members had access to an adequate network of providers. However, one ICO did not meet the minimum standard for Adult Day Program in Region 4, and a second ICO did not meet the minimum standard for Assistive Technology—Van Lifts and Tie Downs in regions 7 and 9, indicating some MI Health Link members residing in these regions may not have adequate access to these services. Additionally, while the median appointment wait time for scheduling an initial dental appointment was 14 calendar days and met MDHHS’ appointment standard of eight weeks, the secret shopper survey findings also demonstrated that 64.7 percent of overall cases (i.e., sampled providers) were unable to be reached, did not accept the ICO (i.e., the insurance plan), did not accept and/or recognize the MI Health Link program, were not accepting new patients, or were unable to offer an appointment date. Further, the maximum wait time for an initial dental appointment exceeded the eight-week standard in all regions except Region 4. These findings suggest that MI Health Link members may have challenges contacting dental providers and scheduling appointments for routine dental services, and may experience long wait times for dental appointments. Further, as indicated through the statewide HEDIS averages within the Respiratory Conditions, Cardiovascular Conditions, Musculoskeletal Conditions, and Overuse/Appropriateness domains, 10 out of 13 performance measure rates declined from the prior year. Within the Behavioral Health domain, while three of the six performance measure rates also</p> | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|--|---|---|
| | <p>declined, the remaining three demonstrated improvement from the prior year.</p> <p>However, the MI Health Link program made progress toward achieving Goal #1 as demonstrated through improvement in all six Prevention and Screening domain performance measure rates, four out of six Diabetes domain performance measure rates, and all four performance measure rates under the Access/Availability of Care domain.</p> <p>Recommendations: MDHHS has a robust CAP process that the ICOs must complete for all identified network adequacy deficiencies and, through this CAP process, must provide evidence to MDHHS demonstrating that evidence of education and training was provided to applicable dental provider offices. Additionally, MDHHS required the ICOs to extend all training and oversight activities implemented through the CAP process to dental providers not included in the NAV study (i.e., not included in the sample of providers selected). HSAG recommends that MDHHS continue to keep the ICOs accountable for correcting deficiencies identified through EQR activities. Additionally, MDHHS has added several quantitative Quality Measures for Goal #1 to monitor high quality and high levels of access to care. HSAG recommends MDHHS evaluate the MI Health Link program's performance against the established Statewide Performance Target and determine whether the defined Quality Measures and/or performance targets need to be updated based on performance. For example, the baseline rate for <i>PM13 Number and percent of enrollees whose HCSP addressed their assessed health and safety risks (HCBS C-waiver population)</i> is high at 98.40 percent; however, the established goal is less than the baseline rate (i.e., ≥ 86 percent). Therefore, MDHHS could determine whether this Quality Measure will promote performance improvement and progress toward achieving Goal #1.</p> | |
| Goal #2 —Strengthen person and family-centered approaches | <p>Conclusions: MDHHS requested that the HCBS CAHPS Survey be conducted in SFY 2023. This survey gathers direct feedback from members receiving HCBS about their experiences and the quality of LTSS they receive. For 10 of the 17 reportable measures, the 2023 top-box scores were statistically significantly higher than the 2021 AHRQ Top-Box Aggregate, indicating many MI Health Link members reported having positive experiences.</p> <p>However, the lowest performing CAHPS measure was <i>Planning Your Time and Activities</i>, with a 2023 top-box score of 63.7 percent, indicating opportunities for the MI Health Link program to promote</p> | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|-----------------------|---|--------------------|
| | <p>community inclusion and empowerment as some members reported not being able to get together with family or friends, do things in the community they like, or take part in deciding what to do with their time each day.</p> <p>Additionally, the SFY 2023 compliance review activity included a review of each ICO's grievance and appeal systems. These systems are important managed care rights that allow members to advocate for themselves and the care they receive by being able to file complaints with the ICO, including expressions of dissatisfaction with any aspect of the operations, activities, or behavior of the ICO or its delegated entity in the provision of healthcare items, services, or prescription drugs; and requesting a review of initial ABDs made by an ICO on requests for healthcare services or items. The MI Health Link program's score for the Grievance and Appeal Systems program area was only 76 percent, indicating multiple opportunities to ensure members receive adequate resolution of complaints and access to all appeal and SFH rights.</p> <p>Recommendations: As <i>Planning Your Time and Activities</i> was the lowest scoring CAHPS measure, MDHHS could consider requiring the ICOs to develop a nonclinical QIP or initiatives that focus on improving the rate for this measure.</p> <p>Additionally, many of the deficiencies related to the Grievance and Appeal Systems standard were related to the ICOs and/or the ICOs' delegates not using current model notices and/or the ICOs not disseminating updated model notices to all applicable internal departments and/or delegates. As such, HSAG recommends that MDHHS require each ICO to provide an email confirmation when model notices have been disseminated to all appropriate individuals, including applicable delegates, when MDHHS distributes updated model notices. MDHHS should also request that the ICOs provide confirmation when the updated model notices have been fully integrated within their systems and processes, both internally and by applicable delegates. Further, in most instances, the ICOs were following Medicare regulations for services that were Medicare primary and not adhering to all applicable Three-Way Contract provisions as required. HSAG recommends that MDHHS add specific language in the Three-Way Contract requiring the ICOs to follow the Three-Way Contract provisions for processing all grievances and appeals. If the Three-Way Contract conflicts with Medicare or Medicaid regulations, MDHHS should mandate that the ICOs follow the most stringent provision and notify MDHHS when a conflict has been identified. As the MI Health Link program is</p> | |

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|---|---|--|
| | <p>transitioning to HIDE SNPs effective January 1, 2026, HSAG also recommends that MDHHS consider ways to integrate Medicare and Medicaid grievance and appeal processes for this new program.</p> <p>Lastly, MDHHS has added <i>SNS-E Social Needs Screening & Intervention</i> as a 2023–2026 CQS Quality Measure for the MI Health Link program; however, a Statewide Baseline Performance rate and a Statewide Performance Target rate have yet to be determined. As such, HSAG recommends that MDHHS proceed with establishing a baseline rate and target rate for this measure.</p> | |
| Goal #3 —Promote effective care coordination and communication of care among managed care programs, providers and stakeholders (internal and external) | <p>Conclusions: One of MDHHS’ objectives to support Goal #3 is to promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes. This objective aligns with CMS’ goal to advance interoperability with the mission of promoting the secure exchange, access, and use of electronic health information to support better informed decision making and a more efficient healthcare system. The SFY 2023 compliance review included a review of the Health Information Systems standard, which included an assessment of each ICO’s implementation of CMS’ interoperability final rules. The MI Health Link program received a score of 98 percent for this standard, and all ICOs implemented the Patient Access API and Provider Directory API, indicating the MI Health Link program is making progress toward achieving Goal #3.</p> <p>Additionally, based on the results of the PMV activity, while the ICOs had opportunities for improvement, all rates were considered <i>Reportable</i>, indicating MDHHS can rely on the validity of the results to monitor care coordination processes employed by the MI Health Link program’s ICOs. Further, all HEDIS performance measure rates under the Medication Management and Care Coordination domain demonstrated improvement from the prior year.</p> <p>Recommendations: CMS has enhanced current interoperability and API requirements as described in CMS-0057-F. However, the due date for implementation of these new provisions is effective after the transition of the MI Health Link program to HIDE SNPs. As such, HSAG recommends that MDHHS consider the provisions of CMS-0057-F when initiating contracts with the new HIDE SNPs. Additionally, as CMS-0057-F will require future reporting of Patient Access API usage and prior authorization metrics, HSAG recommends that MDHHS consider if these metrics align with MDHHS’ current CQS goals and objectives and identify whether a</p> | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|--|--|---|
| | new Quality Measure should be developed to address the new API requirements to further support Goal #3. | |
| Goal #4 —Reduce racial and ethnic disparities in healthcare and health outcomes | <p>Conclusions: MDHHS required the ICOs to continue their QIPs focused on reducing healthcare disparities within their populations. For the SFY 2023 QIP activity, the ICOs reported Remeasurement 1 rates. While only one ICO eliminated the existing disparity during Remeasurement 1, four ICOs increased the rates for their disparate populations. Two ICOs also demonstrated programmatically significant improvement. According to the CDC, racial and ethnic minority groups experience higher rates of illness and death across a wide range of health conditions (i.e., diabetes, hypertension, obesity, asthma, and heart disease) when compared to their White counterparts.⁶⁻¹ Continuing these QIPs in SFY 2024, including placing an emphasis on identifying barriers and implementing targeted interventions that focus specifically on the disparate populations, should have a positive impact for African-American and American Indian/Alaskan Native MI Health Link members relating to diabetes management, transitions of care, management of hypertension, statin therapy, or dental care.</p> <p>Additionally, MDHHS contractually requires each ICO’s QAPI program to incorporate activities that reduce disparities in health and healthcare broadly irrespective of race, ethnicity, national origin, religion, sex, or gender. The SFY 2023 compliance review activity demonstrated that the MI Health Link program received a score of 90 percent in this related program area. All ICOs demonstrated the implementation of various initiatives related to social determinants of health and health disparity reduction.</p> <p>The MI Health Link program has placed a strong emphasis on addressing health disparities as demonstrated through the EQR activities (i.e., through mandating a health equity QIP and contractually requiring the ICOs’ QAPIs to include activities addressing healthcare disparities), in addition to other initiatives implemented by MDHHS outside of the EQR activities such as the Health Equity Project and facilitating health equity training for the ICOs in support of Goal #4.</p> <p>Recommendations: While all ICOs demonstrated the implementation of various initiatives related to social determinants of</p> | <input checked="" type="checkbox"/> Quality <input checked="" type="checkbox"/> Timeliness <input checked="" type="checkbox"/> Access |

⁶⁻¹ Centers for Disease Control and Prevention. Minority Health, September 18, 2023. Available at: <https://www.cdc.gov/minorityhealth/racism-disparities/index.html>. Accessed on: Mar 18, 2024.

| Quality Strategy Goal | Overall Performance Impact | Performance Domain |
|---|---|---|
| | health and health disparity reduction, HSAG identified that these activities were not clearly outlined in the QAPI work plan consistently across the ICOs. HSAG recommends that MDHHS place a strong focus on each ICO's initiatives addressing health disparities during each annual QAPI submission to MDHHS. MDHHS could also consider enhancing templates the ICOs are required to submit as part of the annual QAPI submission to require more specific information on these activities. | |
| Goal #5 —Improve quality outcomes and disparity reduction through value-based initiatives and payment reform | <p>Conclusions: Although the findings of the EQR activities do not allow for a comprehensive evaluation of the MI Health Link program's progress toward achieving Goal #5, MDHHS has implemented a quality withhold policy in which CMS and MDHHS withhold a percentage of their respective components of the capitations payment. The withheld amounts are then repaid subject to each ICO's performance consistent with the established quality thresholds. MDHHS' contract with the ICOs identifies the quality withhold measures for each year of the demonstration and includes a combination of CMS/state-defined measures, HEDIS, CAHPS, and CMS data. In SFY 2023, which relied on MY 2022 data, all ICOs received a portion of their withheld funds.</p> <p>Additionally, according to <i>Effectiveness Evaluation Appendix C Results of 2020–2023 CQS Goals & Objectives Program Evaluation Assessments</i> included as part of the 2023–2026 CQS, the MI Health Link program met both objectives under Goal #5. Specifically, the evaluation indicated that MDHHS contractually requires the ICOs to demonstrate use of APMs that will advance the delivery system innovations inherent in the MI Health Link model, incentivize quality care, and improve health outcomes for members.</p> <p>Recommendations: While MDHHS has updated its 2023–2026 CQS to include Quality Measures under Goal #5, with Statewide Baseline Performance rates and Statewide Performance Target rates, no quantitative Quality Measures specific to the MI Health Link program were included. As the MI Health Link program is transitioning to a HIDE SNP effective January 1, 2026, HSAG recommends that MDHHS consider future Quality Measures to include under Goal #5 for the new HIDE SNP program.</p> | <input checked="" type="checkbox"/> Quality <input type="checkbox"/> Timeliness <input type="checkbox"/> Access |

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Quality Improvement Projects^{A-1}

Activity Objectives

Validating QIPs is one of the mandatory EQR activities described at 42 CFR §438.330(b)(1). In accordance with 42 CFR §438.330(d), ICOs are required to have a comprehensive QAPI program, which includes QIPs that focus on both clinical and nonclinical areas. Each QIP must involve:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve quality improvement.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The EQR technical report must include information on the validation of QIPs required by the State and underway during the preceding 12 months.

The primary objective of QIP validation is to determine the ICO's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the QIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the QIP to ensure that the ICO designs, conducts, and reports the QIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the QIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported QIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the QIP. Once designed, an ICO's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the ICO improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

^{A-1} MCEs that participate in Medicare and/or Medicaid are required by regulation to develop and implement QIPs/PIPs. Medicare plans are required to conduct and report on QIPs, and Medicaid plans are required to conduct and report on PIPs. Because both Medicare and Medicaid plans are referenced in this report, QIPs and PIPs will be referenced throughout the report.

The goal of HSAG's QIP validation is to ensure that MDHHS and key stakeholders can have confidence that the ICO executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted by the ICO during the QIP.

MDHHS requires that each ICO conduct one QIP that is validated by HSAG. For this year's SFY 2023 validation, the ICOs submitted Remeasurement 1 data for their ICO-specific QIP topics. HSAG conducted validation of the QIP Implementation (Steps 7 and 8) and Outcomes (Step 9) stages of the selected QIP topic for each ICO. The QIP topics chosen by the ICOs addressed CMS' requirements related to quality outcomes—specifically, quality and access to care and services. MDHHS requested that the ICOs implement QIPs that focus on eliminating disparities within their populations.

Technical Methods of Data Collection and Analysis

In its QIP evaluation and validation, HSAG used CMS EQR Protocol 1. Using this protocol, HSAG, in collaboration with MDHHS, developed the QIP Submission Form, which each ICO completed and submitted to HSAG for review and evaluation. The QIP Submission Form standardized the process for submitting information regarding QIPs and ensured all CMS EQR Protocol 1 requirements were addressed.

HSAG, with MDHHS' input and approval, developed a QIP Validation Tool to ensure uniform validation of QIPs. Using this tool, HSAG evaluated each of the QIPs according to the CMS EQR Protocol 1. The HSAG QIP review team consisted of, at a minimum, an analyst with expertise in statistics and QIP design and a clinician with expertise in quality improvement processes. The CMS EQR Protocol 1 identifies nine steps that should be validated for each QIP. For the SFY 2023 submissions, the ICOs reported Remeasurement 1 data and were validated for Steps 7 through 9 in the QIP Validation Tool.

The nine steps included in the QIP Validation Tool are listed below:

1. Review the Selected QIP Topic
2. Review the QIP Aim Statement
3. Review the Identified QIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of QIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate QIPs conducted by the ICOs to determine if a QIP is valid and to rate the percentage of compliance with CMS' protocol for conducting QIPs.

Each required step is evaluated on one or more elements that form a valid QIP. The HSAG QIP review team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the QIP process as “critical elements.” For a QIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the QIP of *Not Met*. The ICO is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the QIP activities and evaluation elements.

In addition to the validation rating (e.g., *Met*), HSAG assigns the QIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the QIP’s findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported QIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported QIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Partially Met*.
- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Not Met*.

The ICOs had the opportunity to receive initial QIP validation scores, request additional technical assistance from HSAG, make any necessary corrections, and resubmit the QIP for final validation. HSAG conducted a final validation for any resubmitted QIPs and documented the findings and recommendations for each QIP. Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each ICO. These reports, which complied with 42 CFR §438.364, were provided to MDHHS and the ICOs.

Description of Data Obtained and Related Time Period

For SFY 2023, the ICOs submitted Remeasurement 1 data for their QIP topic. The performance indicator measurement period dates for the QIP are listed in Table A-1.

Table A-1—Description of Data Obtained and Measurement Periods

| ICO | Data Obtained | Measurement Period | Period to Which the Data Applied |
|------|----------------|--------------------|----------------------------------|
| AET | Hybrid | Remeasurement 1 | SFY 2023 (CY 2022) |
| AMI | Hybrid | | |
| HAP | Hybrid | | |
| MER | Administrative | | |
| MOL | Administrative | | |
| UPHP | Administrative | | |

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG validated the QIPs to ensure they used a sound methodology in their design and QIP implementation. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *Met*, *Partially Met*, or *Not Met*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline and QIP goals) and qualitative results (e.g., technical design of the QIP) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to ICO Medicaid members.

Performance Measure Validation

Activity Objectives

42 CFR §438.350(a) requires states that contract with ICOs to perform validation of performance measures as one of the mandatory EQR activities. The primary objectives of the PMV activities were to:

- Evaluate the accuracy of the performance measure data reported by the ICO.
- Determine the extent to which the specific performance measures reported by the ICO followed the State and federal specifications and reporting requirements.
- Identify overall strengths and areas for improvement in the PMV.

HSAG validated a set of performance measures that were selected by MDHHS for validation in SFY 2023. Table A-2 lists the performance measures calculated by the ICOs for CY 2022 (i.e., January 1, 2022, through December 31, 2022), along with the performance measure number. The performance measures are numbered as they appear in the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements*^{A-2} and the *Medicare-Medicaid Capitated Financial Alignment Reporting Requirements: Michigan-Specific Reporting Requirements*^{A-3} technical specification manuals.

Table A-2—Performance Measures for Validation

| Performance Measures | |
|----------------------|--|
| Core Measure 9.3 | <i>Minimizing Institutional Length of Stay</i> |
| MI2.6 | <i>Timely Transmission of Care Transition Record to Health Care Professional</i> |
| MI5.6 | <i>Care for Adults—Medication Review</i> |
| MI7.3 | <i>Annual Dental Visit</i> |

Technical Methods of Data Collection and Analysis

HSAG developed the PMV protocol for ICOs in accordance with the CMS EQR Protocols. The CMS MMP Core Reporting Requirements (issued November 1, 2022, and effective as of January 1, 2023) and Michigan-Specific Reporting Requirements (issued February 28, 2023) documents provide the reporting specifications that ICOs were required to follow.

The CMS EQR Protocol 2 identifies key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of the data:

- **ISCAT**—The ICOs were required to submit a completed ISCAT that provided information on their IS; processes used for collecting, storing, and processing data; and processes used for performance measure reporting. Upon receipt by HSAG, the ISCAT(s) underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures**—ICOs that reported the performance measures using computer programming language were required to submit source code for each performance measure being validated. HSAG completed line-by-line review on the supplied source code to ensure compliance with the state-defined performance measure specifications. HSAG

^{A-2} The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements*, November 1, 2021. Available at: <https://www.cms.gov/files/document/mmpcorereportingrequirements2023.pdf>. Accessed on: Mar 11, 2024.

^{A-3} The Centers for Medicare & Medicaid Services. *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements*, February 28, 2023. Available at: <https://www.cms.gov/files/document/mireportingrequirements02282023.pdf>. Accessed on: Mar 11, 2024.

identified areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). ICOs that did not use computer programming language to report the performance measures were required to submit documentation describing the actions taken to report each measure.

- **Medical record documentation**—As applicable, the ICOs submitted the following documentation for review: medical record hybrid tools, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from the hybrid sample to ensure the accuracy of the hybrid data being abstracted by the ICOs. HSAG followed the CMS EQR Protocol 2 and NCQA guidelines to validate the integrity of the ICOs' medical record review validation (MRRV) processes and used the MRRV results to determine if the findings impacted the performance measure rates' audit results.
- **Performance measure reports**—HSAG also reviewed the ICOs' SFY 2022 performance measure reports. The previous year's reports were used along with the current reports to assess trending patterns and rate reasonability.
- **Supporting documentation**—The ICOs submitted documentation to HSAG that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up. This additional documentation also included measure-level detail files provided for each measure for data verification.

Performance Measure Activities

HSAG conducted PMV virtually with each ICO. HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities are described as follows:

- **Opening session**—The opening session included introductions of the validation team and key ICO staff members involved in the PMV activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the IS, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and report the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether denominators were identified correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key ICO staff members familiar with the processing, monitoring, and reporting of the performance measures. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the

analytic file used for reporting the performance measures was generated. HSAG performed PSV to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.

- **PSV**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each ICO provided HSAG with measure-level detail files which included the data the ICOs had reported to MDHHS. HSAG selected a random sample from the submitted data, then requested that the ICOs provide proof-of-service documents or system screen shots that allowed for validation against the source data in the system. During the pre-PMV and virtual review, these data were also reviewed for verification, both live and using screen shots in the ICOs' systems, which provided the ICOs an opportunity to explain processes regarding any exception processing or any unique, case-specific nuances that may not impact final measure reporting. Instances could exist in which a sample case is acceptable based on clarification during the virtual review and follow-up documentation provided by the ICOs. Using this technique, HSAG assessed the ICOs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the ICOs have system documentation which supports that the measures appropriately include records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the virtual meeting and reviewed the documentation requirements for any post-virtual review activities.

Virtual Review Activities

- **Follow-up Documentation**—The ICOs had at least three business days after the virtual review to submit all follow-up items to HSAG. Follow-up documentation submitted by each ICO was reviewed by HSAG. This follow-up review was conducted to confirm information provided during the virtual review by the ICO. In instances when the follow-up documentation did not meet requirements to complete the validation process, additional documentation and questions were requested by HSAG, or an additional virtual review was recommended. In certain instances, ICOs had to provide multiple rounds of follow-up documentation when the prior submission failed to provide HSAG with the necessary information or data.

Final Validation Results

Based on the validation activities described above, HSAG provided each ICO a validation designation for Core Measure 9.3, MI2.6, MI 5.6, and MI7.3. The ICO received a validation designation of either

Reportable (R), *Do Not Report (DNR)*, or *Not Applicable (NA)* for each performance measure. Table A-3 includes a definition of each validation designation.

Table A-3—Measure-Specific Validation Designations

| Validation Designation | Definition |
|----------------------------|--|
| REPORTABLE (R) | Measure was compliant with State and federal specifications. |
| DO NOT REPORT (DNR) | ICO rate was materially biased and should not be reported. |
| NOT APPLICABLE (NA) | The ICO was not required to report the measure. |

According to the protocol, the validation designation for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *DNR* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of *R*.

Description of Data Obtained and Related Time Period

HSAG validated data submitted for the appropriate quarterly and CY reporting periods. The reporting periods and are specified in Table A-4.

Table A-4—Reporting Periods

| Performance Measure | Reporting Period |
|---------------------|------------------|
| Core Measure 9.3 | CY 2022 |
| MI2.6 | CY 2022 |
| MI5.6 | CY 2022 |
| MI7.3 | CY 2022 |

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, or *Not Applicable*. HSAG further analyzed the qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support

improvement in the quality, timeliness, and accessibility of care and services furnished to ICO Medicaid members.

Performance Measure Rates

Activity Objectives

HSAG completed a review of each ICO's performance measure data that was audited by an organization licensed to conduct NCQA HEDIS Compliance Audits^{TM.A-4} for 2022, as provided by MDHHS, for the SFY 2023 EQR.

Technical Methods of Data Collection and Analysis

MDHHS and CMS required each ICO to contract with an organization licensed by NCQA to conduct HEDIS Compliance Audits and undergo a full audit of its HEDIS reporting process. For this EQR technical report, HSAG reviewed HEDIS MY 2022 performance data for each ICO, as well as statewide comparison data, to assess performance in the areas of prevention and screening, respiratory conditions, cardiovascular conditions, diabetes, musculoskeletal conditions, behavioral health, medication management and care coordination, overuse/appropriateness, access/availability of care, and utilization. These data were compiled by a CMS vendor and provided to MDHHS, and subsequently to HSAG, for inclusion into this EQR.

Description of Data Obtained and Related Time Period

In accordance with the Three-Way Contract between CMS, MDHHS, and each ICO, HEDIS data must be reported consistent with Medicare requirements. The ICOs are required to report a combined set of core measures annually. For this EQR, HSAG reviewed HEDIS MY 2022 reported data.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG analyzed the results of the ICO's HEDIS MY 2022 performance measure rates and 2022 performance levels based on comparisons to HEDIS MY 2021 performance levels and MY 2022 statewide averages to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of, timeliness of, and access to care and services furnished to ICO Medicaid members.

^{A-4} HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the ICOs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the six ICOs contracted with MDHHS to deliver services to MI Health Link members. HSAG followed the guidelines set forth in CMS EQR Protocol 3.

The SFY 2023 compliance review is the second year of the three-year cycle of compliance reviews. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific requirements. The compliance reviews for the MI Health Link program consist of 14 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first seven standards in Year One (SFY 2022) and a review of the remaining seven standards in Year Two (SFY 2023). In Year Three (SFY 2024), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2022 and SFY 2023 compliance reviews.

As demonstrated in Table A-5, HSAG completed a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358 within a three-year period.

Table A-5—Current Three-Year Cycle (SFY 2022–SFY 2024)

| Standard | Associated Federal Citations ¹ | Year One (SFY 2022) | Year Two (SFY 2023) | Year Three (SFY 2024) |
|---|---|---------------------|---------------------|--|
| Standard I—Disenrollment: Requirements and Limitations | §438.56 | ✓ | | Review of ICOs' implementation of Year One and Year Two CAPs |
| Standard II—Member Rights and Member Information | §438.10 §438.100 | ✓ | | |
| Standard III—Emergency and Poststabilization Services | §438.114 | ✓ | | |
| Standard IV—Availability of Services | §438.206 | ✓ | | |
| Standard V—Assurances of Adequate Capacity and Services | §438.207 | ✓ | | |
| Standard VI—Coordination and Continuity of Care | §438.208 | ✓ | | |
| Standard VII—Coverage and Authorization of Services | §438.210 | ✓ | | |
| Standard VIII—Provider Selection | §438.214 | | ✓ | |
| Standard IX—Confidentiality | §438.224 | | ✓ | |
| Standard X—Grievance and Appeal Systems | §438.228 | | ✓ | |

| Standard | Associated Federal Citations ¹ | Year One (SFY 2022) | Year Two (SFY 2023) | Year Three (SFY 2024) |
|---|---|---------------------|---------------------|-----------------------|
| Standard XI—Subcontractual Relationships and Delegation | §438.230 | | ✓ | |
| Standard XII—Practice Guidelines | §438.236 | | ✓ | |
| Standard XIII—Health Information Systems ² | §438.242 | | ✓ | |
| Standard XIV—Quality Assessment and Performance Improvement Program | §438.330 | | ✓ | |

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

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

MDHHS and the individual ICOs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the ICOs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the SFY 2023 compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the Three-Way Contract agreement among CMS, the State of Michigan, and the ICOs as they related to the scope of the review. The review processes used by HSAG to evaluate the ICOs’ compliance were consistent with the CMS EQR Protocol 3.

For each of the ICOs, HSAG’s desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the ICO a detailed timeline, description of the compliance review process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the ICO.
- Hosted a pre-site review preparation session with all ICOs.

- Generated a sample of cases for grievances, appeals, credentialing, and delegation for case file reviews.
- Conducted a desk review of supporting documentation the ICO submitted to HSAG.
- Followed up with the ICO, as needed, based on the results of HSAG’s preliminary desk review.
- Developed an agenda for the site review interview sessions and provided the agenda to the ICO to facilitate preparation for HSAG’s review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG’s review activities.
- Interviewed ICO key program staff members.
- Conducted a review of grievance, appeal, credentialing, and delegation records.
- Conducted an IS review of the data systems that the ICO used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the ICO.
- Documented findings and assigned each element a score (*Met*, *Not Met*, or *NA*) as described in the below Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an ICO-specific report and CAP template for the ICO to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the ICO’s performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an ICO during the period covered by HSAG’s review. This scoring methodology is consistent with CMS EQR Protocol 3.

Table A-6—Scoring Methodology

| Compliance Score | Point Value | Definition |
|------------------|-----------------|--|
| <i>Met</i> | Value = 1 point | <p><i>Met</i> indicates “full compliance” defined as <i>all</i> of the following:</p> <ul style="list-style-type: none"> • All documentation listed under a regulatory provision, or component thereof, is present. • Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation. |

| Compliance Score | Point Value | Definition |
|-----------------------|------------------|--|
| | | <ul style="list-style-type: none"> Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement. |
| <i>Not Met</i> | Value = 0 points | <p><i>Not Met</i> indicates “noncompliance” defined as <i>one or more</i> of the following:</p> <ul style="list-style-type: none"> There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews. Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice. Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement. No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. For those provisions with multiple components, key components of the provision could not be identified and any <i>Not Met</i> findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components. |
| <i>Not Applicable</i> | No value | <ul style="list-style-type: none"> The requirement does not apply to the ICO line of business during the review period. |

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements not applicable to the ICO were scored *NA* and were not included in the denominator of the total score.

HSAG determined the overall compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the ICO’s records for grievances, appeals, credentialing, and delegation to verify that the ICO had put into practice what the ICO had documented in its policies. HSAG selected 10 records each for grievances and appeals; five records each for initial practitioner credentialing, practitioner recredentialing, initial organizational credentialing, and organizational recredentialing; and three records for delegation from the full universe of records provided by the ICO. The file reviews were

not intended to be a statistically significant representation of all the ICO's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by ICO staff members. Based on the results of the file reviews, the ICO must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the ICO provided to members, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the ICO's progress in achieving compliance with State and federal requirements.
- Scores assigned to the ICO's performance for each requirement.
- The total compliance score calculated for each standard.
- The overall compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Corrective Action Plan Process:

HSAG created a CAP template that contained the findings and required actions for each element scored *Not Met*. When submitting its CAP to MDHHS and HSAG, the ICOs must use this template to propose its plan to bring all elements scored as *Not Met* into compliance with the applicable standard(s). The CAP process included the following activities:

- ICOs completed the CAP template describing the action plans to be implemented to remediate each deficient element.
- HSAG and MDHHS reviewed the ICOs' action plans for each deficient element and assigned each element a designation of *Accepted*, *Accepted With Recommendations*, or *Not Accepted*.
- For any deficient element that received a designation of *Not Accepted*, the ICOs were required to revise the CAP until HSAG and MDHHS determined the action plan is sufficient to ensure compliance with the requirements of the element.
- ICOs were required to submit periodic progress updates to report the status of each action plan to HSAG and MDHHS.

Follow-Up on Recommendations Process:

HSAG created a Follow-Up on Recommendations template that contained the findings and recommendations for each element, whether the element scored *Met* or *Not Met*. When submitting its Follow-Up on Recommendations to MDHHS and HSAG, the ICOs must use this template to propose its

plan to address all elements with recommendations for program enhancement for each applicable standard. The Follow-Up on Recommendations process included the following activities:

- The ICOs completed the Follow-Up on Recommendations template describing the action plans to be implemented to address each recommendation.
- HSAG and MDHHS reviewed the ICOs’ action plans for each recommendation and provided a response indicating whether or not the plans were sufficient.
- The ICOs were required to submit periodic progress updates to report the status of each action plan to HSAG and MDHHS.

Description of Data Obtained and Related Time Period

To assess the ICO’s compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the ICO, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for credentialing and recredentialing, grievances and appeals, and contracts with delegated entities.
- Online member handbook and provider directory.

HSAG obtained additional information for the compliance review through IS reviews of the ICO’s data systems and through interactions, discussions, and interviews with the ICO’s key staff members. Table A-7 lists the major data sources HSAG used to determine the ICO’s performance in complying with requirements and the time period to which the data applied.

Table A-7—Description of ICO Data Sources and Applicable Time Period

| Data Obtained | Time Period to Which the Data Applied |
|--|--|
| Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during and after the site review | July 1, 2022–February 28, 2023 |
| Information obtained through interviews | June 5–15, 2023 |
| Information obtained from a review of a sample of grievances, appeals, and credentialing records | Listing of all records closed between July 1, 2022–February 28, 2023 |
| Information obtained from a review of a sample of delegated entity files | Listing of all delegates serving the MI Health Link program at any time between July 1, 2022–February 28, 2023 |

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each ICO individually, HSAG used the results of the comprehensive case file reviews for seven program areas. For any program area that was determined to be out of compliance, the ICOs were required to submit a CAP, and for any recommendations to enhance program areas, the ICOs were required to submit a Follow-Up on Recommendations template.

HSAG determined each ICO's substantial strengths and weaknesses as follows:

- Strength—Any program area that achieved 100 percent compliance.^{A-5}
- Weakness—Any program area that received more than three *Not Met* elements.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that the ICO provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the ICO's Medicaid members.

Network Adequacy Validation

Time/Distance and Provider Capacity Analysis

Activity Objectives

HSAG's SFY 2023 NAV validated the ICOs' Medicaid and LTSS networks, which included providers under contract and members currently in the program as of August 1, 2023, using time/distance and provider capacity analyses for the 25 Medicaid and LTSS provider types listed below. HSAG used the MI Health Link member data supplied by each ICO when calculating time/distance results. Member data were limited to only those individuals residing in a county covered by the ICO's MI Health Link region. To assess the network requirement of a minimum of 90 percent of members within 30 miles or 30 minutes of a given provider type, HSAG calculated travel times and distances from residential addresses for each ICO's region-specific members to the service addresses for the ICO's network data for each of the following provider types:

- Adult Day Program

^{A-5} For Standard I—Disenrollment: Requirements and Limitations and Standard III—Emergency and Poststabilization Services, there were noted opportunities for all ICOs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the ICOs' services; therefore, full compliance in this program area is not considered a strength within this annual EQR, and the ICOs' progress in implementing HSAG's recommendations in this program area will be further assessed for continued compliance in future reviews.

- Dental (preventive and restorative)
- Eye Examinations
- Eye Wear (providers dispensing eyeglasses and contact lenses)
- Hearing Aids
- Hearing Examinations

HSAG considered an ICO's region to have a network deficiency for these provider types when fewer than 90 percent of the members residing in the region were within 30 miles of driving distance or 30 minutes from the nearest two providers.

For the below provider types with no time/distance requirements but where the providers still need to be within a reasonable traveling distance from members, HSAG identified providers outside of the 30-mile distance from the region borders or provider records listing post office (PO) boxes in lieu of physical addresses for MDHHS' information and applied exclusions on a case-by-case basis according to MDHHS' discretion. HSAG proceeded with the NAV analyses and assessed the ICOs' network adequacy in each region according to the established minimum network capacity standards (at least two providers located in each region for each ICO).

- Chore Services
- Environmental Modifications
- ECLS
- NEMT
- Non-Medical Transportation (waiver services only)
- Personal Care Services
- Preventive Nursing Services
- Private Duty Nursing
- Respite
- Skilled Nursing Home

For each of the following provider types, services can be rendered from any location or can be delivered to the member from any location. Therefore, while ICOs are required to have at least two providers contracted to deliver services to MI Health Link members in each region, the contracted providers are not required to have a physical address within the region or within the 30-mile minimum travel distance from the region borders. HSAG proceeded with the NAV analyses, regardless of provider location, and assessed the ICOs' network adequacy in each region according to the established minimum network adequacy capacity standards (at least two providers contracted to serve members in each region for each ICO).

- Adaptive Medical Equipment and Supplies
- Assistive Technology—Devices
- Assistive Technology—Van Lifts and Tie Downs

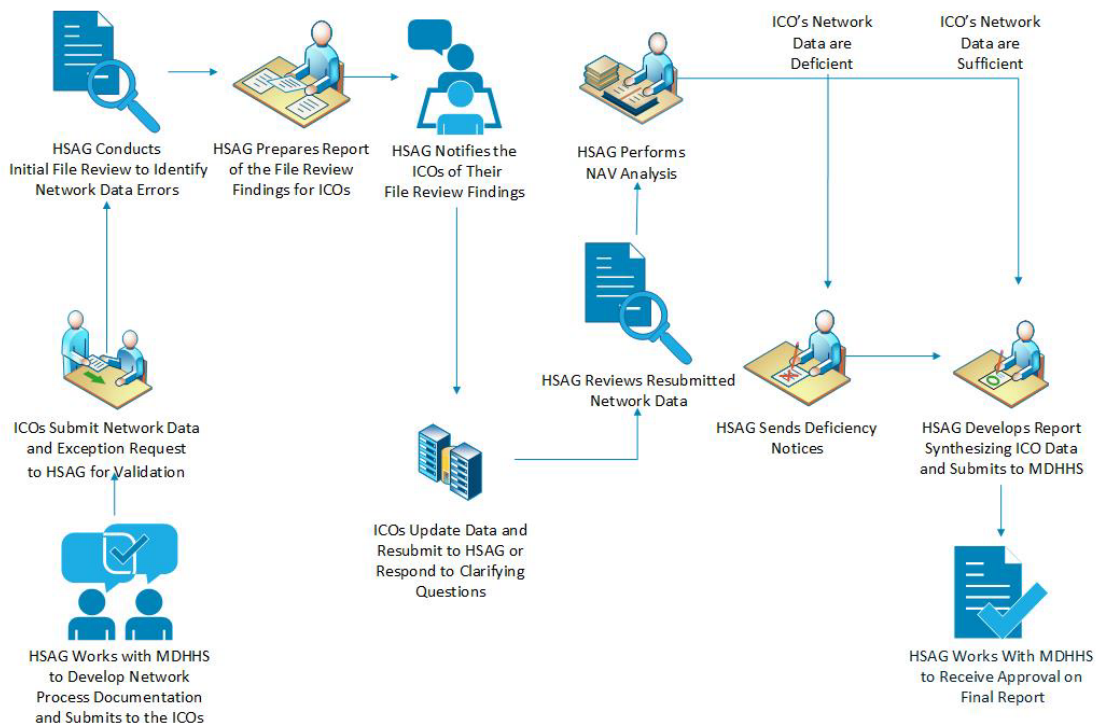
- Community Transition Services
- Fiscal Intermediary
- Home Delivered Meals
- Medical Supplies
- MIHP Agency^{A-6}
- Personal Emergency Response System

Technical Methods of Data Collection

Using an MDHHS-approved ICO Document Request and MI Health Link NAV Microsoft Excel Template, each ICO submitted a region-specific electronic listing to HSAG and MDHHS of all providers and facilities that had a signed contract with the ICO to participate in MI Health Link. Each ICO also submitted an electronic listing of all members assigned to the ICO for the specified MI Health Link region.

Beginning in the lower-left corner, Figure A-1 summarizes HSAG’s SFY 2023 NAV process.

Figure A-1—SFY 2023 NAV Process



^{A-6} ICOs must contract with at least two MIHP agencies listed in the MIHP Directory for each applicable service region to meet the network adequacy requirement for the MIHP Agency provider type.

To initiate the NAV activity, each ICO submitted member and network provider data files and exception requests to HSAG in September 2023, followed by an initial data file review. Following the initial data file review, HSAG requested that applicable ICOs submit updated data files and/or exception^{A-7} requests during October 2023 to address potential data quality and validity concerns prior to completing the NAV analyses.

After final data submission, HSAG validated that the ICOs' data files reflected a provider network that met the MI Health Link minimum network requirements for each Medicaid and LTSS provider type:

- For the seven provider types that typically require members to travel to receive services at a provider's location (i.e., provider types with travel time/distance requirements), HSAG considered an ICO's region to have a network deficiency for these provider types when fewer than 90 percent of the members residing in the region were within 30 miles of driving distance or 30 minutes from the nearest two providers.^{A-8}
- For the 10 provider types with no time/distance requirements but still needed to be within a reasonable traveling distance from members, HSAG identified providers outside of the 30-mile distance from the region borders or provider records listing PO boxes in lieu of physical addresses for MDHHS' information and applied exclusions on a case-by-case basis according to MDHHS' discretion. HSAG proceeded with the NAV analyses and assessed the ICOs' network adequacy in each region according to the established minimum network capacity standards (at least two providers located in each region for each ICO).
- For the eight provider types where services can be rendered from any location or can be delivered to the member from any location, the ICOs were required to have at least two providers contracted to deliver services to MI Health Link members in each region. Therefore, it was not required that the contracted providers have a physical address within the region or within the 30-mile minimum travel distance from the region borders. HSAG proceeded with the NAV analysis, regardless of provider location, and assessed the ICO's network adequacy in each region according to the established minimum network capacity standards (at least two providers located in each region for each ICO).

Upon receipt of the ICOs' Excel template files, HSAG reviewed the data to ensure that all worksheets were populated as requested. HSAG collaborated with MDHHS to identify the data validation checks that HSAG would apply to assess the ICOs' fidelity to the data submission instructions and identify potential data anomalies (e.g., invalid NPI or provider taxonomy code values).

^{A-7} MDHHS allowed the ICOs to request exceptions to the minimum network requirements for any provider types for which there are known network access gaps. Exception requests were allowed when the ICO had contracted to the fullest extent of the available providers but was unable to meet the minimum network requirements.

^{A-8} If a region did not contain an adequate number of providers to meet the travel time/distance requirement, MDHHS required the ICO to submit an exception request to HSAG. Historically, this situation is not unusual for Adult Day Program and MIHP Agency provider types. MDHHS directed HSAG to deem the ICO compliant with the travel time/distance requirement if the ICO's exemption request indicates that the ICO attempted to contract or hold contracts with all available providers in the region.

Following these data validation checks, HSAG communicated via email with each ICO to address any questions regarding the data file that may have affected the NAV calculations (e.g., use of an incorrect data template, missing provider types, or unexpected data values) and to request a resubmission of data to meet the needs of the NAV activity, if needed.

MDHHS Follow-Up Process—To address any network adequacy-related concerns, MDHHS requested the ICOs provide information to ensure the ICOs maintained accountability and were addressing any areas of the network with noted gaps. MDHHS specifically required the ICOs to provide documentation on any provider type for which the ICO was noncompliant with minimum provider network requirements and an exception request was submitted. The ICOs had to provide responses to the following questions for noncompliant providers:

- What is your ICO doing to close this provider type network gap?
- When does your ICO anticipate the gap to be closed?
- What is your ICO doing to ensure members are able to easily and timely access these services before the coverage gap is closed?

The ICOs had to provide responses to the following questions for providers with exceptions:

- What does your ICO do to increase the number of contracted providers?
- How does your ICO ensure you are contracted with all available providers?
- What does your ICO do to ensure there are no gaps in access to care/access to services for this provider type?
- How does your ICO assist members in timely access to care/services for this provider type?
- How does your ICO track any issues members might experience trying to access these services?
- How does your ICO address these issues?

Description of Data Obtained and Related Time Period

During September 2023, the ICOs supplied HSAG and MDHHS with the following data:

- Member data reflecting all members assigned to the ICO as of August 1, 2023.
- Provider data reflecting the 25 Medicaid and LTSS provider types for all providers and facilities that had a signed contract with the ICO to participate in the MI Health Link program as of August 1, 2023, through at least September 1, 2023.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG calculated region-specific time/distance results and capacity results for each provider type and ICO. HSAG then compared these analytic results to MDHHS' minimum network standards and identified the ICOs that failed to meet the minimum network requirements. HSAG determined each ICO's substantial strengths and weaknesses by considering the degree to which the ICO

met minimum network requirements for its regional geographical area(s) and the exceptions or extensions determined by MDHHS.

Secret Shopper Survey

Activity Objectives

The primary purpose of the SFY 2023 secret shopper survey was to collect appointment availability information for preventive dental visits among new patients enrolled with an ICO under the MI Health Link program. As a secondary survey objective, HSAG evaluated the accuracy of selected provider data elements related to members' access to dental care. Specific survey objectives included the following:

- Determine whether dental service locations accept patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligns with the ICOs' provider data.
- Determine whether dental service locations accepting MI Health Link for the requested ICO accept new patients and the degree to which new patient acceptance aligns with the ICOs' provider data.
- Determine appointment availability with the sampled dental service locations for preventive dental care.

Technical Methods of Data Collection and Analysis

To address the survey objectives, HSAG conducted a secret shopper telephone survey of dental provider offices contracted with ICOs serving Regions 1, 4, 7, and 9. The secret shopper approach allows for objective data collection from healthcare providers while minimizing potential bias introduced by revealing the surveyor's identity. Secret shopper callers inquired about appointment availability for routine dental visits for Medicaid managed care members served by at least one of the participating ICOs.

Each ICO submitted dental provider data to HSAG, reflecting individual practitioners^{A-9} actively enrolled with the ICO to serve members in the MI Health Link program at the time the data file was created. Out-of-state dental practitioners located in Indiana, Ohio, or Wisconsin were included in the study if they were adjacent to the demonstration region and located within a reasonable distance. Dental practitioners specializing in endodontics, orthodontics, periodontics, or prosthodontics were excluded from the study. HSAG randomly selected survey cases by ICO from a de-duplicated list of unique provider locations.^{A-10}

^{A-9} HSAG identified dental practitioners from the ICOs' data based on provider type, specialty, and taxonomy code. Provider types and specialties indicating that the provider was a general dentist, pediatric dentist, or hygienist were included unless the corresponding taxonomy code was that of a student or dental specialist.

^{A-10} To minimize the number of repeat phone calls to providers, HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple regions or addresses within a plan, HSAG randomly assigned the

During the survey, HSAG's callers used an MDHHS-approved script to complete survey calls to all sampled provider locations, recording survey responses in an electronic data collection tool.

Several limitations and analytic considerations must be noted when reviewing secret shopper telephone survey results:

- Survey calls were conducted at least four weeks following HSAG's receipt of each ICO's provider data, resulting in the possibility that provider locations updated their contact information with the ICO prior to HSAG's survey calls.
- ICOs may contract the provision of dental services for its MI Health Link members with a dental benefits administrator (DBA), a vendor that maintains the dental provider network, processes payments, and provides member support. The ICOs are responsible for the oversight of vendors such as DBAs. Actions by an ICO's DBA may impact the timeliness and quality of dental provider data, and the ICOs' adherence to MDHHS' network standards. HSAG continued the survey if the location confirmed acceptance of the ICO or DBA.
- Time to the first available appointment is based on appointments requested with the sampled provider location. Cases were counted as being unable to offer an appointment if the case offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which MI Health Link members are willing to travel to an alternate location.
- Survey findings were compiled from self-reported responses supplied to HSAG's callers by the providers' office personnel. Therefore, survey responses may vary from information obtained at other times or using other data sources (e.g., the ICO's online provider directory, MDHHS' encounter data files).
- To maintain the secret nature of the survey, callers posed as members who were not existing patients at the sampled provider locations. As such, survey results may not represent appointment timeliness among members who are existing patients with these provider locations.

MDHHS CAP Requirements—Based on the survey's findings, the ICOs were required to develop and implement remediations for all identified deficiencies/cases in which HSAG was unable to reach the provider, no appointment date was offered, or the offered appointment's wait time exceeded the contractual Appointment and Timely Access to Care Standard for a new patient routine appointment (Three-Way Contract: 2.7.1.7 Exhibit 4). The ICOs were required to review the case-level analytic data file provided by MDHHS. At a minimum, the remediation plan was expected to include the following:

- The ICOs were required to correct provider data deficiencies identified during the survey (e.g., incorrect or disconnected telephone number, incorrect address, listing non-medical facility, medical facility that does not provide dental services).

number to a single region, plan, and standardized address, prioritizing assignment to the least represented plans and regions.

- Based on comparison of 2020, 2022, and 2023 results, the ICOs were required to evaluate the effectiveness of previous remediations and make appropriate modifications to the interventions in the 2023 CAP:
 - The ICOs were required to review the previous two CAPs and identify whether the cases/locations found deficient in 2023 received remediations during any of the previous two CAP cycles. As part of root cause analysis, the ICOs were required to evaluate why the previous intervention was not effective. The interventions were required to be based on root causes of the deficiency specific to each case/location.
- The ICOs were required to collect wait times for routine appointments for a new ICO/MI Health Link member for all locations that did not offer an appointment during the survey or that offered a wait time exceeding the Appointment and Timely Access to Care Standards. The ICOs were required to calculate and enter the number of calendar days between when the information was collected and when the appointment was offered.
- The ICOs were required to provide MDHHS with evidence of training offered to dental providers' offices regarding the ICO plan name, MI Health Link program, and benefit coverage.
 - Evidence was required to demonstrate that all office staff scheduling appointments were educated on the ICO name and benefit coverage, and the offices had a plan in place for educating new staff in the event of staff turnover.
- If the ICO delegated the CAP to a DBA, the ICOs were required to assign a staff member to oversee the CAP, including review of any documents submitted to MDHHS for completeness and accuracy as well as appropriateness of the intervention(s) to remediate the deficiency based on the specific root cause for each case/location.

The CAP implementation and reporting consisted of two steps:

1. **The CAP Report** was due by **October 18, 2023**. In this step, the ICOs were required to complete the Analytic Dataset + CAP Template Tab.
2. **The CAP Follow-Up Report** was due by **February 21, 2024**. In this step, within three months of completing the CAP remediations, the ICOs were required to conduct a follow-up with each deficient location to validate that the implemented interventions were effective, and location is no longer non-compliant. The follow up was to include, at a minimum, validating that the location accepts ICO and MI Health Link members and that the wait time for a new patient routine appointment is compliant with the required Appointment and Timely Access to Care Standards.

The ICOs were expected to extend all training and oversight activities implemented for the purpose of this CAP to dental providers not included in the survey's sample. The ICOs were required to provide evidence of including all MI Health Link dental provider network in CAP remediation activities.

Description of Data Obtained and Related Time Period

HSAG completed the survey calls during March and April 2023. 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 ICO provided to members, HSAG analyzed the results of the activity to determine each ICO's substantial strengths and weaknesses by assessing (1) which dental service locations accepted patients enrolled with the requested ICO for the MI Health Link program and the degree to which ICO and MI Health Link acceptance aligned with the ICOs' provider data, (2) whether dental service locations accepting MI Health Link for the requested ICO accepted new patients and the degree to which new patient acceptance aligned with the ICOs' provider data, and (3) appointment availability with the sampled dental service locations for preventive dental visits.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted ICOs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2023, MDHHS contracted with HSAG to conduct an EDV study. HSAG conducted the following two core evaluation activities for all six ICOs:

- IS review—assessment of MDHHS' and the ICOs' IS and processes. The goal of this activity is to examine the extent to which MDHHS' and the ICOs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the ICOs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

Information Systems Review

To ensure the collection of critical information, HSAG employed a three-stage process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- In Stage 1: HSAG conducted a document review, examining various documents related to MDHHS' encounter data initiatives. This review included data dictionaries, process flow charts, system

diagrams, and other relevant materials. The information from this review was used to create a questionnaire for MDHHS.

- In Stage 2: HSAG worked with MDHHS to develop a customized questionnaire that delved into specific data processing procedures, staff responsibilities, and data acquisition capabilities. This assessment also considered additional data systems and key topics important to MDHHS.
- In Stage 3: HSAG followed up with key staff members to clarify questionnaire responses. These follow ups allowed HSAG to document current processes and create a process map highlighting crucial factors affecting the quality of encounter data submissions.

Administrative Profile

HSAG submitted a data submission requirements document to notify MDHHS of the required data needed. The data submission requirements document was developed based on the study objectives and data elements to be evaluated in the study. It included a brief description of the study, the review period, required data elements, and information regarding the submission of the requested files.

To assist MDHHS in preparing the requested data files, HSAG took two actions. First, since it was the first-time requesting data from MDHHS' warehouse, HSAG asked for test files before the complete data extraction. These smaller test files, covering a month's encounters, served two purposes. They helped detect extraction issues early and allowed HSAG to begin analysis preparations while waiting for complete data. Details were provided in the data requirements document.

Secondly, after submitting the draft data submission requirements to MDHHS, HSAG scheduled a meeting to address questions about data preparation and extraction. Depending on the complexity, an updated/final document was submitted for MDHHS review and approval.

Once the data arrived from MDHHS, HSAG conducted a preliminary file review. This ensured that the data were reasonable for evaluation, checking data extraction, field presence, and value validity. If necessary, HSAG requested data resubmission based on these results.

Once the final data had been received and processed, HSAG conducted a series of analyses for metrics listed in the sections below. In general, HSAG calculated rates for each metric by encounter type (i.e., 837P, 837I, 837 Dental [837D], National Council for Prescription Drug Programs [NCPDP]), and ICO. However, when the results indicated a data quality issue(s), HSAG conducted an additional investigation to determine whether the issue was for a specific category of service (e.g., nursing facilities, hospice), provider type (e.g., vision vendor, non-emergency medical transportation [NEMT] vendor), or subpopulation. HSAG documented all noteworthy findings in this aggregate report.

Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur or the last date of service): If the number of members remains stable and there are no major changes to

members' medical/dental needs, the monthly visit/service counts should have minimal variation. A low count for any month indicates incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key is based on the member ID, rendering provider NPI, and date of service.

- Monthly encounter volume (i.e., visits) per 1,000 member months by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each ICO based on the member enrollment data extracted by MDHHS.
- Paid amount PMPM by service month: This metric helps MDHHS determine whether the encounter data were complete from a payment perspective. Of note, HSAG used the header paid amount or detail paid amount to calculate this metric.
- Percentage of duplicate encounters: HSAG determined the detailed methodology (e.g., data elements and criteria) for defining duplicates after reviewing the encounter data extracted for the study and documented the method in the final report. This metric allows MDHHS to assess the number of potential duplicate encounters in MDHHS' database.

Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by MDHHS within 360 days from the ICO payment date, in 30-day increments. This metric allows MDHHS to evaluate the extent to which the ICOs are in compliance with MDHHS' encounter data timeliness requirements.
- Claims lag triangle to illustrate the percentage of encounters received by MDHHS within two calendar months, three months, etc., from the service month. This metric allows MDHHS to evaluate how soon it may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters were complete and accurate through the two study indicators described in Table A-8 for the key data elements listed in Table A-9. In addition, Table A-8 shows the criteria HSAG used to evaluate the validity of each data element. These criteria are based on standard reference code sets or referential integrity checks against member or provider data.

Table A-8—Study Indicators for Percent Present and Percent Valid

| Study Indicator | Denominator | Numerator |
|--|---|---|
| Percent Present: Percentage of records with values present for a specific key data element. | Total number of final paid encounter records based on the level of evaluation noted in Table A-9 (i.e., at either the header or detail line level) with dates of service in the study period. | Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-9. |
| Percent Valid: Percentage of records with values valid for a specific key data element. | Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-9. | Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-9. The criteria for validity are listed in Table A-9. |

Table A-9—Key Data Elements for Percent Present and Percent Valid

| Key Data Element | 837P Encounters | 837I Encounters | 837D Encounters | NCPDP Encounters | Criteria for Validity |
|---------------------------------------|-----------------|-----------------|-----------------|------------------|---|
| Member ID ^H | √ | √ | √ | √ | <ul style="list-style-type: none"> • In member file • Enrolled in a specific ICO on the date of service • Member date of birth is on or before date of service |
| Header Service From Date ^H | √ | √ | √ | | <ul style="list-style-type: none"> • Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date |
| Header Service To Date ^H | √ | √ | √ | | <ul style="list-style-type: none"> • Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date |
| Detail Service From Date ^D | √ | √ | √ | | <ul style="list-style-type: none"> • Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date |
| Detail Service To Date ^D | √ | √ | √ | | <ul style="list-style-type: none"> • Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date |

| Key Data Element | 837P Encounters | 837I Encounters | 837D Encounters | NCPDP Encounters | Criteria for Validity |
|---|-----------------|-----------------|-----------------|------------------|--|
| Date of Service | | | | √ | <ul style="list-style-type: none"> Detail Service To Date ≤ Paid Date |
| Billing Provider NPI ^H | √ | √ | √ | √ | <ul style="list-style-type: none"> In provider data when service occurred Meets Luhn formula requirements |
| Rendering Provider NPI ^H | √ | | √ | | <ul style="list-style-type: none"> In provider data when service occurred Meets Luhn formula requirements |
| Attending Provider NPI ^H | | √ | | | <ul style="list-style-type: none"> In provider data when service occurred Meets Luhn formula requirements |
| Referring Provider NPI ^H | √ | √ | √ | | <ul style="list-style-type: none"> In provider data when service occurred Meets Luhn formula requirements |
| Prescribing Provider NPI | | | | √ | <ul style="list-style-type: none"> In provider data when service occurred Meets Luhn formula requirements |
| Rendering Provider Taxonomy Code ^H | √ | | | | <ul style="list-style-type: none"> In standard taxonomy code set Matches the value in provider data |
| Attending Provider Taxonomy Code ^H | | √ | | | <ul style="list-style-type: none"> In standard taxonomy code set Matches the value in provider data |
| Primary Diagnosis Codes ^H | √ | √ | √ | | <ul style="list-style-type: none"> In national ICD-10-Clinical Modification (CM) diagnosis code sets for the correct code year (e.g., in 2022, code set for services that occurred between October 1, 2021, and September 30, 2022) |

| Key Data Element | 837P Encounters | 837I Encounters | 837D Encounters | NCPDP Encounters | Criteria for Validity |
|---|--------------------|--------------------|--------------------|---------------------|--|
| Secondary Diagnosis Codes ^H | √ | √ | | | <ul style="list-style-type: none"> In national ICD-10-CM diagnosis code sets for the correct code year |
| CPT/HCPCS Codes ^D | √ | √ | | | <ul style="list-style-type: none"> In national CPT/HCPCS code sets for the correct code year (e.g., in 2022, code set for services that occurred in 2022) AND satisfies CMS' PTP edits |
| Current Dental Terminology (CDT) Codes ^D | | | √ | | <ul style="list-style-type: none"> In national CDT code sets for the correct code year (e.g., in 2022, code set for services that occurred in 2022) |
| Tooth Number | | | √ | | Primary <ul style="list-style-type: none"> A–J: Maxillary K–T: Mandibular Permanent <ul style="list-style-type: none"> 1–16: Maxillary 17–32: Mandibular |
| Tooth Surface 1–5 | | | √ | | <ul style="list-style-type: none"> M—Mesial O—Occlusal D—Distal I—Incisal L—Lingual B—Buccal F—Facial (or Labial) |

| Key Data Element | 837P Encounters | 837I Encounters | 837D Encounters | NCPDP Encounters | Criteria for Validity |
|---|--------------------|--------------------|--------------------|---------------------|--|
| Oral Cavity Code | | | √ | | <ul style="list-style-type: none"> • 00—Entire oral cavity • 01—Maxillary arch • 02—Mandibular arch • 03—Upper right sextant • 04—Upper anterior sextant • 05—Upper left sextant • 06—Lower left sextant • 07—Lower anterior sextant • 08—Lower right sextant • 09—Other area of oral cavity • 10—Upper right quadrant • 20—Upper left quadrant • 30—Lower left quadrant • 40—Lower right quadrant |
| Primary Surgical Procedure Codes ^H | | √ | | | <ul style="list-style-type: none"> • In national ICD-10-CM surgical procedure code sets for the correct code year |
| Secondary Surgical Procedure Codes ^H | | √ | | | <ul style="list-style-type: none"> • In national ICD-10-CM surgical procedure code sets for the correct code year |
| Revenue Codes ^D | | √ | | | <ul style="list-style-type: none"> • In national standard revenue code sets for the correct code year |
| DRG Codes ^H | | √ | | | <ul style="list-style-type: none"> • In national standard All Patients Refined (APR)-DRG code sets for the correct code year |
| Type of Bill Codes ^H | | √ | | | <ul style="list-style-type: none"> • In national standard type of code set |
| National Drug Codes (NDCs) ^D | √ | √ | | √ | <ul style="list-style-type: none"> • In national NDC code sets |
| Submit Date ^D | √ | √ | √ | √ | <ul style="list-style-type: none"> • ICO Submission Date (i.e., the date when ICO submits encounters to MDHHS) ≥ ICO Paid Date |

| Key Data Element | 837P Encounters | 837I Encounters | 837D Encounters | NCPDP Encounters | Criteria for Validity |
|-------------------------------------|-----------------|-----------------|-----------------|------------------|---|
| ICO Paid Date ^D | √ | √ | √ | √ | • ICO Paid Date ≥ Detail Service To Date |
| Header Paid Amount ^H | √ | √ | √ | | • Header Paid Amount equal to sum of the Detail Paid Amount |
| Detail Paid Amount ^D | √ | √ | √ | | • Zero or positive |
| Paid Amount | | | | √ | • Zero or positive |
| Header TPL Paid Amount ^H | √ | √ | √ | | • Header TPL Paid Amount equal to sum of the Detail TPL Paid Amount |
| Detail TPL Paid Amount ^D | √ | √ | √ | | • Zero or positive |
| TPL Paid Amount | | | | √ | • Zero or positive |

^H Conduct evaluation at the header level

^D Conduct evaluation at the detail level

Encounter Data Referential Integrity

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID, unique provider NPI) was present in both data sources (i.e., unique member IDs that are in both the encounter and member enrollment files). If an encounter contained more than one NPI (e.g., rendering provider NPI and billing provider NPI on a professional encounter), HSAG included both unique NPIs in the analysis. Table A-10 lists the study indicators that HSAG calculated.

Table A-10—Key Indicators of Referential Integrity

| Data Source | Indicator |
|--|--|
| Medical/Dental Encounters vs Member Enrollment | <ul style="list-style-type: none"> • Direction 1: Percentage of Members With a Medical/Dental Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Medical/Dental Encounter |
| Pharmacy Encounters vs Member Enrollment | <ul style="list-style-type: none"> • Direction 1: Percentage of Members With a Pharmacy Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Pharmacy Encounter |
| Medical/Dental Encounters vs Pharmacy Encounters | <ul style="list-style-type: none"> • Direction 1: Percentage of Members With a Medical/Dental Encounter Who Also Have a Pharmacy Encounter • Direction 2: Percentage of Members With a Pharmacy Encounter Who Also Have a Medical/Dental Encounter |

| Data Source | Indicator |
|--|--|
| Medical/Dental Encounters vs Provider File | <ul style="list-style-type: none"> Direction 1: Percentage of Providers in the Medical/Dental Encounter File Who Were Also in the Provider File Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical/Dental Encounter File |
| Pharmacy Encounters vs Provider File | <ul style="list-style-type: none"> Direction 1: Percentage of Providers in the Pharmacy Encounter File Who Were Also in the Provider File Direction 2: Percentage of Providers in the Provider File Who Were Also in the Pharmacy Encounter File |

Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG developed logic-based checks to ensure the encounter data could appropriately support additional activities.

- Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provides insight into how well encounter data may be used to support future analyses, such as HEDIS performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

Description of Data Obtained and Related Time Period

Information Systems Review

Representatives from each ICO completed the MDHHS-approved questionnaire and then submitted their responses and relevant documents to HSAG for review. Of note, the questionnaire included an attestation statement for the ICO's chief executive officers or responsible individuals to certify that the information provided was complete and accurate.

Administrative Profile

Data obtained from MDHHS included:

- Claims and encounter data with dates of service from October 1, 2021, through September 30, 2022.
- Member demographic and enrollment data.
- Provider data.

Process for Drawing Conclusions

Information Systems Review

HSAG compiled findings from the review of the received questionnaire responses, identifying critical points that affected the submission of quality encounter data. HSAG made conclusions based on CMS EQR Protocol 5, the ICO contract, MDHHS' data submission requirements (e.g., companion guides), and HSAG's experience working with other states regarding the IS review.

Administrative Profile

To draw conclusions about the quality of each ICO's encounter data submissions to MDHHS, HSAG evaluated the results based on the predefined study and/or key metrics described above. To identify substantial strengths and weaknesses, HSAG assessed the results based on its experience in working with other states in assessing the completeness, accuracy, and timeliness of the ICOs' encounter data submissions to MDHHS. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to MDHHS.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

The goal of the HCBS CAHPS Survey is to gather direct feedback from MI Health Link HCBS C-waiver program members receiving HCBS about their experiences and the quality of the LTSS they receive. The survey provides state Medicaid agencies with standard individual experience metrics for HCBS programs that are applicable to all populations served by these programs, including frail elderly and people with one or more disabilities, such as physical disabilities, cognitive disabilities, intellectual impairments, or disabilities due to mental illness.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the HCBS CAHPS Survey. The method of data collection for the surveys was via computer assisted telephone interviewing, known as computer-assisted telephone interviewing (CATI). Members could complete the survey over the telephone in either English or Spanish. Prior to survey administration, a pre-notification letter was sent out to members alerting them to expect a telephone call to complete the survey, and assured members that the survey was sponsored by the federal government and endorsed by MDHHS. For the HCBS CAHPS Survey, HSAG sampled MI Health Link adult members who were enrolled in the HCBS C-

waiver program at any time during the measurement period (i.e., November 18, 2022, to March 17, 2023) and receiving at least one qualifying service.^{A-11}

The survey questions were categorized into various measures of member experience. The survey included 96 core questions that yielded 19 measures. These measures included three global ratings, seven composite measures, three recommendation measures, five unmet need measures, and one physical safety measure. The global ratings reflect overall member experience with the personal assistance and behavioral health staff, homemaker, and case manager. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Helpful Case Manager* or *Personal Safety and Respect*). The recommendation measures evaluate whether a member would recommend their personal assistance and behavioral health staff, homemaker, or case manager to family and friends. The unmet need measures assess whether certain needs are not being met due to lack of staff. The physical safety measure evaluates whether any staff hit or hurt the member.

Description of Data Obtained and Related Time Period

The survey was administered to eligible adult members in the MI Health Link ICOs from May to July 2023.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each ICO provided to members, HSAG evaluated the top-box scores^{A-12} for each measure assigned to one or more of these three domains depicted in Table A-11.

Top-box scores represent the percentage of eligible respondents who answered with the most positive response. Top-box responses were defined as follows:

- “9” or “10” for the standard Global Rating response or “Excellent” for the alternative response option.
- “Always,” “Yes,” or “All” for the standard Composite Measure response, or “Mostly yes” for the alternative response option.
- “Definitely yes” for the standard Recommendation Measure response.
- “Yes” for Question 27 in the *No Unmet Need in Toileting* measure.

^{A-11} The eligible criteria for the 2023 survey were different than the 2022 and 2021 surveys. In 2022 and 2021, the eligible population included all MI Health Link program members receiving at least one qualifying personal care service or enrolled in the MI Health Link HCBS C-waiver program. In 2023, the eligible population was limited to only the MI Health Link HCBS C-waiver program members receiving qualifying services. Caution should be exercised when comparing 2023 results to the 2022 and 2021 results.

^{A-12} HSAG updated its analysis of 2023 results from mean scores to top-box scores, and recalculated the 2022 and 2021 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability.

For reverse coded response options, the top-box responses were defined as follows:

- “No” for the standard Physical Safety Measure response and standard Unmet Need Measure response.
- “Never” or “Mostly no” for Question 29 and Question 42 in the *Staff Listen and Communicate Well* composite measure.
- “No” for Question 65 and Question 68 in the *Personal Safety and Respect* composite measure.
- “No” for Question 79 in the *Planning Your Time and Activities* composite measure.

HSAG performed significance testing to determine whether results in 2023 were statistically significantly different from results in 2022 and 2021, and the 2021 AHRQ Top-Box Aggregate.^{A-13}

Table A-11—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

| CAHPS Topic | Quality | Timeliness | Access |
|--|---------|------------|--------|
| Global Ratings | | | |
| <i>Rating of Personal Assistance and Behavioral Health Staff</i> | ✓ | | |
| <i>Rating of Homemaker</i> | ✓ | | |
| <i>Rating of Case Manager</i> | ✓ | | |
| Composite Measures | | | |
| <i>Reliable and Helpful Staff</i> | ✓ | ✓ | |
| <i>Staff Listen and Communicate Well</i> | ✓ | | |
| <i>Helpful Case Manager</i> | ✓ | | |
| <i>Choosing the Services that Matter to You</i> | ✓ | | ✓ |
| <i>Transportation to Medical Appointments</i> | ✓ | | ✓ |
| <i>Personal Safety and Respect</i> | ✓ | | |
| <i>Planning Your Time and Activities</i> | | | ✓ |
| Recommendation Measures | | | |
| <i>Recommend Personal Assistance/Behavioral Health Staff</i> | ✓ | | |
| <i>Recommend Homemaker</i> | ✓ | | |
| <i>Recommend Case Manager</i> | ✓ | | |
| Unmet Need Measures | | | |
| <i>No Unmet Need in Dressing/Bathing</i> | ✓ | | |
| <i>No Unmet Need in Meal Preparation/Eating</i> | ✓ | | |
| <i>No Unmet Need in Medication Administration</i> | ✓ | | |

^{A-13} The HCBS CAHPS Database benchmark (i.e., AHRQ Top-Box Aggregate) was not available for 2023 at the time this report was prepared; therefore, 2021 data were used for this comparative analysis. Caution should be exercised when comparing the 2021 HCBS CAHPS Database benchmarks to the 2023 results.

| CAHPS Topic | Quality | Timeliness | Access |
|---|---------|------------|--------|
| <i>No Unmet Need in Toileting</i> | ✓ | | |
| <i>No Unmet Need with Household Tasks</i> | ✓ | | |
| Physical Safety Measure | | | |
| <i>Not Hit or Hurt by Staff</i> | ✓ | | |